Report of the Vermont State Auditor

September 15, 2011

MEDICAID

Many Provider Enrollment and Claims Controls in Place, but Gaps Exist

Thomas M. Salmon, CPA
Vermont State Auditor
Rpt. No. 11-5

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THOMAS M. SALMON, CPA
STATE AUDITOR

STATE OF VERMONT
OFFICE OF THE STATE AUDITOR

September 15, 2011

The Honorable Shap Smith
Speaker of the House of Representatives

The Honorable John Campbell
President Pro Tempore of the Senate

The Honorable Peter Shumlin
Governor

Mr. Douglas Racine
Secretary, Agency of Human Services

Mr. Mark Larson
Commissioner, Department of Vermont Health Access

Mr. Armando Vilaseca
Commissioner, Department of Education

Dear Colleagues,

As you are aware, the Medicaid program annually consumes a substantial amount of federal and state resources. Unfortunately, programs with significant expenditures can also attract unqualified, dishonest, and unethical individuals who try to take advantage of weak and ineffective controls. One of the ways that the state can combat attempts by such individuals to defraud the Medicaid program is to employ strong and consistently applied controls over provider enrollment and claims processing.

This report evaluates the controls the state has in place related to Medicaid providers. It looks at both the provider enrollment process as well as the claims processing edits that are provider-related. In general, we found that the Department of Vermont Health Access, the Department of Education, and the state's fiscal agent, HP Enterprise Services, have implemented many controls in these areas, but there are gaps that exist that could be intentionally or unintentionally exploited. Accordingly, we are making a number of recommendations geared towards closing these gaps and strengthening controls.

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To complete this project, we received the cooperation of many organizations throughout state government, including the Department of Health, Department of Disabilities, Aging, and Independent Living, Department for Children and Families, Department of Mental Health, and the Office of the Secretary of State. I would like to particularly acknowledge the high level of cooperation that we received and thank the management and staff of the Department of Vermont Health Access, the Department of Education, and HP Enterprise Services.

If you would like to discuss any of the issues raised by this audit, I can be reached at (802) 828-2281 or auditor@state.vt.us.

Sincerely,

Thomas M. Salmon, CPA
Vermont State Auditor

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Abbreviations

AHS	Agency of Human Services
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Act
CMS	Centers for Medicare and Medicaid Services
CRNA	Certified Registered Nurse Anesthetist
DAIL	Department of Disabilities, Aging, and Independent Living
DEA	Drug Enforcement Administration
DOE	Department of Education
DVHA	Department of Vermont Health Access
EPLS	Excluded Parties List System
ESC	Error Status Code
HPES	HP Enterprise Services
IEP	Individualized Education Plan
LEIE	List of Excluded Individuals/Entities
MED	Medicare Exclusion Database
MMIS	Medicaid Management Information System
OIG	Office of the Inspector General
OPR	Office of Professional Regulation

Introduction

In fiscal year 2010, about $1.24 billion was expended on Vermont's Medicaid program, a joint federal/state program that provides health insurance to certain low-income individuals. Of this amount, about $375 million came from state funds and the rest from the federal government. The federal government's Centers for Medicare and Medicaid Services (CMS) is responsible for overseeing the program at the federal level while each state administers its Medicaid program in accordance with a State Plan within broad federal requirements. Vermont's State Plan names the Agency of Human Services (AHS) as the single designated Medicaid agency for the state. Within AHS, the Department of Vermont Health Access (DVHA) is responsible for the management of Vermont's publicly funded health insurance programs, including Medicaid.[1] DVHA, in turn, utilizes HP Enterprise Services (HPES) as its fiscal agent to operate the state's Medicaid Management Information System (MMIS) for the purpose of paying Medicaid and other state health care claims, enrolling providers, and managing provider communications.

The enormity of the expenditures in the Medicaid program attracts certain individuals and entities that may seek to exploit this program for financial gain. According to the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, the parent department of CMS, "a small percentage of providers and suppliers intent on defrauding [the Medicare[2] and Medicaid programs] has exploited weaknesses in the enrollment process, causing significant harm." The OIG's work has identified weaknesses in provider and supplier enrollment that enable unqualified, dishonest, and unethical individuals to access a system they can easily exploit. The U.S. Government Accountability Office has designated the Medicaid program as a high-risk area due to concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate spending.[3] For example, the federal Department of Health and Human Services estimated that the federal share of Medicaid improper payments in federal fiscal year

[1]There are a wide variety of state programs that encompass the Medicaid program in Vermont, including traditional Medicaid, Dr. Dynasaur, and the Vermont Health Access Plan.

[2]Medicare is the federally financed health insurance program for persons age 65 or older, certain individuals with disabilities, and individuals with end-state renal disease.

[3]*High-Risk Series: An Update* (U.S. Government Accountability Office, GAO-11-278, February 2011).

2010 was $22.5 billion.[4] While this indicates a substantial level of financial risk, differences in program design can lead to differences in state programs' vulnerabilities to improper payments and state approaches to protecting the program.

The OIG has identified five principles for designing integrity safeguards, including enrollment—the process of scrutinizing individuals and entities that seek to participate as providers and suppliers before they can enroll in health care programs.[5] According to the OIG, ensuring adequate and appropriate provider and supplier enrollment standards is an essential key step to strengthening the integrity of Medicaid programs. Our audit objective related to this important principle, namely to ascertain the effectiveness of the processes and controls in place to ensure that only legitimate Medicaid providers are paid claims for services they are entitled to perform.

To address our objective, we reviewed federal and state regulations, rules,[6] guidance, and procedures related to provider enrollment. We obtained electronic copies of Medicaid provider records as of February 25, 2011, and performed a variety of tests of this data. In particular, we compared the providers in the provider files to applicable license databases at the Board of Medical Practice and the Secretary of State's Office of Professional Regulation (OPR).[7] We also obtained an electronic copy of claims paid in calendar years 2009 and 2010. As part of assessing Medicaid claims processing, we reviewed edits related to providers in the system used by HPES to process and pay claims. We interviewed DVHA and other state officials as well as HPES provider services, claims, and system staff. Appendix I contains additional detail on our scope and methodology.

[4]In its *FY 2010 Agency Financial Report* (November 15, 2010), the Department of Health and Human Services calculated and reported the 3-year (2008, 2009, and 2010) weighted average national payment error rate for Medicaid of 9.4 percent.

[5]The four other principles are payment, compliance, oversight, and response.

[6]Shortly after the start of our audit, CMS published a final rule providing for additional provider screening requirements in the Medicare and Medicaid programs, effective March 25, 2011. We used the new standards in our audit if they pertained to screening processes already employed by DVHA or HPES (e.g., checking whether a provider is excluded from participation in federal health care programs). We did not evaluate new screening processes required by this rule (e.g., site visits to certain providers) because DVHA was in the process of evaluating how it would meet these new requirements.

[7]We did not validate the data in the systems that we used to verify the license information in the MMIS. However, in those cases in which we found an exception, we checked whether the HPES provider files contained a copy of the license and/or confirmed the exception with the applicable authorizing organizations to validate our results.

Highlights: Report of the Vermont State Auditor

Medicaid: Many Provider Enrollment and Claims Controls in Place, but Gaps Exist

(September 15, 2011, Rpt. No. 11-5)

Why We Did This Audit

Medicaid is at risk of fraud attempts by unscrupulous individuals. One of the ways to combat fraud attempts is to implement robust provider enrollment and claims controls. Accordingly, the objective of this audit was to ascertain the effectiveness of the processes and controls in place to ensure that only legitimate Medicaid providers are paid claims for services they are entitled to perform.

What We Recommend

We made a variety of recommendations to DVHA to address the control weaknesses that we found. For example, we recommended that DVHA direct HPES to modify its credential verification process to eliminate gaps in the independent verification of provider credentials. We also recommended that DVHA modify its monthly excluded parties process to be in accordance with federal regulations, including checking out-of-state providers and all providers' ownership and controlling interests, and managing employees.

Findings

Improvements to the state's processes and controls over Medicaid providers are needed in order to provide greater assurance that only legitimate providers are paid for claims to which they are entitled. Table 1 shows the Medicaid enrollment control areas that were complete, needed improvement, or were lacking.

Table 1: Summary of SAO Assessment of Enrollment Controls and Testing Results

Control Attribute	Control Design Assessment	Exception Found During Testing?
Provider Agreement	●	Yes
Credentials and other requirements for enrollment	●	Yes
Excluded parties lists	●	No
State approval of providers	●	Yes
Post-enrollment checks	○	Yes
Provider record accuracy mechanisms	●	Yes

● = Control attribute performed
● = Weakness in design of control attribute
○ = Control attribute not performed

Examples in which the state's controls were generally in place were (1) regular updates of provider agreements due to reenrollment frequency and (2) provider approval by state officials. Nevertheless, our testing of the Medicaid provider records found numerous errors, some significant. For example, errors in about 420 provider records (e.g., providers whose records should have been terminated because they were no longer affiliated with an institution or because they were deceased) could have led to improper claim payments. (HPES corrected errors as we brought them to their attention.) Gaps in provider enrollment controls can be inadvertently or intentionally exploited to allow the payment of claims that the provider would otherwise not be entitled to receive.

Regarding claims processing, the applicable logic in the MMIS edits related to confirming that providers were legitimate and were submitting claims for appropriate procedures appeared generally sound. However, the MMIS did not have edits to enforce some provider restrictions. For example, laboratory certifications issued by CMS are generally limited to specific service locations, but the MMIS does not capture the relationship between the location on the certificate and the provider's service location(s). According to an HPES systems manager, this is because the MMIS is not designed to track claims at the service location level and the required usage of a single national provider identifier for most Medicaid providers makes establishing such a tracking process a difficult challenge. However, without a system mechanism to link the laboratory certificate to a specific service location or a compensating manual control, the MMIS could be paying for laboratory services that a provider is not authorized to carry out at a particular location.

Background

The Vermont Medicaid program is complex from a programmatic, operational, and organizational perspective. Basic policies are set at the national level, but states are given wide latitude to define what is covered, who is covered, and how the program is going to operate. In Vermont, Medicaid is administered by various departments within the Agency of Human Services utilizing contractor services.

Medicaid Program and Operations

Medicaid was established by the federal government as a result of amendments in 1965 that added Title XIX to the Social Security Act. It is a federal-state program[8] that covers acute health care, long-term care, and other services for low income people and consists of more than 50 distinct state-based programs. States have considerable flexibility in structuring their Medicaid programs within broad federal guidelines governing eligibility, payment levels, and benefits. As a result, Medicaid programs vary widely from state to state.

At the federal level, CMS is the operational and policy center for the formulation, coordination, and operations related to Medicaid. Within Vermont, AHS has been designated as the single state agency to administer or supervise the administration of the Medicaid program. DVHA—a component entity of AHS—has been designated as the medical assistance department. Among the duties performed by DVHA are (1) program policy, (2) quality improvement and program integrity, and (3) provider relations.

Other AHS departments also have critical roles related to the Medicaid program. For example, according to the State Plan, the Department of Disabilities, Aging, and Independent Living (DAIL), the state entity that licenses health institutions, such as nursing homes, is responsible for determining whether institutions and agencies meet the requirements for participation in the Medicaid program. In addition, organizations such as the Department of Mental Health, and the Department for Children and Families issue contracts or grants for Medicaid-reimbursed services.

[8]The federal government matches states' expenditures for most Medicaid services using a statutory formula based on each state's per capita income.

Another state organization, the Department of Education (DOE), monitors school-based Medicaid services, which are administered through each of the state's 60 supervisory unions. In order for these services to be eligible for Medicaid reimbursement, a student must be (1) receiving special education services as outlined in an Individualized Education Plan (IEP), (2) enrolled in Medicaid, and (3) receiving Medicaid-billable services.[9] Examples of the types of services covered by these plans are nutrition services, physical therapy, speech, hearing, and language services, occupational therapy, and mental health counseling.

Private sector organizations also have major roles in operating Vemont's Medicaid program. In particular, HPES is the state's fiscal agent and as such is the contractor responsible for processing claims on behalf of the state via the MMIS—a system that was created in November 1993. HPES also has other duties, such as processing provider enrollment applications and verifying required licenses and certifications. The MMIS captures data that is used to enroll, classify, and identify members of the provider community. This data is used by the claims processing component of the MMIS to adjudicate, price, and pay claims.

MedMetrics Health Partners, Inc., the state's pharmacy benefits manager, also assists the state in administering the Medicaid program. MedMetrics is responsible for the processing of pharmacy claims,[10] which is performed utilizing the RxClaim® systems, operated by SXC Health Solutions, Inc.

Medicaid Providers

Vermont's Provider Manual states that for providers to participate in, and receive reimbursement from, Medicaid, they must first become enrolled.

[9]The process for billing for school-based Medicaid services is different than other types of Medicaid billing. In this case, the supervisory union employs or contracts for services for Medicaid beneficiaries as authorized by an IEP. The service provider agrees to accept reimbursement for their services from the supervisory union and not to submit a bill to Medicaid. The service provider submits documentation to the supervisory union to support the services provided under the Medicaid program. The supervisory union submits bills to HPES for the services provided to Medicaid based on a bundled case rate. The bundled rate is calculated per student per billing period based on the frequency of services provided, the type of service provided, the group size in which services were provided and the provider type. HPES transfers the amount of the federal Medicaid share to a designated state special fund. DOE returns 50 percent of the transferred funds to the applicable supervisory unions in the form of prevention and intervention grants. Various state organizations can use up to 30 percent of this special fund to pay for administrative costs. According to 16 VSA §2959a(g), any remaining amount is to be transferred to the state's education fund.

[10]RxClaim® submits approved drug claims to the MMIS for payment to the applicable pharmacy.

There are thousands[11] of individual, group, and institutional providers enrolled in Medicaid.[12] During initial enrollment these providers are assigned a provider number[13] and a provider type and specialty. As of February 25, 2011 there were 61 provider types and 103 specialties used in the active provider records. As demonstrated by the examples of provider types in Table 2, Medicaid providers have a wide range of occupations.

