Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Iowa Comprehensive Program Integrity Review

Final Report

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Reviewers:
Tonya Fullen, Review Team Leader
Leatrice Berman Sandler
Margi Charleston
Randy Anderson

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Iowa Medicaid Program. The MIG review team conducted the onsite portion of the review at the Iowa Medicaid Enterprise (IME) offices. The review team also met with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the IME, which is primarily responsible for Medicaid program integrity oversight. This report describes one noteworthy practice, two effective practices, six regulatory compliance issues, and seven vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Iowa improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Iowa's Medicaid Program

The IME administers the Iowa Medicaid program. In January 2010, the program served 432,917 beneficiaries. Iowa contracts with a behavioral health organization (BHO) that provides behavioral health services on a managed care basis to 80 percent of the Medicaid population. With this exception, Medicaid services were provided on a fee-for-service (FFS) basis. Iowa had 198,303 beneficiaries enrolled in a primary care case management program called Medipass. The State had approximately 52,652 FFS enrolled providers, 1,999 BHO providers and 1,754 Medipass primary care providers.

During Federal fiscal year (FFY) 2009, Iowa's total computable Medicaid expenditures were $2,920,972,816. The Federal medical assistance percentage (FMAP) for Iowa in FFY 2009 was 62.62 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 68.82 percent for the first three quarters of FFY 2009 and 70.71 percent for the fourth quarter.

Program Integrity Section

The Iowa Department of Human Services (DHS) is the Single State Agency for the Medicaid program. The IME is a division within DHS that has the responsibility for the management of the program. Program integrity operations are the responsibility of the program integrity director and the program integrity manager, who both are State employees working for IME. However, IME contracts out for the performance of program integrity case reviews, follow-up, and virtually all other program integrity functions. Contract staff comprises the State's Surveillance

and Utilization Review Subsystem/Program Integrity Unit (henceforth called PIU). On July 1, 2010, shortly before the CMS team's onsite visit, a new contractor had transitioned into this role. The IME also identified eight other contractors which perform core Medicaid agency and program integrity-related functions, such as audits and provider enrollment. Each contract is the responsibility of a specific IME unit, with a State employee assigned to provide oversight and coordination. Additionally, the contractors have employees and managers stationed onsite in the offices of IME.

The table below presents the total number of investigations and overpayment amounts identified and collected for the last four State fiscal years (SFYs) as a result of program integrity activities overseen by IME. The number of preliminary and full investigations includes audits conducted by IME or its contractors (IME reported that State staff undertook some audits until March 2010).

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Overpayments Identified Through Program Integrity Activities	Overpayments Collected Through Program Integrity Activities
2006	43	14	$2,916,174	$874,798
2007	60	5	$2,879,354	$1,065,390
2008	160	20	$3,924,371	$1,468,296
2009	109	32	$3,960,772	$2,726,043

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. The report lists the total number of Medicaid post-payment claims reviews and audits undertaken in the past four SFYs.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition. The figures represent cases referred to the MFCU.

Methodology of the Review

In advance of the onsite visit, the review team requested that Iowa complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosure, managed care, and the MFCU. A four-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of July 12, 2010 the MIG review team visited the offices of IME. The team conducted interviews with numerous IME officials, contractor staff, and the MFCU director. To determine whether the statewide behavioral health plan was complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the State's BHO contract. The team conducted in-depth interviews with representatives from the BHO and met separately with IME staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity case files, and other primary data to validate Iowa's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of IME, but also considered the work of other contractors within IME responsible for a range of program integrity functions, including provider enrollment, managed care and non-emergency medical transportation (NEMT). Iowa operates both a stand alone Children's Health Insurance Program (CHIP) and a Title XIX expansion program. The expansion program operates under the same billing and provider enrollment policies as Iowa's Title XIX program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the expansion CHIP. The stand alone program operates under the authority of Title XXI and is beyond the scope of this review.

Unless otherwise noted, IME provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that IME provided.