[11]HPES provided us with a copy of its provider files as of February 25, 2011. These files contained 12,145 provider numbers in active status whose date of enrollment had not expired on or before this date. However, an entity can have multiple provider numbers (for example, one provider had at least 11 provider numbers due to reasons such as multiple funding sources) so we could not determine the number of unique providers in these files.

[12]Although this audit focused on Medicaid, other programs utilize the Medicaid provider network and their claims are processed and paid via the MMIS. The State Children's Health Insurance Program, which covers a certain category of uninsured children, is an example of such a program.

[13]The Vermont provider number is a unique seven-digit number assigned to each enrolled provider. As of May 2008 providers that are not atypical were required to use their National Provider Identifier in lieu of their Vermont provider number in claims (the MMIS contains a crosswalk between providers' Vermont provider numbers and their National Provider Identifier). An atypical provider is one who is not required by federal regulation to have a National Provider Identifier. An example of a provider that is required to have a National Provider Identifier is a physician or hospital while an example of an atypical provider is a transportation service provider.

Table 2: Examples of Medicaid Provider Types (the quantity of active provider numbers is as of February 25, 2011)

Provider Type Code	Provider Type Name	Quantity[a] of Provider Numbers as of 2/25/11
001	General hospital	114
004	Dentist	445
005	Physician	7,777
009	Pharmacy	298
010	Home health agency	13
012	Independent laboratory	38
013	Ambulance	109
014	Durable medical equipment supplier	164
020	Nursing home, Medicare participating	52
035	Audiologist	51
T06	Nurse practitioner	791
T25	Alcohol and drug abuse prevention	26
T26	Adult day care	15
T37	Physician assistant	340

[a]The active provider number quantities only include those providers who were listed as being in active status and whose expiration date was after February 25, 2011. About 100 providers in the file provided by HPES were in active status with an expiration date on or before February 25, 2011, and had their expiration dates subsequently extended in the MMIS. We did not include these providers in our analyses.

Another key data element that is added to a provider record at initial enrollment (and updated as applicable) is whether the provider is participating or non-participating. A participating provider is one that is fully enrolled in Medicaid and can bill Medicaid directly. A non-participating provider is also enrolled, but cannot bill Medicaid for the services provided. For example, a non-participating provider may choose to only issue prescriptions to Medicaid beneficiaries.

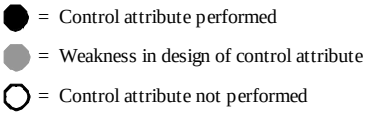
Claims are submitted that show providers in a variety of roles. Specifically, depending on the type of claims submitted for payment, mandatory claim fields might include a provider number for the billing provider, attending provider, referring provider (e.g., durable medical equipment claims), or prescribing provider (drug claims). A given claim can have the same or different provider numbers in these various roles.

Gaps Exist in Provider Enrollment Controls

DVHA and HPES have instituted a variety of controls over provider enrollment, but gaps remain. Examples in which the state's controls were generally in place were (1) regular updates of provider agreements due to reenrollment frequency and (2) provider approval by state officials. On the other hand, our testing of the Medicaid provider records found numerous errors, some significant. For example, errors in about 420 provider records (e.g., providers whose records should have been made inactive because they were no longer affiliated with an institution or were deceased or who were incorrectly authorized to be paid for laboratory procedures) that could have led to improper claim payments. As we found data errors we brought them to the attention of HPES, which corrected the MMIS records. Table 3 summarizes the areas in which there were gaps. It provides an overall assessment of the areas in which the control design of the Medicaid enrollment process was complete, needed improvement, or was lacking. The table also indicates whether our tests of the Medicaid provider file as of February 25, 2011 and review of a sample of 60 provider files found exceptions in the implementation of a particular control attribute.

Table 3: Summary of SAO Assessment of Enrollment Controls and Testing Results

Control Attribute	Control Design Assessment	Exception Found During Testing?
Provider Agreement		Yes
Credentials and other requirements for enrollment		Yes
Excluded parties lists		No
State approval of providers		Yes
Post-enrollment checks		Yes
Provider record accuracy mechanisms		Yes



Control design gaps weaken the state's overall provider enrollment control environment, which is critical because ensuring adequate and appropriate provider enrollment standards and screening against those standards is a critical first step in the process of ensuring the integrity of the Medicaid program. DVHA and HPES cited a variety of causes for these gaps, including that certain data is not captured in the MMIS or that HPES provider services staff were unaware of how they could validate certain types of credentials. Both DVHA and HPES have begun to take corrective action to address some of these causes.

Except for Certain Providers, Provider Agreements Were Largely in Place

Control Attribute	Control Design Assessment	Exception Found During Testing?
Provider Agreement	●	Yes
Credentials and other requirements for enrollment	●	Yes
Excluded parties lists	●	No
State approval of providers	●	Yes
Post-enrollment checks	○	Yes
Provider record accuracy mechanisms	●	Yes

According to 42 Code of Federal Regulations (CFR) §431.107, the state Medicaid agency is required to have an agreement with each provider or organization furnishing services. A DVHA operating principle and the Vermont Provider Manual specify that for providers to participate in and receive reimbursement from Medicaid they must first become enrolled, which requires a signed provider agreement and copies of applicable licensure and certification documentation. The provider agreement includes (1) practice information (such as service locations), (2) disclosures, such as information on ownership and controlling interests[14] and managing employees,[15] and (3) assertions and certifications, such as that the contracting organization and its principals are not debarred or suspended by the U.S. General Services Administration from federal procurement and non-procurement programs (see appendix II for a copy of the provider agreement). These agreements are a critical element of the Medicaid enrollment control environment because they are legal documents and the provider's signature "legally and financially binds [the] provider to the laws, regulations, and program instructions of the Vermont Medicaid program and state/federal assisted healthcare programs."

Vermont Medicaid requires that provider agreements be submitted during both initial enrollment and reenrollment.[16] Providers are typically required to undergo reenrollment (and therefore have an updated agreement) every

[14]42 CFR §455.101 defines a controlling interest as the possession of equity in the capital, stock, or profits of the disclosing entity. A person with an ownership or control interest means a person or corporation that (1) has an ownership interest totaling five percent or more in a disclosing entity, (2) has an indirect ownership interest equal to five percent or more in a disclosing entity, (3) has a combination of direct and indirect ownership equal to five percent or more in a disclosing entity, (4) owns an interest of five percent or more in any mortgage, deed of trust, note, or ether obligation secured by the disclosing entity if the interest equals at least five percent of the value of the property or assets of the disclosing entity, (5) is an officer or director of a disclosing entity that is organized as a corporation, or (6) is a partner in a disclosing entity that is organized as a partnership.

[15]42 CFR §455.101 defines a managing employee as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or indirectly conducts, the day-to-day operations of an institution, organization, or agency.

[16]During reenrollment, providers are sent a copy of the existing agreements and told to update and submit them along with a copy of the applicable licenses.

2 years,[17] which has been cited as a noteworthy practice by CMS.[18] The federal standard requires that providers have their enrollment revalidated no less than every 5 years.[19] More frequent reenrollment reduces the risk of fraud because it provides the state with the opportunity to cull its rolls of providers who have not submitted claims for payment or referred claims for payment for several years.

Our analysis of Vermont's processes related to provider agreements had mixed results. On one hand, provider agreements are generally regularly updated because of the frequency of Vermont's typical reenrollment period. Further, our review of a non-statistical sample of 60 provider files at HPES found that almost all had current signed agreements. One provider's file did not include a current agreement while the agreement of a second provider was not signed. On the other hand, as shown in the following subsections, there were significant categories of providers for which agreements were not obtained or which were not current. This was generally related to whether these providers were enrolled or periodically reenrolled.

Medical Professionals at Three Institutions

Certain medical personnel[20] at three institutions (Fletcher Allen Health Care, Dartmouth-Hitchcock Clinic, and Children's Hospital Boston) were not required to sign provider agreements (as of February 25, 2011, the number of such Medicaid providers[21] in these organizations was 376, 619, and 11, respectively). Instead, DVHA agreed that these organizations would provide a list of personnel that HPES would enroll as active non-participating providers[22] (with provider numbers starting with F for Fletcher Allen Health Care, D for Dartmouth-Hitchcock Clinic, and B for Children's Hospital Boston). According to the DVHA director of provider and member relations, these organizations were supposed to provide updated lists to HPES at least

[17]Reenrollment requirements vary by provider type and are generally related to the length of a provider's license to practice. Providers not required to be licensed undergo reenrollment annually.

[18]*Medicaid Integrity Program: Vermont Comprehensive Program Integrity Review* (CMS, August 2009).

[19]42 CFR §455.414.

[20]In most cases these medical personnel are residents.

[21]One provider had two provider numbers.

[22]As active non-participating providers, these providers cannot bill Medicaid directly. They are limited to being the prescribing or referring provider on claims. The file HPES provided us of claims paid in calendar years 2009 and 2010 did not have any claims paid with any of the active non-participating providers listed as the billing provider.

annually.[23] According to an HPES provider services staff member, these organizations had been submitting new staff rosters, but not providing updates to previously submitted lists.

In May 2011, HPES obtained updated lists from these three institutions and found that 308 providers (about 31 percent of the B, D, and F providers enrolled as of February 25, 2011) were no longer affiliated with these institutions. The dates of expiration of the affiliation ranging from less than a month to 6 years (e.g., six providers had not been affiliated with the hospitals since 2007 or earlier). In mid-May 2011, HPES terminated the provider numbers of these individuals. However, during the time in which these providers were incorrectly listed as active, their provider numbers could have been used in claims (e.g., as the referring provider) and the MMIS would not have denied these claims on the basis of an inactive provider number. As of mid-August, HPES was in the process of reviewing whether any such claims had been submitted and paid.

School-based Medicaid Services

School-based Medicaid services involve various types of organizations or professionals—e.g., supervisory unions, practitioners who authorize Medicaid services, and school service providers (which may be employed by or under contract to, the supervisory union)—for which provider agreements were not in place, not current, or for which we could not make that determination.

- *Supervisory Unions.* The intergovernmental agreement between DOE and DVHA calls for DVHA to notify supervisory unions when it is necessary to re-enroll. Nevertheless, such reenrollments have not been occurring and the supervisory unions do not have up-to-date provider agreements. For example, some of the agreements are dated in the mid to late 1990s.[24] Without a periodic renewal of provider agreements with the supervisory unions, DVHA does not have a mechanism to ensure that these providers agree to adhere to new federal or state requirements as they are implemented through these agreements.

[23]We were provided unsigned copies of DVHA's agreements with Dartmouth-Hitchcock and Fletcher Allen that contained this requirement (DVHA could not find signed copies). Also, DVHA did not provide us with evidence of an agreement with Children's Hospital Boston.

[24]We could not review many of these agreements because they had been archived and were not available at HPES's Williston location.

- *Practitioners Who Authorize Medicaid-Reimbursable Services.* Medicaid-reimbursable services included in a student's IEP are required to be approved by a licensed physician or other licensed practitioner of the healing arts. However, DOE's Medicaid Manual does not require that the supervisory union check whether the practitioner authorizing the services is enrolled in Medicaid and, according to the DOE Medicaid Coordinator, the supervisory unions do not perform such a check. A contractor who was involved in establishing the school-based program asserted that the authorizer did not need to be enrolled in Medicaid because the authorizer was required to be licensed and operating under the scope of his or her license. We do not believe that this position is consistent with DVHA rule 7105.1, which states that "no payment will be made for certain items and services including the following… items and services ordered by an individual not enrolled as a Medicaid provider." The DVHA rule is in line with 42 CFR §455.410, which requires that all ordering or referring physicians under the State Medicaid Plan or under a waiver of the plan be enrolled as participating providers. We do not know the extent to which the practitioners who authorized the school-based Medicaid services were enrolled and therefore had existing provider agreements because there was no central list of these practitioners.

- *School Service Providers.* 42 CFR §455.410 requires that professionals providing services under the State Medicaid Plan or under a waiver of the plan be enrolled as participating providers. Nevertheless, school service providers are not required to be enrolled in Medicaid. Providers who are enrolled must agree in writing that they will not bill Medicaid directly for school-based services. Individuals or organizations who provide school-based Medicaid services, but are not enrolled must agree that they will (1) conform to applicable federal and state laws and regulations, (2) offer services in accordance with Title VI of the 1964 Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as amended, and (3) keep records to document the services provided and provide these records to the Vermont Attorney General's Office, if requested.

  Federal guidance regarding the implementation of 42 CFR §455.410 recognizes that this rule could be an administrative burden for school based services. It allows for a streamlined enrollment process for such service providers. In particular, state Medicaid agencies are allowed to delegate to school or local governmental agencies, such as public school districts the responsibility to screen public school-based

providers and to assign unique provider identification numbers for claims identification. While this is a more flexible standard, it still imposes more requirements on school-based providers than Vermont currently has implemented. For example, the two-page agreement that school-based service providers that are not enrolled in Medicaid are required to sign does not cover all critical Medicaid disclosures, such as convictions of a criminal or civil offense related to Medicare, Medicaid, or other federal health care programs.

Providers Enrolled "Forever"

As of February 25, 2011, there were 1,193 provider numbers[25] (about 10 percent of the active provider numbers) in which the provider status end date in the system, which triggers the reenrollment process, was listed as December 31, 2382, or a "forever" date. The consequences of this practice can be the lack of a current provider agreement as well as stale information in the MMIS. For example, 65 of the 73 providers that are approved by the Department for Children and Families that provide various health care services related to, for example, intensive family-based services, foster care, and child sexual abuse treatment (known as fund code I) had active status end dates of December 31, 2382. The Department for Children and Families official responsible for approving providers under this program stated that she was unaware of seven of these providers and that another 15 no longer had contracts with the Department for Children and Families. In addition, we checked the HPES provider files for 10 of these fund code I providers and found either no provider agreement or an agreement that was not current (i.e., last submitted in 2005 or 2006).

[25]Most of these providers were related to the 1,006 providers that are in the "B," "D," and "F" categories previously mentioned.

Credentials and Other Requirements Were Often, but Not Always, Verified

Control Attribute	Control Design Assessment	Exception Found During Testing?
Provider Agreement		Yes
Credentials and other requirements for enrollment		Yes
Excluded parties lists		No
State approval of providers		Yes
Post-enrollment checks		Yes
Provider record accuracy mechanisms		Yes

Federal regulations, the State Plan, and DVHA rules require providers, where applicable, to be authorized to provide services by either the federal or state government—in other words to be licensed, certified, or registered (to simplify, we will refer to these types of authorizations as credentials). In addition, specialized services, such as laboratory services and prescribing a controlled substance require a Clinical Laboratory Improvement Act (CLIA) certificate issued by CMS and registration by the U.S. Drug Enforcement Administration (DEA), respectively. Federal regulations and state rules also require that certain providers meet other requirements in order to be enrolled, such as to be bonded.

Vermont Medicaid enrollment processes did not always verify providers' credentials or validate that other enrollment requirements were being met.

Health Care Services Credentials

According to the U.S. Department of Health and Human Services, holding a valid professional license should be a prerequisite in any state prior to the assignment of a Medicaid provider identification number. Moreover, according to the Department, as a matter of public policy it is not "unreasonable to expect that licensure status of all in-state and out-of-state providers be checked prior to enrollment, and that any limitations on their licenses be checked as well." Accordingly, federal rules require that the state Medicaid agency has a method for verifying that any provider purporting to be licensed in accordance with the laws of any state be licensed by such state and to confirm that the provider's license has not expired and that there are no current limitations on the license.

HPES' current Medicaid enrollment process varies with respect to whether copies of licenses must be submitted and whether the submitted credentials are independently verified. Table 4 summarizes these variances. In general, HPES verified those credentials for which it was aware of a website with which it could perform the verification.

Table 4: Summary of HPES Verification of Credentials

Issuing Authority	Copy of Credential Submitted to HPES	Independent Verification of License
Vermont Board of Medical Practice, which is located within the Department of Health (e.g. physicians, podiatrists)	Yes	Generally yes, except anesthesiologist assistants are not verified
Vermont OPR within the Office of the Secretary of State (e.g., physical therapists, dentists)	Yes	Yes
Vermont DOE (audiologists and speech language pathologists)	Yes	No
Vermont Department of Health (e.g., ambulances, hospitals)	Yes	The Department of Health reported that it provides credential data to HPES for ambulances
Vermont DAIL[a] (e.g., nursing homes and assisted living facilities)	Yes	No
Licenses for medical professionals or other Medicaid-related services issued by other states	Yes	Only if HPES is aware of a website that contains this information
CLIA certificates issued by CMS	Yes	No
Registration with DEA for providers authorized to prescribe or dispense controlled substances	No	No

[a]DAIL performs surveys on behalf of CMS. In some cases, CMS issues the relevant certifications.

Providers who are not appropriately credentialed could be reimbursed for services beyond the scope of their authority.

We compared several thousand records in the MMIS of providers who were expected to hold Vermont credentials to records of the authorizing entity (e.g., Board of Medical Practice, OPR) as well as to the database of CLIA certificates on the CMS website.[26] The vast majority of these providers were licensed with the appropriate authority. However, there were about 20 MMIS records in which we could not substantiate that the provider held a valid credential for the provider type or service location. For example,

- *Physician Assistants.* There were seven physician assistants whose credential information was incorrect in the MMIS. For example, four providers did not have active licenses as of February 25, 2011—these providers were licensed at the time of enrollment, but subsequently

[26]We did not validate the data in the systems that we used to verify the license information in the MMIS. However, in those cases in which we found an exception, we checked whether the HPES provider files contained a copy of the license and/or confirmed the exception with the applicable authorizing organizations to validate our results.

became inactive (the earliest became inactive in May 2010). HPES corrected the MMIS in the seven cases.

- *Pharmacies.* Five entities were listed as pharmacies in the MMIS that did not have a current license issued by the Vermont Board of Pharmacy. In two cases, the pharmacies' licenses had become inactive in 2010. In three cases, the organizations contended to HPES that they did not need a pharmacy license because of their particular circumstances. We did not see evidence in the provider file that these provider assertions were confirmed with OPR or the Board of Pharmacy. Our review of the Vermont statute related to the licensing of pharmacies and the rules of the Board of Pharmacy did not find that the circumstances described by the providers (e.g., that a license was not required because they were a rural health clinic or licensed physicians) were exceptions to licensing requirements. We referred these providers to OPR for further review. In early August, an OPR staff member told us that this issue was being discussed between the Board of Pharmacy and the Board of Medical Practice.

- *Laboratories.* Six providers were incorrectly listed in the MMIS as having CLIA certificates.[27] The certificates had been issued to other entities. This occurred because HPES was not checking the CMS website that verifies CLIA certificates because the provider services staff members were unaware that this website was available. HPES removed the CLIA data in the MMIS for the six providers.

There is a substantial number of Vermont Medicaid providers who are located out-of-state (almost half of the provider numbers as of February 25, 2011 had been issued to providers listed with an out-of-state address).[28] We checked a non-statistical random sample of 60 out-of-state providers to verify that they had valid credentials and found no exceptions.

[27]CLIA requires all facilities that perform even one test on materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of human beings have a CLIA certificate. Medicaid providers such as independent laboratories, physician offices, and ambulance services often had CLIA certificates.

[28]Most of these out-of-state providers are in the border states of New Hampshire, New York, and Massachusetts.

School-based Medicaid Services

Personnel authorizing or providing school-based medical services are required to meet certain licensing requirements. For example, the Medicaid State Plan requires that specialists providing services, such as physical therapy, speech, hearing, and language services, and mental health counseling have the appropriate credentials. DOE's provider manual requires supervisory unions to verify these credentials. DOE periodically confirms that this verification is being performed.

Medicaid-reimbursable services included in a student's IEP are also required to be approved by a licensed physician or other licensed practitioner of the healing arts. DOE does not require that the supervisory unions verify the licenses of these approving practitioners. Moreover, according to the DOE Medicaid coordinator the supervisory unions do not perform such verifications.

Medicare Enrollment

Often providers who are enrolled in federally-run Medicare also serve Medicaid beneficiaries and are enrolled in the applicable states' Medicaid programs. CMS has implemented a variety of mechanisms to perform enrollment screening of Medicare providers. The federal government recognizes that it is inefficient to require states to conduct the same screening that Medicare contractors perform for dually-enrolled providers, and its new regulations effective March 25, 2011, specify that states may rely on the results of the screening conducted by a Medicare contractor to meet the provider screening requirements under Medicaid.[29]

DVHA's Medicaid rules require certain providers to be approved for participation in Medicare or to meet Medicare standards. For example, according to DVHA rule 7501, providers of pharmaceuticals, medical supplies, and equipment—for items other than prescribed drugs—are limited to (1) Vermont providers approved for participation in Medicare or (2) out-of-state providers approved for participation in Medicare or the applicable state's Medicaid program. In another example, the Medicaid State Plan limits ambulance services to "Medicare certified and participating ambulance providers." However, neither DVHA nor HPES check whether these providers are enrolled in Medicare. Moreover, they do not check whether these providers meet the enrollment criteria for Medicare. Verification of

[29]This same regulation also states that a state Medicaid agency can rely on the screening performed by other states.

Medicare enrollment for those provider types where such enrollment is required would ensure that providers are following Vermont's Medicaid enrollment rules as well as be an efficient mechanism to reduce Vermont's risk of enrolling fraudulent or unqualified providers.

Home Health Agency Surety Requirement

Based on its experience in Medicare, CMS considers home health agencies to be at a higher risk of fraud than other types of providers. Because of the high-risk nature of these agencies, 42 CFR §441.16 requires each home health agency (except for state, local, or tribal government agencies) to obtain a surety bond[30] and to furnish this bond to the Medicaid agency. This regulation goes on to state that the Medicaid agency must terminate the home health agency's provider agreement if the agency fails to obtain, file timely, and maintain the surety bond in accordance with the federal regulation. Moreover, the Medicaid agency must refuse to enter into a provider agreement with a home health agency without a surety bond.

DVHA's Medicaid rule does not require that home health agencies obtain a surety bond to enroll as a Medicaid provider. Moreover, neither DVHA nor HPES check whether a home health agency has such a bond in place. DVHA's director of provider and member relations did not know why neither DVHA nor HPES check whether this requirement is being met, but said that DVHA would do so in the future.

[30] 42 CFR §441.16 defines a surety bond as one or more bonds issued by one or more surety companies under 31 USC 9304 to 9308 and 31 CFR parts 223, 224, and 225, provided that the bond otherwise meets the requirements of 42 CFR §441.16.

HPES and DVHA Screening for Excluded Parties Not in Compliance with Federal Requirements

Control Attribute	Control Design Assessment	Exception Found During Testing?
Provider Agreement		Yes
Credentials and other requirements for enrollment		Yes
Excluded parties lists		No
State approval of providers		Yes
Post-enrollment checks		Yes
Provider record accuracy mechanisms		Yes

Federal statutes and regulations prohibit states from paying for items or services furnished, ordered, or prescribed by excluded individuals or entities. The federal government has established multiple databases of excluded parties. The Department of Health and Human Services' OIG hosts a public website that contains information on parties that are excluded from federal health care participation, called the List of Excluded Individuals/Entities (LEIE).[31] CMS provides monthly files of excluded parties to DVHA, called the Medicare Exclusion Database (MED). These files include Social Security numbers and are not available to the public.[32] Lastly, the U.S. General Services Administration maintains a publicly available web-based list of parties that are excluded from receiving federal contracts, certain subcontracts, and certain types of federal financial and non-financial assistance and benefits called the Excluded Parties List System (EPLS).[33]

Table 5 summarizes the requirements pertaining to checking excluded parties lists and the extent to which DVHA or HPES perform these activities. It shows that there are significant differences between federal requirements related to excluded parties and the practices that are currently in place. Some of these deficiencies were also noted in a 2009 CMS review of Vermont's Medicaid integrity program.[34]

[31]OIG LEIE exclusions can be mandatory (required by law) or permissive (imposed at the discretion of the OIG). Examples of mandatory exclusion are a felony conviction for health care fraud or conviction for patient abuse/neglect. Permissive exclusion examples include conviction for obstruction of an investigation or a license revocation or suspension.

[32]CMS developed the MED in 2002, which it provides to state Medicaid agencies every month. Two of the information sources used in populating the MED are the LEIE and the Social Security Administration.

[33]Parties can be added to the EPLS for various reasons, including (1) suspensions by an agency pending completion of investigations related to fraud, embezzlement, theft, or forgery and (2) debarment by the U.S. Office of Personnel Management from participation as a health care provider in the Federal Health Benefits Program.

[34]*Medicaid Integrity Program: Vermont Comprehensive Program Integrity Review* (CMS, August 2009).

Table 5: Summary of Excluded Parties Verification Requirements versus Practices Utilized by HPES and DVHA (exceptions are in bold)

Entities required to be checked	Enrollment		Post Enrollment	
	Requirement	Practice	Requirement	Practice
Providers	Verify that providers are not on LEIE and EPLS	LEIE—HPES checks for all enrollments **EPLS—Not checked**	Verify every month that providers are not on LEIE and EPLS	**Neither HPES nor DVHA check the LEIE or EPLS monthly** DVHA obtains a list of excluded parties with Vermont addresses from the MED every month and provides them to HPES to terminate any of these parties that are enrolled in Medicaid **No checks of any of the excluded parties databases for out-of-state Medicaid providers are performed** (almost half of the active provider numbers in the MMIS as of February 25, 2011 were listed with an out-of-state service address)
Ownership or controlling interests[a]	Verify that individuals or entities that have at least a 5 percent controlling interest are not on LEIE and EPLS	**LEIE—Not checked** **EPLS—Not checked**	Verify every month that individuals or entities that have at least a 5 percent controlling interest are not on LEIE and EPLS	**LEIE—Neither HPES nor DVHA check on a monthly basis** **EPLS—Neither HPES nor DVHA check on a monthly basis**
Managing employees[b]	Verify that managing employees are not on LEIE and EPLS	**LEIE—Not checked** **EPLS—Not checked**	Verify every month that managing employees are not on LEIE and EPLS	**LEIE—Neither HPES nor DVHA check on a monthly basis** **EPLS—Neither HPES nor DVHA check on a monthly basis**

[a] 42 CFR §455.101 defines a controlling interest as the possession of equity in the capital, stock, or profits of the disclosing entity. A person with an ownership or control interest means a person or corporation that (1) has an ownership interest totaling five percent or more in a disclosing entity, (2) has an indirect ownership interest equal to five percent or more in a disclosing entity, (3) has a combination of direct and indirect ownership equal to five percent or more in a disclosing entity, (4) owns an interest of five percent or more in any mortgage, deed of trust, note, or ether obligation secured by the disclosing entity if the interest equals at least five percent of the value of the property or assets of the disclosing entity, (5) is an officer or director of a disclosing entity that is organized as a corporation, or (5) is a partner in a disclosing entity that is organized as a partnership.

[b] 42 CFR §455.101 defines a managing employee as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or indirectly conducts the day-to-day operations of an institution, organization, or agency.

Among the reasons why the excluded parties lists were not being checked in accordance with federal requirements is that the MMIS does not capture data on ownership and controlling interest or managing employees. Not having this data available electronically on the thousands of Medicaid providers has made checking the lists impracticable. However, DVHA has recognized that it needs to comply with the federal requirements and is considering alternatives to making this information available electronically (e.g., either through a modification of the MMIS or through a spreadsheet maintained outside of this system).

DVHA also plans to make changes to its monthly excluded parties screening. The department plans to use a contractor to perform automated matches of the MMIS provider file to identify potential excluded parties, which would

then be checked by DVHA staff. However, as of mid-August, DVHA did not have an estimated implementation date for this project.