RESULTS OF THE REVIEW

Noteworthy Practice

As part of its comprehensive review process, the CMS review team has identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Extensive training of personal care attendant (PCA) providers

Based on each beneficiary's approved care plan hours in the State's Consumer Directed Attendant Care (CDAC) program, Iowa requires detailed documentation including the completion of a Daily Service Record form by PCAs. The Daily Service Record form went into use in November 2008. It includes fields for identifying provider and consumer information; agency name; date, time and location of provided service; amount of provider time with the consumer; actual hours of CDAC services; description of services provided to the consumer; and documentation of any concerns. The Daily Service Record must be signed by both the consumer and the provider.

The IME has made operational changes to facilitate the accuracy of Daily Service Records. The Provider Services Unit has been divided to ensure that there are representatives available to answer calls, as well as support and educate providers. The unit has also developed a training module on video (digital video disc) for providers to educate them on filing out the forms.

Since its inception, the Daily Service Record has come to be used as a tool for audit purposes to assist Iowa in various program integrity activities, such as monthly and quarterly post-payment queries identifying outliers and potentially conflicting episodes in which the dates of personal care services overlap with institutional stays.

The CDAC Daily Service Record is instrumental in enforcing certain CDAC upper payment limits mandated by section 79.1(2) of the Iowa Administrative Code. The payment restrictions involve daily rates and monthly caps in the program. During SFY 2009-2010, four CDAC providers were excluded as a result of overbilling. The DHS took action to recoup $29,000 from the excluded parties' salaries during the time they were employed by a Medicaid provider. All funds were repaid, and the Federal share was reported to CMS and returned through offsets in the quarterly claiming process.

Effective Practices

As part of its comprehensive review process, the CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Iowa reported its Iowa Workforce Development (IWD) data match and innovative and aggressive follow up with providers to ensure that excluded parties are not hired as providers, contractors or agents.

Matching names of excluded individuals to the IWD database

Iowa's PIU receives the monthly List of Excluded Individuals/Entities (LEIE) published by the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG). Upon receipt of the LEIE, the PIU manager matches these names to the IWD database to determine if and where excluded individuals were working in the past four quarters. If an excluded individual is working for an agency or provider receiving Medicaid funding, a letter is sent to the provider informing them that they may have hired an excluded individual. This letter requires the provider to send the excluded individual's job description and W-2 forms from the beginning of their employment or their exclusion date, whichever is later, and their current year-to-date salary, expenses and benefits. Providers may also submit any other information they believe IME should review in determining if an overpayment exists. If the State judges that an overpayment exists, the PIU will request repayment.

During interviews, IME representatives indicated that they plan to conduct a full match of the HHS-OIG and State exclusion lists with the IWD database on a quarterly basis to more aggressively identify excluded parties and ferret out providers and agencies that are not regularly checking the exclusion databases. Since October 2009, the IWD-LEIE matching process has identified four excluded providers who were working in intermediate care facilities for the mentally retarded, resulting in a total recoupment of approximately $12,000. The overpayment was reclaimed through a combination of checks from the providers and the retroactive reduction of per diem reimbursement.

Although the cross-referencing of tax and labor documents in identifying excluded parties is a commendable practice that other States should consider, the review team found other issues related to the search for exclusions which are discussed in the Vulnerabilities section of this report.

Provider education and outreach

Iowa has been innovative and aggressive in following up with providers to ensure that excluded parties are not hired as providers, contractors or agents. From 2007 to the present, IME has sent annual letters to providers reminding them of the prohibition against hiring and contracting with excluded parties. These letters originally relied on earlier HHS-OIG guidance. Since the publication of CMS' State Medicaid Director Letter of January 16, 2009 (SMDL #09-001), the letters reference and link to CMS guidance on how providers are expected to check their employees regularly for exclusions. Iowa was writing clear and forceful letters to providers before receiving any CMS guidance and continues to do so. These letters annually remind providers of their continuing obligations and the consequences of non-compliance (i.e., the recoupment of Medicaid payments).

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding communication and coordination with the MFCU, as well as a number of required disclosure and notification requirements.

Lack of effective communication and coordination with the MFCU.