The federal government has also set standards for Medicaid providers to screen for excluded parties within their organizations. Specifically, in January 2009 guidance, CMS instructed state Medicaid agencies to inform providers (1) of their obligation to screen all employees and contractors to determine whether any of them are excluded and (2) that they must search the LEIE website monthly to capture exclusions and reinstatements since the last search. DVHA has implemented these requirements through its provider agreements. However, the agreement requires providers to check the LEIE "periodically" rather than monthly. In addition, DVHA does not confirm or otherwise verify that the providers are performing the required screenings of employees and contractors.

Another exception to the excluded parties requirements relates to school-based Medicaid services. The intergovernmental agreement between DVHA and DOE related to school-based Medicaid services does not address screening school-based service providers against the excluded parties lists. Neither DOE nor the supervisory unions perform such screening.

The state's deficiencies in checking the federal excluded parties lists or in not having assurance that Vermont Medicaid providers are checking these lists can have severe consequences. For example, the effect of the OIG exclusion from federal programs is that no federal health care payment may be made for any items or services (1) furnished by an excluded party or entity or (2) directed or prescribed by an excluded provider. This prohibition applies even when the federal payment is made to a provider, practitioner, or supplier who is not excluded, but employs or subcontracts with an excluded provider. For example, the following would not be reimbursable if provided by excluded parties, (1) services provided by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing, (2) services performed by ambulance drivers, dispatchers, and other employees involved in providing transportation reimbursed by Medicaid, and (3) services provided by an excluded administrator, billing agent, accountant, or utilization reviewer that are related to, and reimbursed, directly or indirectly by Medicaid. According to the OIG, any such payments actually claimed for federal financial participation constitute an overpayment and are therefore subject to recoupment.

Providers Almost Always Approved

Control Attribute	Control Design Assessment	Exception Found During Testing?
Provider Agreement		Yes
Credentials and other requirements for enrollment		Yes
Excluded parties lists		No
State approval of providers		Yes
Post-enrollment checks		Yes
Provider record accuracy mechanisms		Yes

HPES generally performs the Medicaid enrollment and reenrollment processes. However, Medicaid providers are supposed to be approved by state officials prior to their enrollment or reenrollment being finalized. Most providers are approved by DVHA's director of provider and member relations through an approval screen in the MMIS. Providers that perform services for other AHS departments are approved by officials in these other entities (either in the MMIS system directly or through an email authorization to HPES).

Our review of the Medicaid provider file of February 25, 2011 demonstrated that this approval process almost always occurred for those providers that are periodically reenrolled. Out of the approximately 11,000 provider numbers that were enrolled for a specific period of time,[35] fewer than 25 did not have an approving authority listed in the file.

[35]This does not include the 1,193 providers that were not undergoing periodic reenrollment (e.g., largely certain medical professionals at Fletcher Allen Health Care, Dartmouth-Hitchcock Clinic, and Children's Hospital Boston).

Post-Enrollment Checks of Providers Not Performed

Control Attribute	Control Design Assessment	Exception Found During Testing?
Provider Agreement		Yes
Credentials and other requirements for enrollment		Yes
Excluded parties lists		No
State approval of providers		Yes
Post-enrollment checks		Yes
Provider record accuracy mechanisms		Yes

DVHA generally requires providers to reenroll every 2 years, which exceeds the federal 5-year minimum reenrollment period. Vermont's reenrollment period was cited as a noteworthy practice by CMS in 2009.[36] Greater frequency in reenrollment improves the chances that the state will become aware of provider circumstances that adversely affect their Medicaid status in a timely manner. However, there are some additional controls that DVHA or HPES could implement between enrollment periods to discover relevant information that would affect claims payments and reduce the risk of improper claims payments. For example,

- *Checks of the Social Security Administration's Death Master File.*[37] We compared the active providers in the MMIS with a status end date subsequent to February 25, 2011 to the Death Master File. We discovered five providers in active status in the MMIS were deceased (the earliest has been deceased since November 2009 and the most recent since January 2011). We brought these providers to DVHA's attention and they were put in inactive status in the MMIS.[38] In addition, our comparison showed other anomalies, including providers whose Social Security number in the MMIS was the same as a deceased person in the Death Master File. All of these other cases were found to be as a result of inaccurate information in the MMIS (e.g., there were 29 cases in which the providers' Social Security number was incorrect in the MMIS), which was subsequently corrected. Effective March 25, 2011, federal rules required states to check the Death Master File. As of mid-August, DVHA had not implemented this requirement, but were looking into automated

[36] *Medicaid Integrity Program: Vermont Comprehensive Program Integrity Review* (CMS, August 2009).

[37] The Social Security Administration maintains a national file of reported death information called the Death Master File.

[38] According to DVHA, no claims were paid using the provider numbers of the deceased providers subsequent to their deaths. To validate this assertion, we checked the copy of the file of claims paid between January 1, 2009 and December 31, 2010 that we received from HPES and confirmed that no such claims were paid during this time period.

solutions for checking the validity of Social Security numbers and employer identification numbers.

- *Obtaining Information on Sanctioned Providers.* DVHA rule 7106.4.1 requires that when providers fail to retain licensure, certification, or registration required by state or federal law for participation in Medicaid they be immediately suspended from participation. Organizations such as the Board of Medical Practice and OPR investigate allegations of wrongdoing on the part of licensees. These investigations can result in the revocation or suspension of a license or other sanctions. Moreover, at least in the cases of the Medical Practice Board and OPR, adverse decisions affecting licenses are posted on their web sites. Also, providers may simply choose to surrender their license. Nevertheless, there is no process in place to obtain such information between enrollment periods. Without such a process, HPES may not become aware that a provider is no longer eligible to be a Medicaid provider for months or even years.

- *Changes in a Provider's Enrollment Status.* A provider's enrollment can be revoked or cancelled before the end of his or her enrollment period. For example, one provider informed HPES in March 2011 that he was terminating his Medicaid enrollment effective December 31, 2010. According to a HPES enrollment specialist, when such information becomes available, the provider's status is changed to inactive. However, this specialist indicated that no checks are made to determine whether a claim was filed with a date of service between the effective end date and the date the change was actually made in the system (a 3 month period in the example above). Since a provider could have submitted and been paid for a claim with a date of service after the effective termination date, but before this date was added to the system, we believe that such a check would be prudent. In the course of performing another test, we found that this situation had occurred. Specifically, we identified several providers whose enrollment had been cancelled effective from 1 day to over 2 years prior to the data being entered into the system. In calendar years 2009 and 2010, it appeared that claims totaling several thousand dollars were submitted and paid with these providers listed as the attending, prescribing, or referring provider. (We provided this data to HPES in June, which as of mid-August 2011 had not completed its research into claims related to these providers.)

Accuracy of Provider Records Could Be Improved

Control Attribute	Control Design Assessment	Exception Found During Testing?
Provider Agreement	●	Yes
Credentials and other requirements for enrollment	●	Yes
Excluded parties lists	●	No
State approval of providers	●	Yes
Post-enrollment checks	○	Yes
Provider record accuracy mechanisms	●	Yes

Employing controls that provide assurance of the accuracy of provider data in the MMIS is a critical first step to ensuring that key processes, such as reenrollment and claims processing are executed appropriately. HPES is responsible for developing methods to edit and verify the accuracy of provider file data. Such methods can be manual, automated, or a combination of both. Our tests of the provider enrollment files disclosed errors in a wide-ranging number of records and fields that indicate weaknesses in these controls.

Manual Coding of Provider Records

About 70 provider records contained an inaccurate provider type or specialty. For example,

- Nine providers were incorrectly coded as physicians. Instead, (1) two were nurse practitioners, (2) one was a physician's assistant, (3) one was an optometrist, (4) one was an independent radiology laboratory, and (5) four were podiatrists.

- Four providers were incorrectly coded as psychologist-doctorate providers. Three of these providers had licenses for psychologist-master and one was licensed as a mental health counselor and a marriage and family therapist.[39]

- Three providers were incorrectly coded with the air ambulance specialty code. Their ambulance licenses did not include air ambulance services.

Coding the wrong provider type or specialty in the MMIS can affect claims payments because (1) not all types are paid the same rate (e.g., a physician's assistant is generally[40] paid at 90 percent of the Vermont Medicaid rate for a physician providing the same service) and (2) some procedures are restricted

[39]Providers in the psychologist-doctorate category are reimbursed at the lower of the provider's charges or 110 percent of the Vermont Medicaid rate. Providers in the psychologist-master category are reimbursed at the lower of the provider's charge or the Vermont Medicaid rate.

[40]The physician's assistant could also be paid the amount billed, if that amount is lower than the Medicaid rate.

to certain provider types or specialties (e.g., there are four procedure codes that are specifically related to air ambulance transport—we found no evidence that the three providers incorrectly listed with this specialty had charged these codes). At the end of our audit, HPES was researching whether the providers that had the wrong provider type codes in the MMIS had received any improper payments.

It was not always clear why the wrong provider type or specialty was entered into the system. We were told that these decisions were made on the basis of common sense. In some cases it appeared to be human error since the provider file contained the licensing data with which to make the correct provider type choice. However, in other cases, the HPES process seemed to be responsible. For example, HPES had a reference table listing the valid relationships that can occur between provider types and specialties, but the data in this table was obsolete because it was not maintained and was not utilized by provider services staff.

Another area in which provider records were not coded accurately relates to organizational types. The MMIS has three organizational types—"0" is used for an individual, "1" is used for a group practice, and "2" is used for an institution (e.g., hospital). As of February 25, 2011, there were about a thousand providers[41] that were entities that were listed in the system as organization type "0." In some of these cases, HPES was directed by DVHA to characterize entities in the system in this manner. For example, for certain providers[42] AHS and DVHA agreed to change their organization type to that of an individual so that these organizations can use their group provider numbers in both the billing and attending provider fields when submitting claims. However, by taking this action the claims edit in the MMIS requiring attending providers to be individuals is by-passed. This reduces accountability and transparency related to claims because the actual person providing or authorizing the service is not identified. Moreover, DVHA loses confirmation that the individual providing or authorizing the service is enrolled in Medicaid. According to the DVHA director of provider and member relations, he plans to develop criteria, in conjunction with HPES, of the circumstances in which it is appropriate to code an organization as an individual. We agree that criteria are needed to ensure the consistent

[41]We calculated this figure by extracting those providers who had an organization type code of "0" or individual, but had an organization name code of "2" or institution.

[42]These were designated agencies, which are organizations that provide mental health and developmental disability services.

application of the organization type code. However, because of the reduction in accountability that can result from organizations being coded as individuals, we believe that this criteria should allow this to happen only rarely.

Another area in which errors were found was related to CLIA certificates. 42 CFR §493.1809 requires that payment for laboratory services may be made only if those services are furnished by a laboratory that has a CLIA certificate. There are five levels of CLIA certificates, as follows:

- *Certificate of Waiver*. Issued to a laboratory that performs only waived tests. Waived tests are simple laboratory examinations and procedures that have an insignificant risk of an erroneous result.

- *Certificate for Provider Performed Microscopy.* Issued to a laboratory in which a physician, midlevel practitioner, or dentist performs specific microscopy procedures during the course of a patient's visit. A limited list of microscopy procedures is included under this certificate type, which are categorized as moderate complexity.

- *Certificate of Compliance.* This type of certificate is issued to a laboratory that performs nonwaived (moderate and/or high complexity) testing. It is issued once the state's Department of Health conducts a survey (inspection) and determines that a laboratory is compliant with all applicable CLIA requirements.

- *Certificate of Accreditation.* This type of certificate is issued to a laboratory that performs nonwaived (moderate and/or high complexity) testing. It is issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by CMS.

- *Certificate of Registration.* Issued to a laboratory to allow the laboratory to conduct nonwaived (moderate and/or high complexity) testing.

In addition, certificates of compliance, accreditation, and registration are issued with specific laboratory codes that designate the specialty/subspecialty for which the laboratory has been authorized.

As of February 25, 2011 there were 394 provider numbers that had CLIA certificates listed in the MMIS, of which 14 had the incorrect CLIA

certification level[43] and/or laboratory codes. For example, one provider was listed in the MMIS as having a certificate of compliance, but actually was only authorized for a certificate for provider-performed microscopy. In another example, HPES provider services staff did appropriately update a provider's CLIA certificate from a certificate of compliance to a certificate for provider-performed microscopy, but did not change the associated laboratory codes in the provider's record (the laboratory codes define the types of procedures that the provider is authorized to execute). Errors such as these can lead to improper payments because the claims processing edits in the MMIS use these codes to determine whether the procedures listed on a claim are allowable for that provider. An HPES provider services staff member attributed these errors to CLIA being a new requirement (Vermont Medicaid's implementation of the CLIA requirement was effective December 1, 2009) that they did not fully understand.

Lastly, we found many records with other types of errors. Examples include errors in (1) provider names, (2) addresses, (3) location codes, and (4) Social Security numbers. As we brought these errors to the attention of HPES they were corrected. In addition, with respect to the Social Security number errors, HPES plans to implement corrective actions to address the various issues found, such as improving procedures and performing an ad hoc query of the system to look for duplicate Social Security numbers and employer identification numbers. Moreover, HPES evaluated whether Social Security number errors had resulted in inaccurate reports to the U.S. Internal Revenue Service (i.e., form 1099 reporting) and found that they had not.

Some of the errors in Medicaid provider records could have been prevented through the use of automated edits during the provider data entry process that would not allow records to be created or updated with obvious errors (e.g., would prevent a provider number that starts with "B," "D," or "F" to be coded with a status of active participating[44] rather than the required active non-participating), or inconsistencies among data elements (e.g., incompatible provider types and specialties). According to the U.S. Government Accountability Office, input data should be validated and edited to provide reasonable assurance that erroneous data are prevented or detected

[43]This does not include those providers who were listed as having a compliance certificate instead of an accreditation certificate or vice versa because both of these certificate types allow the provider to perform moderate- and high-complexity testing.

[44]We found five such providers in the February 25, 2011, provider file we received from HPES. All were fixed once we brought them to HPES' attention.

before processing.[45] However, the MMIS does not have edits related to the input of provider data. Moreover, while DVHA has a process in place to check a sample of eight provider enrollment or reenrollment packages on a monthly basis, this process does not include verifying the accuracy of provider data in the MMIS.

System-Generated Errors

At the end of the enrollment period, if a provider does not submit a reenrollment package the system is supposed to change the status of the provider from active to inactive. As of February 25, 2011, the file of active providers contained 2,128 providers who were listed as still active, but with an enrollment expiration date on or before this date.[46] Some of these providers were within a 90-day grace period that a provider has to reenroll before the system automatically switches the provider to inactive status. However, only 436 providers met these criteria—the rest had expiration dates greater than the 90-day period and many were listed in active status for years past their expiration date.

An HPES systems manager explained that the MMIS process that tracks provider reenrollment and automatically switches the provider from active to inactive status after the 90 days is not triggered if the provider's status end date is manually extended. When a manual extension of the status end date occurs and the provider does not reenroll, a provider services staff member must remember to manually change the provider status to inactive. If this manual change does not occur, the provider's record will show that the provider is in active status, but with an expired end date. Although the provider's status is listed incorrectly in the MMIS, the HPES systems manager provided evidence that the system is designed to prevent claims from being paid with these providers numbers listed in the billing, attending, referring, or prescribing provider fields, with one exception. The exception was related to claims for vision services (claim type P) in which the system did not check whether the provider number listed in the attending provider field had an expired status end date.

[45]*Federal Information System Controls Audit Manual* (U.S. Government Accountability Office, GAO-09-232G, February 2009).

[46]We did not include these providers in our tests of the MMIS provider file.

Claims Processing Logic Generally Suitable, but Edits Not in Place to Address Some Provider Restrictions

The edit process in place in the MMIS claims processing component generally utilized applicable logic related to confirming that providers were legitimate and were submitting claims for appropriate procedures. However, the MMIS did not always have edits to enforce provider restrictions. In addition, there was no process in place in the MMIS or the pharmacy claims processing system (RxClaim®) to ensure that drug claims for controlled substances were prescribed only by those practitioners appropriately authorized by the DEA.

Logic of MMIS Claims Processing Appeared Sound, but Some Provider Restrictions Were Not Enforced through Edits

The MMIS processes non-drug claims against about 800 edits[47] and audits[48]—called Error Status Codes (ESC). ESCs are pivotal to ensuring the integrity of the Medicaid payment process because they check the validity of claims before payment is made. Not all claims trigger the execution of every ESC. Some ESCs are only applicable when a claim has specific attributes, such as claim type (e.g., dental, vision, or in-patient services) or procedure or revenue codes (e.g. surgery, office visit, consultation, etc.). In addition, once the system determines that a claim meets the criteria in the ESC and "sets" the edit, a table in the system determines the disposition of the edit. The disposition can be set to ignore the ESC result or to deny or suspend the claim. If a claim suspends for failing one or more ESCs, it is reviewed by an HPES employee (generally a member of the claims resolution staff) to determine whether the claim is valid (or partially valid). In making such decisions, claims resolution staff consult a procedures manual (called the Reso Manual) that contains guidance on how to handle various circumstances related to suspended claims for each ESC. If the claim is deemed to be valid (e.g., if an exception to certain criteria had been previously authorized in the Reso Manual or additional supporting documentation provided) then the ESC is overridden (or "forced") and the claim is paid.

[47] An edit is a computer system inspection of claim data for validity, accuracy and the relationship of information within the claim.

[48] An audit compares each new claim to the beneficiary's claims history. For example, a limitation audit checks whether a beneficiary has exceeded certain criteria, such as the number of units (e.g., office visits or type of procedure) allowed in a given period of time. We did not review these types of ESCs because they were not applicable to our objective.

DVHA and HPES share responsibility for the management of the ESC process. For example, DVHA is responsible for providing operational and policy parameters to be used by HPES in designing or modifying edits and audits, determining edit and audit criteria, and approving new ESCs or changes to existing ones. HPES' responsibilities, in turn, include maintaining up-to-date reference files (which are used in the ESC process), including disposition indicators.

We reviewed the logic[49] of 82 ESCs that HPES identified as enforcing provider-based rules. Examples of such rules are to check whether (1) the claim was submitted by a provider with a legitimate provider number, (2) the claim included a legitimate attending or referring provider, as appropriate, (3) a service was performed by a provider with appropriate laboratory credentials, and (4) a provider type was restricted from submitting claims for certain types of services (or conversely, that only specified providers can submit claims for certain services).

Of the 82 ESCs in our review, we found about a dozen that had incomplete criteria. In most cases the exceptions involved (1) not including all provider types in tables referenced by the ESC or in the disposition of claims that "set" an ESC and (2) reference tables that did not have all applicable procedure codes related to laboratory services. In general, these appeared to be oversights. For example, the laboratory service codes were not updated because the individual responsible was not aware that such updates were needed and there were no written procedures laying out a process of what to do and when. (Procedures were subsequently written.) We do not consider these exceptions to be significant because they were narrow in scope and so the risk of improper payments was limited. In addition, HPES fixed, or plans to fix, those ESCs with incomplete criteria that we brought to their attention.

There are some rules that the MMIS does not enforce during claims processing (i.e., there are no applicable ESCs). Specifically,

- *Provider Categories with Certain Limitations.* The MMIS enforces rules related to active non-participating providers. These types of providers have limited Medicaid privileges. For example, they can issue prescriptions for Medicaid beneficiaries, but cannot bill

[49]We reviewed the ESCs rules as set forth in the Reso Manual, checking for consistency with these rules by reviewing the MMIS tables that establish which types of claims call the edit and determines the disposition of claims that "set' the edit, and inquiry of HPES systems and claims personnel. We did not review the programming code in the system itself.

Medicaid. There is an ESC that would prevent payment of a claim to a physician and certain other types of practitioners, such as a podiatrist, who are coded in the system as active non-participating and are listed as the billing provider. However, there are categories of active, non-participating providers that have additional restrictions for which there are no edits. For example, certain subcategories of active, non-participating providers are not supposed to be listed as attending providers on claims. These providers can be identified by the beginning digits of their provider numbers (i.e., they start with B, D, F, or 7000).[50] There were a little over 1,000 providers in these subcategories as of February 25, 2011 and some of them were listed as attending providers in paid claims. The MMIS would not have rejected these claims because it does not have specific ESCs that address restrictions related to provider numbers. Although we did not find evidence that the lack of an edit for these types of providers was widely exploited, we believe that this is a risk that should be mitigated.

- *Laboratory Claims.* The MMIS includes three ESCs that limit payment of claims for laboratory procedures to those providers that have the appropriate CLIA certificate. However, the authority of the CLIA certificate is generally limited to the specific service location listed on the certificate.[51] The MMIS allows a provider record to include multiple service locations and multiple CLIA certificates. However, the system does not capture the relationship between the location on the CLIA certificate and the related service location for a particular provider number. As a result, regardless of whether a CLIA certificate is only applicable to a specific provider location, the system would pay claims associated with that CLIA certificate for any service location linked to the provider number (assuming that there were no other errors in the claim). An HPES systems manager explained that when implementing the modifications to implement CLIA, HPES did not program the system to capture the relationship

[50]Agreements related to the providers whose numbers start with D (Dartmouth-Hitchcock Clinic) and F (Fletcher Allen Health Care) limit their services to pharmacy and durable medical equipment claims. We were told that this restriction also applies to providers whose numbers start with "B" (Children's Hospital Boston). Providers whose numbers start with 7000 are limited to verification of beneficiary enrollment.

[51]Exceptions include (1) laboratories that are not at a fixed location, (2) not-for-profit or federal, state or local government laboratories that engage in limited public health testing, and (3) laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction.

between the location on a CLIA certificate and the related service location for a particular provider number because the MMIS is not designed to track claims at the service location level and the required usage of a single national provider identifier for most Medicaid providers makes establishing such a tracking process a difficult challenge. Without a system mechanism to link the CLIA certificate to a specific service location or a compensating manual control, the MMIS could be paying for laboratory services that a provider is not authorized to carry out at a particular location. According to the HPES director of provider services, HPES plans to research this issue and consider possible system solutions to address this weakness.

- *Restricting Referring Providers to Individuals.* The MMIS does not have an edit that would restrict a referring provider on a claim to an individual (the referring provider field is typically used for claims related to durable medical equipment, laboratory services, and consultations). As a result, providers that are group practice or institutional organization types would be allowed to be listed as the referring provider on a claim. This would not identify the specific person who could be held accountable for the service being ordered.

We also found discrepancies in the rates that the MMIS pays certain provider type/specialties versus the rates that are in the Vermont Medicaid Provider Manual. The Provider Manual lists the reimbursement rates that certain providers are supposed to be paid. For example, the reimbursement basis for physician assistants is the lower of the provider's charge or 90 percent of the Vermont Medicaid rate for a physician providing the same service. Our review of the applicable MMIS screens indicates that the system appropriately enforces this reimbursement rate for physician assistants. However, we could not substantiate that the MMIS is enforcing the rates in the Provider Manual for other provider types/specialties. Specifically,

- *Certified nurse-midwives*. The Provider Manual indicates that certified nurse-midwives' reimbursement rate is the lower of the provider's charge or 90 percent of the Vermont Medicaid rate for a physician providing the same service. However, the MMIS screen that enforces this rate shows a 100 percent reimbursement rate.

- *Anesthesia assistants and certified registered nurse anesthetists.* The provider manual indicates that anesthesia assistants' reimbursement is "80% of the CRNA's [certified registered nurse anesthetist's] 50%." The screens in MMIS that enforce these rates indicate a payment rate of 100 percent for CRNAs and 80 percent for anesthesia assistants.

HPES reported that it has no documentation to indicate which rates are correct—the ones in the MMIS or those in the Provider Manual—and has requested clarification from DVHA. In its response to a draft of this report, DVHA stated that its Data and Reimbursement Unit will clarify these rates and, if overpayments are found, it intends to recoup the funds.

Drug Claims Processing Does Not Verify Authorization to Prescribe Controlled Substances

HPES transmits nightly extracts to the RxClaim® system of (1) pharmacy providers that are in active, participating status and (2) eight provider types authorized to prescribed drugs (e.g., physicians). We confirmed that the logic used to perform these extracts was designed to transmit only those provider types that should be allowed to prescribe and bill for drug claims. RxClaim® uses the data in the extracts as part of the adjudication process for drug claims.[52] Regarding the prescribing providers, according to the DVHA Director of Pharmacy Services, the only provider-related edit that RxClaim® employs is to check that the prescribing provider in the claim has a valid National Provider Identifier[53] that was included in the MMIS extract.

One MMIS data element not transmitted to RxClaim® is the DEA registration number and the RxClaim® system does not edit Vermont Medicaid claims to determine whether the prescriber is using a valid DEA number for prescriptions related to controlled substances. The DEA registration number is a critical data element because a prescription for a controlled substance[54] may only be issued by a physician, dentist, podiatrist, or other type of eligible practitioner who is (1) authorized to prescribe a controlled substance by the

[52]According to an HPES system manager, the only edit related to drug claims in the MMIS is a confirmation that the pharmacy to which the payment will be made is a valid Medicaid provider.

[53]CMS developed the National Plan and Provider Enumeration System to assign unique identifiers for health care providers and health plans as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. Through this system, applicable providers are assigned a 10-digit National Provider Identifier.

[54]The Controlled Substances Act of 1970 established a classification structure for certain drugs and chemicals used in drug manufacturing. Controlled substances are classified into five schedules on the basis of their currently accepted medical use and potential for abuse and dependence. However, only four of the schedules can be prescribed (schedule I drugs cannot be prescribed). Schedule II drugs—including methylphenidate (Ritalin) and opiates such as morphine and oxycodone—have high potential for abuse and abuse may lead to severe psychological or physical dependence, but have currently accepted medical uses. Drugs on Schedules III through V have medical uses and successively lower potentials for abuse and dependence. Schedule III drugs include anabolic steroids, codeine, hydrocodone in combination with aspirin or acetaminophen, and some barbiturates. Schedule IV contains such drugs as the anti-anxiety medications diazepam (Valium) and alprazolam (Xanax). Schedule V includes preparations such as cough syrups with codeine.

jurisdiction in which the practitioner is licensed to practice, (2) registered with the DEA or is exempted from registration (e.g., practitioners with the Public Health Service or the Federal Bureau of Prisons) or (3) an agent or employee of a hospital or other institution acting in the normal course of business or employment in which the hospital or other institution are registered.[55] In addition, as part of registration, DEA specifies which category of controlled substances the practitioner is allowed to prescribe. For example, if a physician wants the authority to prescribe schedule II drugs, he or she must register and be granted the authority by DEA to do so.

According to DVHA's director of pharmacy services, a pharmacist is not allowed by law to dispense a prescription for a controlled substance without having the DEA number of the prescribing physician on the face of the prescription. Accordingly, DVHA relies on the controls in place at the pharmacies to ensure that an applicable Medicaid drug claim is being prescribed by a provider with the appropriate registration level. However, DVHA is relying on its understanding of how pharmacies/pharmacists generally work and not on any systematic and explicit knowledge of whether controls related to ensuring the validity of reported DEA numbers are in place for all of the pharmacies in the VT Medicaid provider network.

The DEA Pharmacist's Manual states that a pharmacist has a responsibility to ensure that a prescription has been issued by an appropriately registered or exempt practitioner.[56] However, this manual does not specify that a DEA number be verified, instead including a description of how a DEA number is constructed to help pharmacies identify fraudulent numbers. Moreover, the Vermont Board of Pharmacy rules do not require that pharmacies or pharmacists validate a prescriber's DEA number.