The regulation at 42 CFR § 455.21 requires States to cooperate with the State Medicaid Fraud Control Units in referring suspected fraud cases and providing open access to case information.

In the course of its interviews and document review, the MIG review team noted problems in the working relationship between IME and the MFCU. Whereas an earlier MIG review team found a high degree of State-MFCU cooperation during the 2008 comprehensive program integrity review in Iowa, the relationship between the two entities seems to have deteriorated after new MFCU leadership came on board in December 2008. In March 2010, the MFCU director made known his frustrations to CMS about a lack of fraud referrals coming from Iowa's capitated behavior health contractor. During the onsite visit, the review team did note an improvement in MFCU communications with the State's contracted BHO and an increase in the number of managed care cases being sent to the MFCU. However, at the time of the review, the State agency-MFCU relationship had not yet fully righted itself.

The MFCU director noted that IME has been expanding its targeted goals for recoupment and recovery, as reflected by the fact that the State agency has set a goal for SFY 2011 of $20 million in cost avoidance and recoveries, almost doubling the current annual estimated amount of recoupments and payouts prevented. The MFCU director indicated that as the State expands its efforts to investigate providers, his office would like to have knowledge of the cases and involvement in developing coordinated strategies to determine whether it is appropriate to bring civil/criminal actions, administrative (recoupment) actions or concurrent actions. The MIG team noted that at the time of the review, the two units were not engaged in direct conversations about these issues and had very different perceptions about their relationship, despite the fact that they held biweekly meetings. For example, the MFCU indicated that the State agency has sent numerous (54) referrals related to PCA services. However, the MFCU director reported that

these cases do not have significant fraud potential, and the State has not involved the MFCU in determining whether there are more significant cases under investigation by the PIU. In contrast, State agency staff indicated that they were not aware of the MFCU's wish to be involved in case development and maintained that they had not omitted any significant cases during the biweekly interagency discussions.

The MFCU further indicated (and emails and interviews appear to verify) that it has been difficult to obtain documents requested from the State's BHO contractor. The MFCU director said he had specifically requested documents, such as the BHO contract, other contract-related material, BHO referrals and case-related material (spreadsheets, logs), which the State agency ultimately provided; but he indicated that it had been difficult in the past to get managed care documents as well as reports on State agency recoupment actions and receivables. Although both parties appear to have worked out many of the difficulties associated with document requests, the MFCU went on to say that IME records are not always readily available, and this continues to create discord between the units. Whether all the historical records sought by the MFCU are in fact available is unclear. However, based on the Federal regulation at 42 CFR § 455.21(a)(2)(i-iii), the State agency is obligated to provide open and free access to the MFCU for any request. Specifically, the State "agency *must…promptly comply with a request* from the unit [the MFCU] for access to, and free copies of, any records or information kept by the agency or its contractors."

Both the MFCU and State agency reported that they had not previously seen or jointly discussed the *CMS Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit*, published and disseminated in September 2008. However, the MFCU director was satisfied with the quality of the referral information and accompanying documentation provided by the State agency. The review team also determined, through a sampling of referred cases, that those referrals being made generally met the performance standards. Although the content of current referrals appeared acceptable, the lack of familiarity with the fraud referral guidelines was a concern, especially in a program where so much of the program integrity work is contracted out. This is discussed in the Vulnerabilities section of the report.

There are indications that relations between the State agency and the MFCU have begun to improve steadily. This may be partly a result of CMS compliance review activity helping to bring both parties together. The review team believes that relations between the State agency and MFCU can continue to improve in a positive way if both parties set down in writing their mutual expectations and responsibilities. Neither the current Memorandum of Understanding (MOU) between the two entities or any other document provides clear guidance in this respect.

Recommendation: Develop and implement a new MOU or other auxiliary agreement that sets down mutual goals and expectations.

The State's notice of payment withholding does not include all required information.

The regulation at 42 CFR § 455.23(b) stipulates that the Medicaid agency's notice of withholding state that payments are being withheld in accordance with the Federal regulation. Iowa's notice of payment withholding letter does not state that payments are being withheld in accordance with this provision.