A 2009 report by the U.S. Government Accountability Office[57] pertaining to fraud and abuse in the Medicaid program related to controlled substances cited examples in four of the five states in its audit in which doctors prescribed controlled substances that they were not registered to prescribe. For example, one provider in Texas prescribed over 6,000 pills on DEA's schedule II drug list (e.g., Ritalin) to over 50 Medicaid beneficiaries when he

[55]Those falling under the third category of registrants must meet additional DEA requirements.

[56]*Pharmacist's Manual: An Informational Outline of the Controlled Substances Act* (U.S. Drug Enforcement Administration, 2010 edition).

[57]*Medicaid: Fraud and Abuse Related to Controlled Substances Indentified in Selected States* (U.S. Government Accountability Office, GAO-09-957, September 9, 2009).

was authorized to prescribe schedule IV drugs. This report also pointed out that none of the five states were accessing the DEA's registrant database, which is available for purchase through the U.S. Department of Commerce's National Technical Information Service.[58]

The U.S. Department of Health and Human Services OIG also found problems related to controls pertaining to DEA numbers in the Medicare program.[59] Specifically, the OIG found about $4.1 million in calendar year 2007 gross drug costs in which the prescription drug event record did not have a DEA number that indicated that the prescriber had the authority to prescribe a schedule II drug. The OIG noted that although CMS had edits in its Drug Data Processing System related to provider identifiers, these edits did not check whether the prescriber identifier had the authority to prescribe schedule II drugs.

According to DEA, the abuse of prescription drugs, especially controlled substances, is a serious social and health problem in the United States. Given that fraud schemes have been found in this area, it would seem to be a prudent step to establish a mechanism to ensure that prescriptions for controlled substances covered by Medicaid are prescribed by providers who are authorized to do so by DEA.

In early August, the DVHA director of pharmacy services indicated that DVHA, with the assistance MedMetrics, is exploring options to validate that prescribers' DEA registration numbers are active and that the prescription drug prescribed by a practitioner is consistent with the practitioner's DEA authorization. She noted that there would be difficulties in trying to implement a prospective mechanism to edit for these attributes and indicated that it may be more practicable to perform audits retrospectively.

Conclusion

The processes relied on by the state to ensure that Medicaid providers are only paid for those claims for services for which they are entitled to perform had strengths and weaknesses. Among its strengths: (1) providers were generally required to undergo reenrollment more frequently than federal

[58]Officials from one of the states in the audit reported to U.S. Government Accountability Office that it now obtains copies of the DEA registration database.

[59]*Oversight of the Prescriber Identifier Field in Prescription Drug Event Data for Schedule II Drugs* (U.S. Department of Health and Human Services' OIG, A-14-09-00302, February 2, 2011).

standards, (2) providers were approved by state officials prior to their being enrolled and reenrolled, and (3) provider-related edits of claims in the MMIS were logically designed. Nevertheless, there were significant gaps in the enrollment and claims processes that could lead to improper claims payments. These gaps were sometimes the result of management choices, lack of knowledge of how certain certifications work, and system limitations. Accordingly, changes in approach by DVHA and additional direction to HPES by this department could lead to significant strengthening of the current controls in place related to provider enrollment and claims processing.

Recommendations

We recommend that the commissioner of the Department of Vermont Health Access:

- Require all Medicaid providers to periodically undergo reenrollment and restrict the use of "forever" active status end dates to state organizations,
- Comply with the federal regulation that requires home health agencies to obtain a surety bond and furnish this bond to DVHA,
- Modify the Medicaid monthly excluded parties process to be in accordance with federal regulations, including checking out-of-state providers and all providers' ownership and controlling interests, and managing employees,
- Establish a process to periodically check whether providers are performing the required screening of employees and contractors against the LEIE and EPLS, which could consist of a written certification from these providers during the enrollment process that such a process has taken place,
- Revise the provider agreement to require that providers search the LEIE website monthly to capture exclusions and reinstatements since the last search,
- Establish a process to periodically compare the Medicaid provider file against the Social Security Administration's Death Master File,

- Arrange to obtain credential status changes subsequent to the date of enrollment or reenrollment of licensed, certified, or registered providers from the Vermont licensing authorities,

- Develop criteria for the consistent application in the use of the MMIS's organization type code to limit the categories of organizations allowed to be coded as individuals,

- Ensure that research into whether those providers identified in this audit as having the wrong provider type, laboratory certification level, or active status be completed and any improper payments recouped,

- Expeditiously respond to HPES' request to clarify the reimbursement rates for certified nurse-midwives, certified registered nurse anesthetists, and anesthesia assistants and, if the MMIS's reimbursement rate is incorrect, direct HPES to change the rate immediately and seek reimbursement for any overpayments that may have been made, and

- Establish a process to verify that drug claims for controlled substances are prescribed by providers with the appropriate DEA registration level.

We recommend that the commissioner of the Department of Vermont Health Access direct HP Enterprise Services to:

- Modify its credential verification process to eliminate gaps in the independent verification of provider credentials, including those issued by Vermont, other states, CMS, and DEA,

- Verify the Medicare enrollment of those provider types required to be enrolled in Medicare per the DVHA Medicaid rules,

- Screen all providers, their ownership and controlling interests, and managing employees against the LEIE and EPLS in accordance with federal regulations,

- Establish a process related to those cases in which HPES is made aware of changes to a provider's enrollment of checking for claims that are filed with a date of service between the effective date of the change and the date the change was actually made in the system, and

- Determine the feasibility of modifying the MMIS, or implementing compensating manual controls, to address weaknesses identified in

this report, including (1) the use of automated edits during the provider enrollment data entry process, (2) the process used to automatically change providers from active to inactive status so that manual extensions of a provider's active status end date does not bypass this process, (3) the lack of an edit to recognize the claims limitations of providers whose number starts with B, D, F, or 7000, (4) capturing the relationship between the specific location on the laboratory certificate and the service location(s) of a provider, and (5) restricting referring providers to individuals.

We recommend that the commissioner of the Department of Vermont Health Access and the commissioner of the Department of Education work together to:

- Ensure that practitioners who authorize school-based Medicaid services are enrolled in Medicaid,
- Enroll individuals or organizations that provide the Medicaid-reimbursed service, which can be a streamlined process in accordance with federal regulations, and
- Periodically screen school-based service providers against the LEIE and EPLS databases in accordance with federal regulations.

Management Comments and Our Evaluation

The commissioner of the Department of Vermont Health Access and the deputy commissioner and chief financial officer of the Department of Education provided written comments on a draft of this report, which are reprinted in appendix III and IV, respectively.

The DVHA commissioner's response, dated August 29, 2011, indicated general agreement with our recommendations and provided short descriptions of the actions that the department planned to take. In particular, this fall DVHA plans to develop a single comprehensive manual describing all of its enrollment processes. The commissioner reported that DVHA expects to implement many of our recommendations through this new process.

For some recommendations, DVHA indicated general agreement, but did not specify how they would be implemented, thereby limiting our evaluation of whether DVHA's actions will address our recommendations. For example, regarding our recommendation that DVHA establish a process to verify that drug claims for controlled substances are prescribed by providers with the

appropriate DEA registration level, the commissioner stated that the department agreed in principle with the recommendation and intended to work with pharmacies, the Board of Pharmacies, and HPES to develop a plan to address this issue. This approach seems to be a prudent first step, but we cannot assess whether the resulting plan would address the recommendation. In another example related to our recommendation that DVHA direct HPES to determine the feasibility of modifying the MMIS, or implementing compensating manual controls, to address weaknesses identified in this report, the commissioner stated that DVHA planned to review the recommendation and incorporate a solution into its upcoming request for proposal for new provider management and claims adjudication systems. While we agree with this approach, we would also urge DVHA to consider implementing additional controls, manual or otherwise, to address the system weaknesses immediately rather than waiting for a new system to be put in place, which can take a significant amount of time.

With respect to the three recommendations that we made jointly to DVHA and DOE, the commissioner stated that DVHA was committed to working with the Department of Education to explore solutions to address the recommendations. Similarly, in his August 25, 2011, response to our draft report, DOE's deputy commissioner and chief financial officer indicated that DOE planned to work with DVHA. DOE also outlined specific actions that it planned to take in response to our recommendations. For example, DOE stated that by January 1, 2012, (1) supervisory unions will be required to verify that any practitioner signing a physician authorization form be enrolled as a Medicaid provider, (2) DOE will maintain a central list of all professional service providers, and (3) supervisory unions will screen all new service providers against the LEIE and EPLS databases. DOE's planned actions appear to be reasonable although we do not believe that screening only new service providers against the federal excluded parties list would fully implement our recommendation on this issue. Since both DVHA and DOE are planning on short-term changes to their provider enrollment processes, we reiterate that we believe that it is imperative that they work together to ensure that planned changes are consistent with federal requirements as it relates to school-based Medicaid services.

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In accordance with 32 VSA §163, we are also providing copies of this report to the secretary of the Agency of Administration, commissioner of the Department of Finance and Management, and the Department of Libraries. In addition, the report will be made available at no charge on the state auditor's website, http://auditor.vermont.gov/.

Appendix I
Scope and Methodology

To fulfill our objective we first identified the federal and state criteria pertaining to the (1) enrollment of providers, (2) required credentials of providers, and (3) limitations on the categories of claims or services that can be performed by types of providers. Among the criteria we reviewed were:

- Federal regulations (i.e., Code of Federal Regulations)
- State Medicaid director letters issued by CMS
- The Vermont Medicaid State Plan
- DVHA Medicaid Rules
- DVHA Operating Principles
- Medicaid provider manuals and supplements to these manuals

We also gathered information on the processes in place at DVHA, HPES, and other state organizations (e.g., Department of Education, Department for Children and Families and DAIL) that ensure that the requirements in these documents are met. We gathered this information through reviews of documents, such as written procedures, and interviews with applicable officials, including the DVHA director of provider and member relations and director of pharmacy services.

We executed a variety of tests of provider data in the MMIS to evaluate whether the controls in place had been fully implemented. In particular, we obtained electronic records of Medicaid providers from HPES as of February 25, 2011. Using an automated data analysis tool, we extracted the providers that were active.[60] We confirmed the completeness of the provider extract and scanned the data in the file to assess its reliability for the purposes of our analyses (e.g., that the data in the fields looked reasonable and that data was not garbled). We concluded that the provider files we received were sufficiently reliable for the purpose of our audit. Examples of the tests that we performed with the MMIS provider files included:

- *Tests of Credentials*. We used the data from the provider files to determine whether the provider types who were required to have

[60]We extracted only those providers who were listed as being in active status and whose expiration date was after February 25, 2011. About 100 providers in the file provided by HPES were in active status with an expiration date on or before February 25, 2011, and had their expiration dates subsequently extended in the MMIS. We did not include these providers in our analyses.

credentials had current credentials. In some cases this work consisted of electronically matching data from the MMIS provider file to the files maintained by the credentialing authority (e.g., the Board of Medical Practice, OPR, DOE, or CMS).[61] In other cases, we performed this match manually (e.g., the Department of Health and DAIL). Because our electronic matching was generally limited to providers that had Vermont credentials, we also chose a non-statistical random sample of 60 out-of-state providers and manually confirmed that these providers had the appropriate credential issued by their states.

- *Tests of Excluded Parties.* We chose to perform this test against the EPLS because neither HPES nor DVHA had been verifying prospective or existing providers against the EPLS database. We downloaded the EPLS database from the U.S. General Services Administration's website[62] and electronically matched it against the provider file. Our verification included Medicaid providers listed in the MMIS as being in active status after February 25, 2011, and a list of school-based service providers provided by DOE. We initially identified possible matches by last and first names and then performed further research using Social Security numbers or tax identification numbers. The follow-up on the school-based providers, using the Social Security numbers, was performed by a DOE official and we validated her verification. In our analysis we identified no providers who were performing Medicaid services who were listed on the EPLS.

- *Death Master File.* We performed an automated match between the provider file and the Social Security Administration's Death Master File[63] to determine whether any of Medicaid's active providers were deceased.

- *Data Validity Tests.* We performed other tests on the provider file looking for logical relationships and other possible invalid data. For

[61]We did not validate the data in the systems that we used to verify the license information in the MMIS. We performed walkthroughs of the processes used by the state organizations that issue licenses to gain a general understanding of their processes. In addition, in those cases in which we found an exception, we checked whether the HPES provider files contained a copy of the license and/or confirmed the exception with the applicable authorizing organizations to validate our results.

[62]We did not validate the data in the EPLS.

[63]We did not validate the data in the Death Master File.

example, we performed tests of (1) state approval of providers, (2) incompatible provider types and specialties combinations, (3) duplicate Social Security numbers, and (4) whether data was missing from critical fields (e.g., provider status end date).

We also obtained electronic copies of professional services and institutional claims paid in calendar years 2009 and 2010. We used these files for the limited purpose of checking whether weaknesses in certain controls could have resulted in improper payments. We scanned the data in the file to assess its reliability for the purposes of our analyses (e.g., that the data in the fields looked reasonable and that data was not garbled) and discussed the limitations of the files with an HPES systems manager. We ascertained that the file did not include reliable data pertaining to crossover claims (claims for beneficiaries that are eligible for both Medicare and Medicaid) at the detail level (i.e., we could determine the total paid amount, but not which details on the claims had been paid and which had been denied). However, we determined that we could rely on the files for the limited purpose of confirming whether specific providers or categories of providers had been listed as the billing, attending, referring, or prescribing providers on paid claims.

Our tests of enrollment design also included a non-statistical random sample of 60 provider files located at HPES. We checked whether these files contained (1) a current signed provider agreement, (2) evidence that the provider's credential was confirmed, and (3) evidence that the provider was screened against the LEIE.

As part of checking the claims process, we reviewed the 82 ESCs that were identified by HPES as provider-related. We reviewed the rules of each of these ESCs as set forth in the Reso Manual, checking for consistency with these rules by reviewing the MMIS tables that establish which types of claims call the edit and ascertaining the disposition of claims that "set' the edit. We also interviewed HPES systems and claims processing officials to obtain a general understanding of how the ESC process works and to explain anomalies. We did not review the programming code in the system itself.

For drug claims, we obtained information on the logic used by HPES in extracting provider data to send to RxClaim®. We also inquired of DVHA's director of pharmacy services regarding the provider-related edits in the RxClaim® system.

We did not evaluate the general controls of the MMIS and RxClaim® systems. However, we reviewed and evaluated the results of the latest SAS

70 reports on controls placed in operation and tests of operating effectiveness pertaining to both of these systems. Neither of these reports reported any material weaknesses or significant deficiencies related to these two systems.

Our audit work was performed between February and mid-August 2011 and included site visits to (1) DVHA and HPES headquarters in Williston, (2) DOE in Berlin, (3) OPR in Montpelier, (4) the Department of Health and the Board of Medical Practice in Burlington, and (5) the Department for Children and Families, the Department of Mental Health, and DAIL, all in Waterbury. Except for the exception described below, we conducted this performance audit in accordance with generally accepted government auditing standards, which 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. The standard that we did not follow requires that our system of quality control for performance audits undergo a peer review every three years. Because of fiscal considerations, we have opted to postpone the peer review of our performance audits. Notwithstanding this exception, we believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II
Provider Agreement

INTRODUCTION

Thank you for your interest in being a Vermont Healthcare Programs provider. As a state and federal Assisted Healthcare Programs provider, you must be enrolled and certified. If you are required to be licensed in your state, you must attach a copy of your license. If your state does not require a license or certification for the service you provide, certification will be verified through the HP Enterprise Services office.

Enclosed is your Provider Agreement. Please complete ALL of the data sheets in Attachment B. These sheets must be completed and the agreement (page 3) must be signed and dated in order for your agreement to be in effect.

Section 8 of Attachment B addresses controlling interests. Completing this information correctly is a Medicaid Program Integrity requirement and must be provided before you may be enrolled as a provider. If a group practice or a corporation employs you or a facility owns your practice, you must list the name of that entity in section 8. If you have any questions, please contact the HP Enterprise Services Provider Enrollment Unit at (802) 878-7871 or 1-800-925-1706 (toll free if you are calling in Vermont).

ALL PROVIDERS - ATTACH A COPY OF YOUR LICENSE

NEW PROVIDERS please also attach a copy of your NPI letter, mail application and required documentation to:

HP ENTERPRISE SERVICES
ENROLLMENT/RECERTIFICATION
P.O. BOX 888
WILLISTON, VT 05495-0888

_____

_____

_____

HP USE ONLY

Date received _____

Provider Enrollment Agreement Cover Page Revised 1/29/2010

Appendix II
Provider Agreement

ATTACHMENT B
PROVIDER IDENTIFICATION RECORD

SECTION 1 - PROVIDER DATA

Name: _____
(Individual - Last name, first name, middle initial title - e.g. Smith, John F. M.D. or group or institution)

UPIN Number: _____ License/Cert #: _____ Exp. Date: _____

Medicare Number: _____ CRNA Cert #: _____ Exp. Date: _____

NABP Number: _____ CLIA Number: _____ Exp. Date: _____

VT Medicaid Number: _____ DEA Number: _____ Fiscal Year End Month: _____

NPI Number: _____ FEIN #: _____
(Attach copy of the official NPI letter) (FEIN for groups/Institutions)

Taxonomy Codes: _____

Other Cert #: _____
Please provide other certification numbers that gives us authority to pay claims.

SSN: _____ Date of Birth: _____ Gender of Provider (M/F): _____
(SSN for Individuals)

SECTION 2 - CONTACT INFORMATION

CONTACT PERSON REGARDING THIS FORM: _____

PHONE: _____ FAX: _____ E-MAIL: _____

SECTION 3 - PROVIDER ADDRESS INFORMATION-ALL FIELDS ARE MANDATORY

PAY TO (For Remittance Advise)

Name: _____

Address: _____

_____

City:

State, Zip Code: _____

Phone: _____

Fax: _____

Email Address: _____

Appendix II
Provider Agreement

SECTION 3 - PROVIDER ADDRESS INFORMATION (Continued)

This section designates your primary service location. Do not provide a P.O. Box address.
Reprint this page as needed for additional addresses.

Name: _____ **Provider Number:** _____

Address: _____ **Fax Number:** _____

_____ **Office Website:** _____

City: _____ **Email Address:** _____

State, Zip: _____ **Phone Number:** _____

Handicap Accessibility of this service location:

None

Partial: At least one building, office and examining room are accessible

Alternate Methods of Access: The provider's office is not accessible, but he or she will see you at an alternate site that is accessible

Totally Accessible

Languages Accommodated at this office:
English; list other(s) (e.g. Bosnian, French, Sign, etc): _____

Patient Age Limits: (Range of patients that you will see-*not the range of your current patients*)

All ages

Newborn

Age Range: ___ youngest ___ oldest

Established patients only? Yes No
(If not accepting new patients check YES, if accepting new patients check NO.)

Are you a Ladies First Provider? Yes No
"Ladies First is a Federally funded breast , cervical & CVD screening program."
By checking the above yes box, the Ladies First Provider will agree to abide with the following provisions:

- Fees for the Ladies First program are based on the Medicare Part B reimbursement schedule. The provider agrees to accept payment of allowable costs as payment in full and will not bill the patient. However, the provider agrees to show the usual and customary charges on the bill so the difference, if any, can be computed as match for the Ladies First program.
- Provider agrees to comply with the instructions and restrictions regarding billing, third party payment and applicable reporting requirements for the Ladies First Program. The Ladies First Manual and Supplements are available on the web at http://healthvermont.gov/prevent/ladies_first/provider.aspx#resources. The Manual and Supplements are incorporated by reference herein.

Are you a Children w/Special Health Needs (CSHN) Provider? Yes No

Are you a Family Infant Toddler Program (FITP) Provider? Yes No

(Complete if different from above service location information)

Fax Number: _____ **Office Website:** _____

Email Address: _____

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SECTION 3 - PROVIDER ADDRESS INFORMATION (Continued)	
LEGAL ADDRESS (This is the name & address that will appear on your 1099)	**MAIL TO ADDRESS** (For correspondence & newsletters)
NAME: _____ ADDRESS: _____ _____ CITY: _____ STATE, ZIP: _____ PHONE: _____ FAX: _____ EMAIL: _____	NAME: _____ ADDRESS: _____ _____ CITY: _____ STATE, ZIP: _____ PHONE: _____ FAX: _____ EMAIL: _____
PRIOR AUTHORIZATION ADDRESS (If your service location has no mail receptacle)	**BILLING SERVICE**
NAME: _____ ADDRESS: _____ _____ CITY: _____ STATE, ZIP: _____ PHONE: _____ FAX: _____ EMAIL: _____	NAME: _____ ADDRESS: _____ _____ CITY: _____ STATE, ZIP: _____ PHONE: _____ FAX: _____ EMAIL: _____

SECTION 4 - MEDICAL OR CLINICAL SPECIALTIES			
SPECIALTY	EFFECTIVE DATE	BOARD CERTIFIED	DATE OF CERTIFICATION
		YES_____NO_____	
		YES_____NO_____	
****All applicants who are physicians, nurse practitioners, dentists, doctoral - level psychologists & social workers or individual DME providers (prosthetics) must complete this section if applicable.**			

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SECTION 5 - APPLICANT'S TYPE OF SERVICES PROVIDED AND TYPE OF BUSINESS

1. List the types of healthcare services you/your agency will provide (such as emergency transportation, psychiatric counseling, physician, pharmacy, personal care, dental, home health, respiratory care services, etc.).

_____

_____

_____

2. Applicant's type of business:

Individual

Corporation Non-Profit

Corporation for Profit

Partnership

Sole Proprietor

Other, specify

_____

_____

SECTION 6 - SUSPENSION AND DEBARMENT

Non-federal entities are prohibited by Federal Executive Order from contracting with or making sub-awards under covered transactions to parties that are suspended or debarred or whose principals are suspended or debarred. Covered transactions include procurement contracts for goods or services equal to or in excess of $100,000 and all non-procurement transactions (sub-awards to sub-recipients). By signing this contract, current Contractor certifies as applicable, that the contracting organization and its principals are not suspended or debarred by the General Services Administration from federal procurement and non-procurement programs. Providers may not knowingly have a relationship with the following:

a) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.

b) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above. Every employee and contractor must be checked at: www.oig.hhs.gov.

SECTION 7 - TERMINATION/CONVICTION/SANCTION INFORMATION

42 CFR § 455.106 Disclosure by providers. Have either you or any employee or person in whom you have a controlling interest, or any person having a controlling interest in you, been convicted of a criminal or civil offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs? Yes or No. If yes, supply the identity and all appropriate documentation .

_____

_____

Have either you or any employee been suspended, disciplined or surrendered a license or certification either in this or some other state? Yes or No. If yes, supply the identity and all appropriate documentation.

_____

_____

SECTION 8 - CONTROLLING INTEREST

As defined by 42 CFR § 455.104

Disclosure by providers and fiscal agents: Information on ownership and control.
Do you, the applicant, have a controlling interest (see above) in any of the entities listed below, or does any entity listed below have a controlling interest in your practice? You must check yes or no to each entity or your application will not be complete. If yes, please complete the section(s) on the next page.

Type of Entity	As an employee do you have a controlling interest in the Entity?		Does the Entity have a controlling interest in your practice?	
Clinical laboratory services	Yes	No	Yes	No
Physical therapy services	Yes	No	Yes	No
Speech and language therapy	Yes	No	Yes	No
Occupational therapy services	Yes	No	Yes	No
Radiology services including MRI and other imaging	Yes	No	Yes	No
Radiation therapy services and supplies	Yes	No	Yes	No
Durable medical equipment and supplies	Yes	No	Yes	No
Potential and enteral nutrients, supplies or equipment	Yes	No	Yes	No
Prosthetic, orthotics, prosthetic devices and supplies	Yes	No	Yes	No
Home health services of any kind	Yes	No	Yes	No
Pharmacy or prescription services (e.g., mail order)	Yes	No	Yes	No
Hospital services of any kind including outpatient services	Yes	No	Yes	No
Group practice	Yes	No	Yes	No
Physicians Health Organization	Yes	No	Yes	No
Nursing home	Yes	No	Yes	No
Assisted Community Care Services	Yes	No	Yes	No
Enhanced Residential Care	Yes	No	Yes	No

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SECTION 8 – CONTROLLING INTEREST (Continued)

Please indicate employer's name in this section. Any employer is considered to have a controlling interest in the services you provide. (If you are an employee only, please do not fill in "Type and percentage of controlling interest/ownership")

Name _____

Medicaid Provider Number (s)_____ SSN/EIN _____

Address _____

City _____ State _____ Zip _____ County _____

Telephone: Business _____ Home _____

Type and percentage of controlling interest or ownership _____

Are you related to anyone else listed? If so, how (spouse, parent, child, sibling) _____

Name _____

Medicaid Provider Number (s)_____ SSN/EIN _____

Address _____

City _____ State _____ Zip _____ County _____

Telephone: Business _____ Home _____

Type and percentage of controlling interest or ownership _____

Are you related to anyone else listed? If so, how (spouse, parent, child, sibling) _____

Are all of the services provided by you and any special service vendors in which you have a controlling interest billed under a single provider number?

Yes

No

If yes, please enter the number _____

NOTE: If there are additional entries, please copy this page as needed.

SECTION 9 - INSTITUTIONAL INFORMATION

NUMBER OF BEDS: _____ NUMBER OF SWING BEDS: _____

(This information is mandatory for all hospitals.) NUMBER OF LICENSED BEDS: _____

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SECTION 10 - GROUP AFFILIATION

PROVIDER NAME: _____

PROVIDER NUMBER: _____
(Enter below the individuals or groups with whom you are affiliated.)

NAME	EFFECTIVE DATE*	PROVIDER #	Currently Affiliated? Yes/No	If NO INDICATE END DATE

*INDICATE DATE PROVIDER JOINED GROUP.

SECTION 11 - MANAGING EMPLOYEES
As defined by 42 CFR § 455.101

List your office manager and contact information for this manager. A managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency. (This section must be completed even if you are the sole practitioner).

Name: Title: Telephone #:

_____

_____

_____

_____

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Provider Agreement

ATTACHMENT C
TERMINATION NOTICE

INSTRUCTIONS:
Please complete this termination notice if you wish to terminate your enrollment with Vermont Medicaid.
If you are a PCP, you need to notify Vermont Medicaid at least 90 days prior to the effective termination date.

NOTICE OF TERMINATION OF PARTICIPATION IN PC PLUS
All individually participating or group identified PCPs must notify HP, in writing, of their intention to withdraw from participation at least 90 days prior to the termination date. Closure of a practice due to the death of a PCP or sale of an individual practice, a group practice or a clinic will automatically terminate participation in the **PC *Plus*** plan.

If you are currently an active provider and you no longer wish to participate as a provider in the State of Vermont assisted health care programs, please indicate below. Your provider file will be closed on the date you specify, upon proof of 30 day notification to beneficiaries.

I no longer wish to be a Provider:

_____ _____
CLOSURE DATE PROVIDER NUMBER

_____ _____
SIGNATURE DATE

I am a PCP. YES_____ NO_____

Cancellation- This agreement may be cancelled by either the provider or the state in accordance with applicable state and federal laws and regulations.

Appendix II
Provider Agreement

ATTACHMENT A
CONDITIONS OF PARTICIPATION
PROVIDER ENROLLMENT/RECERTIFICATION AGREEMENT

Provider agrees to the following:

1. To conform to all applicable Federal and State laws and regulations including Title VI of the 1964 Civil Rights Act, the Rehabilitation Act of 1973 as amended, the Americans with Disabilities Act, and Vermont Agency of Human Services Policy 1.11.

2. To be licensed, certified or registered with the appropriate state authority.

3. To comply fully with the instructions and restrictions regarding billing and third-party payments set out in the pertinent Provider Manual including its supplements. The Manual and Supplements are available on the web at **www.vtmedicaid.com** and also in paper form on request to the HP Provider Services Unit. The Manual and Supplements are incorporated by reference herein.