NOTE: The program integrity regulation at 42 CFR § 455.23 has been substantially revised and the amendment was effective March 25, 2011. The regulation as amended requires payment suspension pending investigations of credible allegations of fraud and referral to the MFCU, or other law enforcement agency if there is no certified MFCU in the State.

Recommendation: Modify the State's withhold letter to include the requirement at 42 CFR § 455.23(b).

The IME does not capture all required ownership, control, and relationship information from the BHO. (Uncorrected Repeat Finding)

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

This is a repeat finding from the previous CMS program integrity review in May 2008. The current review team discussions with State managed care staff and BHO representatives indicated that a full set of contractor ownership disclosures that map to the requirements of § 455.104 were not captured at the point of contracting. In addition, the contract between IME and the BHO does not fully address the requirements of 42 CFR § 455.104. While some ownership and control information is collected for the BHO and subcontractors, Section 2.1(5)(f) of the contract does not ask for the full range of disclosure information that the Federal rule requires, such as the addresses of owners and persons with controlling interests and the relationships among all parties with ownership and control interests.

NOTE: The CMS team reviewed the behavioral health contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section of the program integrity regulations has been substantially revised and the amendment was

effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

***Recommendation*:** Modify the IME-BHO contract and the appropriate Request for Proposal documents to capture all required ownership, control, and relationship information.

Iowa does not require business transaction disclosures, upon request, from its BHO. (Uncorrected Repeat Finding)

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services information about certain business transactions with wholly owned suppliers or any subcontractors. This is a repeat finding from the May 2008 CMS program integrity review. The State Agency's BHO contract does not contain language obligating BHO to provide the required business transaction information upon request.

***Recommendation*:** Modify IME's contract with its capitated BHO to meet the requirement at 42 CFR § 455.105(b).

Iowa does not report to the HHS-OIG adverse actions taken on provider applications for participation in the program.

The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The State has not established a systematic adverse action reporting policy which fully conforms to the requirements of 42 CFR § 1002.3. For example, the PIU said that it would not report applications denied for program integrity reasons and indicated that it was not sure what other adverse actions need to be reported. The program integrity director noted that the PIU had in fact reported to HHS-OIG several terminated individuals working as PCAs in the State's CDAC program. However, a regional HHS-OIG official told the State that the HHS-OIG did not require the reporting of unlicensed persons.

Despite good faith efforts to comply with the regulation, IME has the affirmative obligation to establish a clear internal policy and procedure and understanding with HHS-OIG on what types of adverse actions must be reported.

***Recommendation*:** Develop and implement policies and procedures to ensure the timely reporting to HHS-OIG of adverse actions taken on FFS provider applications for reasons of fraud, integrity, or quality and of actions taken to limit the ability of enrolled FFS providers to continue participating in the Medicaid program.

Iowa does not perform all required notifications when it excludes providers.
Under the regulation at 42 CFR § 1002.212, if a State agency initiates exclusions pursuant to the regulation at 42 CFR § 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in §§ 1001.2005 and 1001.2006.

Interviews with State agency staff and copies of exclusion letters evidence incomplete notification protocols. Notifications of exclusions are primarily made to internal State agency divisions, the MFCU or the U.S. Attorney's office. In one instance reviewed, notice was provided to a supervising provider (in the specific case of the exclusion of a physician's assistant). There was no evidence that IME's notification protocols or practices included the public and beneficiaries or matched the general breadth of the notifications required by the regulation.

***Recommendation*:** Develop and implement policies and procedures to ensure that all parties identified by the regulation are notified of State-initiated exclusions.

Vulnerabilities

The review team identified seven areas of vulnerability in the State's program integrity practices. These involved the failure of its BHO to collect required ownership and control, business transaction and health care-related criminal conviction disclosures from network providers and the failure to report adverse actions taken against providers applying to join the BHO network. Additional issues included the failure to collect managing employee information on FFS and BHO credentialing forms, conduct complete exclusion searches in accordance with current CMS guidelines, and to incorporate published CMS guidance on MFCU fraud referral standards in State policies and procedures for contractors.