4. To maintain and make available for inspection records of any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request. (42 CFR § 455.105)

5. To guard the confidentiality of beneficiary information in a matter consistent with the confidentiality requirements in 45 CFR parts 160 and 164 and as required by state law.

6. To maintain and make available for inspection all medical, case or business records pertaining to the extent of services provided and any other information regarding payments, claimed or received, as they may pertain to the Office of Vermont Health Access programs. Additionally, the provider agrees to furnish these records and the other specified information to the Vermont Agency of Human Services, the U.S. Secretary of Health and Human Services and the Office of the Vermont Attorney General upon request. Such records shall be retained for seven (7) years.

7. To verify the eligibility of each patient prior to providing the service for each date of service, except where EMTALA applies.

8. To file a complete and accurate claim in a timely fashion. The signature of the provider, or the provider's designees, on a paper claim or the signature on the transmittal agreement for electronic claims certifies that the service(s) listed was medi cally necessary and actually rendered to a state health care program beneficiary. The provider is solely responsible for the accuracy of claims submitted whether in paper or electronic form.

9. To give notice to the Medicaid beneficiary in writing and in advance of providing the service, if the provider will not accept Medicaid payment for a service.

10. To establish and maintain a uniform charge for each item or service provided under this agreement.

11. To accept the state health care program payment for any service or item as payment in full, and to make no additional charge to a beneficiary except as allowed under the Provider Manual or OVHA rules.

12. To receive payment for services through Electronic Funds Transfer (EFT).

13. To comply fully with Title 42: Public Health, Part 455 Program Integrity: Medicaid, Subpart B: Disclosure of Information by Providers and Fiscal Agents.

14. Provider attests that all terms of this agreement are met on the date of service provided to Vermont beneficiaries.

15. Providers are required to periodically search the www.oig.hhs.gov website by individual or entity name. The periodic search by the provider is intended to capture exclusions and reinstatements that may have occurred since the last periodic search. Providers should immediately report any exclusion discovery to HP Provider Enrollment.

16. Providers are required to review the member handbook found at www.ovha.vermont.gov/for-consumers for information on enrollee rights, grievances and appeals.

Appendix II
Provider Agreement

VERMONT
AGENCY OF HUMAN SERVICES

OFFICE OF VERMONT HEALTH ACCESS
PROVIDER ENROLLMENT/RECERTIFICATION AGREEMENT

1. Parties This is an agreement between the State of Vermont Agency of Human Services ("State") and _____ ("Provider") doing business as _____

2. Subject Matter The subject matter of this agreement includes provider enrollment requirements and payment for the provision of health services and items to eligible beneficiaries.

3. Payment Amount In consideration of services to be performed by the provider, the State agrees to pay the Provider in accordance with all applicable provisions of the Global Commitment Waiver, Long Term Care (LTC) Waiver, Vermont Medicaid State Plan, Medicaid Rule, and the Provider Manual, including its supplements.

4. Agreement Term The period of this agreement is for one year from the date of signing, at the expiration of the provider's license and/or certification, or at the suspension or surrender of the provider's license or certification.

5. Cancellation This agreement may be cancelled by either the provider or the State in accordance with applicable state and federal laws and regulations.

6. Attachments This agreement includes the following attachments which are incorporated herein:
Attachment A – Conditions of Participation
Attachment B – Provider Identification Record
Attachment C –Termination Notice.

7. Additional Provisions Except as may be reasonably necessary in carrying out obligations under this agreement, the Provider shall not release, disclose, or make statements to third parties regarding data, information, files, documents or other materials generated, compiled, or maintained in connection with this agreement concerning beneficiaries, unless the State consents in writing to the disclosure. The exceptions to this prohibition on the release of information are when a court with appropriate jurisdiction orders the release of information or when the recipient of services rendered by the provider consents. In handling all such information, the Provider shall carry out the provisions of this agreement in accordance with applicable federal and state statutes.

8. Covered Programs By enrolling, the provider will be able to bill for services and items provided to beneficiaries in all state/federal assisted healthcare programs including but not limited to Medicaid, Dr Dynasaur, VScript, VHAP, VHAP Pharmacy, VPharm, Ladies First, Children with Special Health Needs(CSHN), Family Infant Toddler Program(FITP) and General Assistance.

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Provider Agreement

9. **Authorized Official Signature**

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Vermont Medicaid program and state/federal assisted healthcare programs. If I become aware that any information in this application is not true, correct or complete, I agree to notify HP Enterprise Services of this fact immediately (within 30 days of change) at (802) 878-7871 or (800) 925-1706.

A. Individual Practitioner

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentations or concealment of any information requested in the application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.
Individual Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)* **SIGNED**			Date *(mm/dd/yyyy)*

The below section must be completed by a group practice, i.e. Office Manager, Administrator, Director etc.

B. Authorized or Delegated Official

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentations or concealment of any information requested in the application may subject me to liability under civil and criminal laws.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.
Authorized or Delegated Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)* **SIGNED**			Date *(mm/dd/yyyy)*
Title of Authorized Signature			

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

Appendix III
Response of the Commissioner of the Department of Vermont Health Access

VERMONT

State of Vermont
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston VT 05495-2807
dvha.vermont.gov

[Phone] 802-879-5900
[Fax] 802-879-5651

Agency of Human Services

RECEIVED
SEP 08 2011
VERMONT
STATE AUDITOR

August 29, 2011

Mr. Thomas M. Salmon, CPA
State Auditor
132 State Street
Montpelier, VT 05633-5101

Dear Mr. Salmon:

I am writing in response to the draft report of your audit of DVHA's enrollment practices. It is encouraging to see that your recommendations closely match many of the improvements we are already developing. We appreciate your feedback and we are always open to suggestions that will improve our work process.

In response to other audits and reviews over the course of the year (e.g., Medicaid Integrity Group (MIG) audit, External Quality Review Organization (EQRO) audit) we have already initiated several quality improvement activities. These activities will comply with the new CMS 6028 rules and will incorporate your recommendations. This Fall, we will complete a single, comprehensive manual describing all of our enrollment processes.

Attached, you will find our responses to each of your recommendations. In general, you will find that we agree with your recommendations. We look forward to working with you in the future.

Sincerely,

Mark Larson,
Commissioner

Appendix III
Response of the Commissioner of the Department of Vermont Health Access

DVHA Responses to Enrollment Audit Recommendations

• *Require all Medicaid providers to periodically undergo reenrollment and restrict the use of "forever" active status end dates to state organizations*

Response: We agree with this recommendation and have already added it to our new enrollment procedures which will become effective this fall.

• *Comply with the federal regulation that requires home health agencies to obtain a surety bond and furnish this bond to DVHA*

Response: We will discuss a plan to address this issue with the Department for Children and Families as well as our Home Health providers. Our goal is to comply with this federal requirement.

• *Modify the Medicaid monthly excluded parties process to be in accordance with federal regulations, including checking out-of-state providers and all providers' ownership and controlling interests, and managing employees*

Response: We agree with this recommendation and have already added it to our new enrollment procedures which will become effective this fall.

• *Establish a process to periodically check whether providers are performing the required screening of employees and contractors against the LEIE and EPLS, which could consist of a written certification from these providers during the enrollment process that such a process has taken place*

Response: We agree with this recommendation and have already added it to our new enrollment procedures which will become effective this fall.

• *Revise the provider agreement to require that providers search the LEIE website monthly to capture exclusions and reinstatements since the last search,*

Response: We agree with this recommendation and have already added it to our new enrollment procedures which will become effective this fall.

• *Establish a process to periodically compare the Medicaid provider file against the Social Security Administration's Death Master File*

Response: We agree with this recommendation and have already added it to our new enrollment procedures which will become effective this fall.

• *Arrange to obtain credential status changes subsequent to the date of enrollment or reenrollment of licensed, certified, or registered providers from the Vermont licensing authorities*

Response: We recognize the importance of getting "real-time" data from licensing authorities related to license status changes. We will work with the Medical Practice Board and the Office of Professional Regulation to explore this recommendation.

Appendix III
Response of the Commissioner of the Department of Vermont Health Access

• *Develop criteria for the consistent application in the use of the MMIS's organization type code to limit the categories of organizations allowed to be coded as individuals*

Response: We agree with this recommendation and have already added it to our new enrollment procedures which will become effective this fall.

• *Ensure that research into whether those providers identified in this audit as having the wrong provider type, laboratory certification level, or active status be completed and any improper payments recouped*

Response: We are researching this issue and have already corrected some of the discrepancies.

• *Expeditiously respond to HPES' request to clarify the reimbursement rates for certified nurse-midwives, certified registered nurse anesthetists, and anesthesia assistants and, if the MMIS's reimbursement rate is incorrect direct HPES to change the rate immediately and seek reimbursement for any overpayments that may have been made*

Response: Our Data and Reimbursement Unit will clarify this rate and, if overpayments are found, we will recoup these funds.

• *Establish a process to verify that drug claims for controlled substances are prescribed by providers with the appropriate DEA registration level.*

Response: We agree with the general principles of this recommendation. We work with our pharmacies, the Vermont Board of Pharmacy and HPES to develop a plan to address this issue.

• *Modify its credential verification process to eliminate gaps in the independent verification of provider credentials, including those issued by Vermont, other states, CMS, and DEA*

Response: We agree with this recommendation and have already added it to our new enrollment procedures which will become effective this fall.

• *Verify the Medicare enrollment of those provider types required to be enrolled in Medicare per the DVHA Medicaid rules*

Response: This recommendation, as well as the new CMS 6028 rules, prompted us to include proof of Medicare enrollment for the provider types described in your findings. We expect to roll out these new changes in the Fall.

• *Screen all providers, their ownership and controlling interests, and managing employees against the LEIE and EPLS in accordance with federal regulations*

Response: We agree with this recommendation and have already added it to our new enrollment procedures which will become effective this fall. This will initially be a process that we track outside of MMIS.

• *Establish a process related to those cases in which HPES is made aware of changes to a providers' enrollment of checking for claims that are filed with a date of service*

Appendix III
Response of the Commissioner of the Department of Vermont Health Access

between the effective date of the change and the date the change was actually made in the system, and

Response: We generally do perform these checks, although we agree that our lack of a formal process allows for the chance that a change might not be reviewed. We will work with HPES to develop better written procedures to resolve this issue.

• *Determine the feasibility of modifying the MMIS, or implementing compensating manual controls, to address weaknesses identified in this report, including (1) the use of automated edits during the provider enrollment data entry process, (2) the process used to automatically change providers from active to inactive status so that manual extensions of a provider's active status end date does not bypass this process, (3) the lack of an edit to recognize the claims limitations of providers whose number starts with B, D, F, or 7000, (4) capturing the relationship between the specific location on the laboratory certificate and the service location(s) of a provider, and (5) restricting referring providers to individuals.*

Response: We will review this recommendation and incorporate a solution into our upcoming RFP for new provider management and claims adjudication systems.

• *Ensure that practitioners who authorize school-based Medicaid services are enrolled in Medicaid*

Response: We are committed to working with our colleagues at the Department of Education to explore solutions to address this recommendation.

• *Enroll individuals or organizations that provide the Medicaid reimbursed service, which can be a streamlined process in accordance with federal regulations*

Response: We are committed to working with our colleagues at the Department of Education to explore solutions to address this recommendation.

• *Periodically screen school-based service providers against the LEIE and EPLS databases in accordance with federal regulations.*

Response: We are committed to working with our colleagues at the Department of Education to explore solutions to address this recommendation.

Appendix IV
Response of the Deputy Commissioner and Chief Financial Officer of the Department of Education

State of Vermont
Vermont Department of Education
120 State Street
Montpelier, VT 05620-2501

August 25, 2011

Thomas M. Salmon, CPA
Office of the State Auditor
132 State Street
Montpelier, VT 05633-5101

Dear Auditor Salmon,

I write in response to your letter of August 12, 2011, in which you convey the results of the Medicaid provider enrollment audit recently completed by your office, and request comments on the findings included in your report, *Medicaid: Many Provider Enrollment Controls in Place, But Gaps Exist* (Rpt. 11-05), as they relate to the Department of Education.

I have reviewed your report with the Department's staff. Following are the changes that the Department plans to make to the School-Based Health Services Program, based on your findings and recommendations:

Finding: *Ensure that practitioners who authorize school-based Medicaid services are enrolled in Medicaid.*

Effective January 1, 2012, supervisory unions will be required to verify that any practitioner signing a Physician Authorization form is an enrolled Vermont Medicaid provider; supervisory union staff will verify provider enrollment by utilizing the Vermont Medicaid website (www.vtmedicaid.com). In addition, Department staff will modify the audit process to include verification that, for any Physician Authorization form that is part of an audited sample, the practitioner having signed such form is an enrolled Medicaid provider.

Finding: *Enroll individuals or organizations that provide the Medicaid-reimbursed service, which can be a streamlined process in accordance with federal regulations.*

Per the Intergovernmental Agreement between the Department of Vermont Health Access (DVHA) and the Department of Education for the Administration and Operation of School-Based Health Services, the Department will assist supervisory unions with the reenrollment process. The frequency of the supervisory union reenrollment shall be determined by the DHVA.

By January 1, 2012, the Department will maintain a central list of all professional service providers. The Department will work with the Agency of Human Services and the DVHA to determine whether changes are needed to the Provider Certification Agreement in order to meet federal requirements.

Appendix IV
Response of the Deputy Commissioner and Chief Financial Officer of the Department of Education

Finding: *Periodically screen school-based providers against the LEIE and EPLS databases in accordance with federal regulations.*

Effective January 1, 2012, supervisory union staff will screen all new service providers against the LEIE and EPLS databases. Department staff will modify the audit process to determine whether, for all services providers having signed documentation logs included an audited sample, such service providers are listed in the LEIE and EPLS databases.

Should you have questions, you are welcome to contact me at (802) 828-3135 or by email at bill.talbott@state.vt.us.

Sincerely,

William B. Talbott
Deputy Commissioner and Chief Financial Officer