Not collecting all required ownership and control disclosure information.
The capitated behavioral health contract with IME does not require BHO to collect the full range of ownership and control disclosures from network providers that the regulation at 42 CFR § 455.104 would otherwise require from providers participating in Iowa's FFS program. The credentialing process, applications and forms used by BHO do not collect the names and addresses of persons with ownership and control interests in the provider, information on family relationships among such persons, and information on interlocking relationships of ownership and control with subcontractors. Consequently, it is difficult to determine if individuals in key ownership and control positions are excluded from Federal health programs. Moreover, BHO and the State were not able to determine at the time of the review how many disclosing entities in the BHO's provider network were already enrolled by IME. To the extent that providers receiving Medicaid dollars are credentialed outside the IME enrollment process, the State is vulnerable to having excluded parties in ownership and control positions or as subcontractors serving Medicaid recipients.

NOTE: The CMS team reviewed the behavioral health contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section

of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

***Recommendation*:** Modify BHO's contract with IME and its network provider credentialing applications and agreements to require the disclosure of complete ownership, control, and relationship information from all BHO network providers.

Not requiring BHO providers to disclose business transaction information upon request.
The DHS contract with the capitated behavioral health contractor and the latter's provider agreements do not require network providers to disclose the business transaction information on request which Federal regulations at 42 CFR § 455.105 would otherwise require of FFS providers.

***Recommendation*:** Modify IME's behavioral health care contract and BHO's network provider agreements to require disclosure, upon request, of the required business transaction information.

Not requiring the disclosure of complete health care-related criminal conviction information during the managed care credentialing process.
The BHO's credentialing application does not require disclosure of health care-related criminal convictions from all parties that would otherwise be required in the FFS Medicaid program under 42 CFR § 455.106. The form asks if members of the organization's or practice's staff have been expelled or suspended from receiving payment under the Medicare and/or Medicaid program within the last five years. This does not meet the FFS standard, which requires the disclosure of all health care-related criminal convictions since the inception of the referenced Federal health care programs. The form also does not specifically ask about health care-related criminal convictions on the part of the full range of parties affiliated with applying entity, such as the owners, directors, agents and managing employees of providers.

***Recommendation*:** Develop and implement policies and procedures and revise credentialing applications to collect the required health care-related criminal conviction disclosures from all parties affiliated with BHO network providers and to report all applicable disclosures to HHS-OIG.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications.
The IME has not contractually obligated BHO to report provider applicants denied for program integrity reasons or those providers who have been sanctioned or dropped from the network for program integrity reasons, as the State would be required to do with adverse actions taken against FFS providers under the regulation at 42 CFR § 1002.3. Although IME is made aware of

providers under investigation and the outcomes of these investigations, such as sanctions, application denials that result from concerns about program integrity are not reported. In response to a question about this, BHO reported that its data systems do not capture such information. Therefore, BHO is not able to report credentialing denials to the State. As a result, Iowa is unable to report adverse actions of this type to HHS-OIG. The State also must take care to ensure that it requires similar reporting from its transportation broker as part of the transition to a statewide NEMT broker system that it is currently undertaking.

***Recommendations*:** Modify IME's BHO contract to require notification to DHS of adverse actions taken against BHO providers, including the denial of credentialing for fraud-related concerns. Ensure that clear policies and procedures requiring the notification of adverse actions are implemented when the State carries out its current plans to transition to a statewide NEMT broker system.

Not capturing managing employee information on FFS provider enrollment and managed care credentialing forms.

Under 42 CFR § 455.101, a managing employee is defined as "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."

Although the State is moving toward a web portal-based re-enrollment system in the fall of 2010 when it will capture managing employee names and identifying information from FFS providers, the State currently does not solicit managing employee information on its provider enrollment form. Likewise, the BHO provider application does not include the collection of managing employee names at enrollment. Thus, the State and BHO have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

***Recommendation*:** Modify enrollment forms to require disclosure of agent and managing employee information.

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

The regulations at 42 CFR §§ 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. Even if the State were compliant with the requirements in the regulations, the State is neither collecting nor maintaining complete information on owners, officers, and managing employees in the Medicaid Management Information System (MMIS), therefore the State cannot conduct adequate searches of the LEIE or the Medicare Exclusion Database (the MED).

The CMS issued SMDL #08-003 dated June 16, 2008 providing guidance to states on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the Excluded Parties List System (EPLS) on a monthly basis.

While Iowa has been aggressive in outreach to providers on exclusion checking requirements, through interviews and a walk-through of the provider enrollment section, the review team determined that the State was not fully in compliance with the CMS guidance on State exclusion checking. As noted, for example, the review team established that Iowa does not collect full ownership or managing employee information in its FFS or managed care enrollment processes. When information on owners, officers, and Board of Directors members is provided, it is not checked against the LEIE, the MED, or the General Services Administration's EPLS at the time of provider enrollment. Only provider names are checked.

Moreover, while the State collects the names of owners, officers and Board members in many instances (and has a track record of sending numerous applications back to providers for them to supply missing information), IME does not enter information on these parties into the MMIS or another searchable data repository where they can be checked for exclusions on an ongoing basis. In addition, because IME's capitated behavioral health contractor does not collect complete ownership disclosures and managing employee names from its providers, BHO is not in a position to undertake full exclusion checking with respect to its provider network.

These practices demonstrate that Iowa does not conduct complete and automated exclusion checks on all relevant individuals from the time of Medicaid enrollment going forward. This leaves the State open to the risk that Medicaid dollars are flowing to providers who are affiliated with excluded parties.

***Recommendations*:** Develop policies and procedures for appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Search the LEIE (or the MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded person or entities.

Not providing training on the CMS minimum fraud referral standards.
During the onsite review, IME and MFCU officials with whom the team spoke indicated that they were unaware of the *CMS Performance Standard for Referrals of Suspected Fraud from a*

Single State Agency to a Medicaid Fraud Control Unit, which CMS issued in September 2008. Although the team did not observe specific documentation problems in the sample MFCU referrals it reviewed, IME's lack of familiarity with these baseline performance standards is of concern because of the need for consistent policies and procedures in this area. This is especially important in a Medicaid program that contracts out the case investigation and case development functions. Where staff and contractors may be subject to frequent turnover, the need for written institutional memory is all the more imperative. The absence of a frame of reference for fraud referral policies and procedures leaves the State vulnerable to inconsistent operations and ineffective functioning in the event that it loses experienced contractor or in-house staff.

***Recommendation*:** Incorporate the September 2008 CMS fraud referral performance standards into written policies and procedures and training materials on developing suspected Medicaid fraud cases for referral to the MFCU.

CONCLUSION

The State of Iowa applies some noteworthy and effective practices that demonstrate program strengths and the State's commitment to program integrity. These practices include:

- training of PCAs on documentation of services in the CDAC program,
- data matching within the Workforce Development system, and
- aggressive outreach to providers on exclusion checking requirements.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, seven areas of vulnerability were identified. The CMS encourages IME to closely examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require DHS to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Iowa will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Iowa has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Iowa on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

June 16, 2011

Angela Brice-Smith, Director
Center for Program Integrity
Medicaid Integrity Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Brice-Smith

I have received the Iowa Comprehensive Program Integrity Review Final Report from May 2011 and my staff have taken corrective actions for each area of non-compliance. The attached report addresses how the Iowa Medicaid Enterprise will ensure that deficiencies will not recur, as well as timeframes for each correction, along with specific steps that will occur. There is also an explanation or those findings or vulnerabilities that will take more than 90 calendar days from May 17, 2011 to correct.

Iowa is committed to improving all of its Medicaid program integrity procedures and processes, and the information contained in the report is very beneficial in that regard. Please extend my thanks to your staff for all of their assistance during the course of the review.

If you have any questions about Iowa's corrective action plan, please don't hesitate to contact Patti Ernst-Becker, Program Integrity Director for the Iowa Medicaid program. Her contact information is (515) 256-4632 or pernstb@dhs.state.ia.us.

Thank you for the assistance you and your staff have given to Iowa.

Sincerely,

Jennifer H. Vermeer
Medicaid Director

JHV/peb