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Medicaid Integrity Program

Iowa Comprehensive Program Integrity Review

Final Report

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Reviewers:
Tonya Fullen, Review Team Leader
Annette Ellis
Julian Isaacs
LaShonda Mazique
Joel Truman, Review Manager

Table of Contents

Executive Summary and Introduction

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through state comprehensive program integrity reviews, CMS identifies program integrity related risks in state operations and, in turn, helps states improve program integrity efforts. In addition, CMS uses these reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of findings, vulnerabilities, and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Annual Summary Report of Program Integrity Reviews*.

The purpose of this review was to determine whether Iowa's program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid agency receives and uses information about potential fraud and abuse involving Medicaid providers and how the state works with the Medicaid Fraud Control Unit (MFCU) in coordinating efforts related to fraud and abuse issues. Other major focuses of the review include but are not limited to: provider enrollment, disclosures, and reporting; pre-payment and post-payment review; methods for identifying, investigating, and referring fraud; appropriate use of payment suspensions; monitoring of provider compliance with False Claims Act education requirements; managed care oversight at the state level; and program integrity activities conducted by managed care organizations (MCOs).

The review of Iowa's program integrity activities found the state to be in compliance with many of the program integrity requirements. However, the review team found the state's Medicaid program has risks in both its fee-for-service (FFS) and managed care program integrity activities. These risks are related to payment suspension, provider enrollment practices, and program integrity oversight. These issues and CMS's recommendations for improvement are described in detail in this report.

CMS is concerned that some of the issues described in this review were also identified in CMS's 2010 review and are still uncorrected. CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review, are satisfactorily resolved as soon as possible.

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 areas such as state program integrity infrastructure, provider enrollment and disclosure activities, fraud and abuse detection, interagency and intra-agency relationships, and oversight of managed care and other special programs. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit. The review team also conducted an in-depth telephone interview with representatives from the MFCU, which is affiliated with the Iowa Department of Inspections and Appeals.

During the week of August 5, 2013, the CMS review team visited the State Medicaid agency, known as the Iowa Medicaid Enterprise (IME), which is part of the Department of Human Services (DHS). The team conducted interviews with program integrity, IME, and long term care officials in addition to representatives from the state's non-emergency medical transportation (NEMT) broker.

CMS also paid close attention to the oversight of program integrity in managed care. At the time of the review, Iowa contracted with two MCOs: a physical health plan and a behavioral health organization operating statewide that functioned as a prepaid inpatient health plan (PIHP). Although managed care was still a relatively small part of the Medicaid program, accounting for roughly 7.6 percent of all fiscal year 2013 Medicaid expenditures, the state indicated that it had plans to expand its risk capitation programs significantly in coming years. In addition, the behavioral health plan alone was paid over $235 million in fiscal year 2013 to serve Medicaid beneficiaries; and behavioral health is an area in which CMS has identified many fraud and abuse concerns nationwide. Accordingly, to determine whether Iowa's MCOs were complying with the contract provisions and other federal regulations relating to program integrity, the team reviewed the state's managed care contracts. The team conducted in-depth interviews with representatives from the two MCOs and met separately with IME's contracted staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications and program integrity cases and reviewed other primary data to validate Iowa's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the IME but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care, and contract management. Iowa operates its Children's Health Insurance Program (CHIP) as a Title XXI Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as Iowa's Title XIX program. The same effective practices, findings, and vulnerabilities discussed in relation to the Medicaid program also apply to the CHIP expansion program. Unless otherwise noted, Iowa 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 the IME provided.

Medicaid Program Integrity Unit

In Iowa, the IME houses the component responsible for program integrity. The state program integrity (PI) unit is composed of a manager and director who are state employees and contracted program integrity staff who perform virtually all program integrity functions. With the exception of two full-time equivalent contractor positions for algorithm development, the other contracted program integrity staff (roughly 15 positions in federal fiscal year [FFY] 2012) were co-located with state personnel at the IME offices.

The program integrity contractor's duties include: conducting preliminary investigations, post-payment claims reviews (including medical necessity reviews), and data analytics. The IME program integrity staff coordinates all program integrity functions with the contractor and other state agencies. In this report we will refer to the combined state and contracted program integrity staff who work together as the IME PI unit.

The IME PI unit utilizes a Fraud and Abuse Detection System (FADS) for claims analysis. The State Medicaid agency believes that the FADS is a more robust analytical and investigative support tool than the older surveillance and utilization review subsystem (SURS) which is part of the state's Medicaid Management Information System (MMIS). The state is in the process of requesting CMS certification for the FADS as the replacement for the existing SURS. The table below presents the total number of preliminary and full investigations, and the amount of identified and collected overpayments related to program integrity activities in the last four complete FFYs.

Table 1

FFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified†	Amount of Overpayments Collected†
2009	122	110	$5,982,127	$5,596,941
2010	213	179	$8,099,420	$8,056,855
2011	127	112	$19,344,118††	$17,939,559††
2012	172	159	$19,537,247	$15,949,679

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.

**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 overpayments identified for FFYs 2010, 2011, and 2012 include global settlements in the following proportions: 42.9, 31.2, and 29.4 percent, respectively. The overpayments collected for FFYs 2010, 2011, and 2012 include global settlements in the following proportions: 43.1, 33.6, and 36.0 percent, respectively.

††Increase from FFY 2010 to FFY 2011 was due to the IME PI unit taking on accounts receivable from the Provider Cost Audit Unit (Nursing Facility Referrals) for cost report related overpayments that providers would not repay.

Results of the Review

The CMS review team found a number of risks related to program integrity in the Iowa Medicaid program. These issues fall into three major categories and are discussed below. To address these issues, Iowa should improve oversight and build more robust program safeguards.

Risk Area 1: Risks were identified in the state's procedures to suspend payments in cases involving a credible allegation of fraud.

The state is not making timely payment suspensions to providers or documenting timely good cause exceptions in some cases where it determines that a credible allegation of fraud exists as required by the regulation at 42 CFR 455.23. Additionally, the memorandum of understanding (MOU) between the IME PI unit and Iowa's MFCU states that the MFCU would accept or reject a referral within twenty calendar days of receipt and provide written notification. This time frame does not necessarily permit a timely suspension of payments or the exercise of good cause

exceptions in instances where the state agency has determined that a credible allegation of fraud exists and referred the case to the MFCU.

During the onsite review, the team examined 16 case files from FFY 2011 and 2012 that included formal referrals from the IME PI unit to the MFCU. Of these cases, the MFCU accepted nine within two weeks of the referral being made. However, the state did not suspend payments until an average of 15 days after the MFCU's acceptance of these cases. In only one instance (a tenth case) was payment suspended before the MFCU referral occurred. The remaining six cases were more significant outliers. The state suspended payment in these cases an average of 47 days after the MFCU accepted them. The state treated all of the cases where payment suspension lagged behind the MFCU's acceptance as formal referrals but noted in interviews that it needed to have the MFCU's assent before declaring the cases credible allegations of fraud. Based on payment data furnished by the IME PI unit and discounting cases where a good cause exception was invoked, the state paid $292,544 in Medicaid funds to the referred providers in question before the payment suspensions were invoked. These payments were potentially at risk per the regulatory requirements.

Recommendations:

- Clarify in the state's policies and procedures that the regulation at 42 CFR 455.23 requires the timely suspension of payments upon the State Medicaid agency's determination that a credible allegation of fraud exists. If the State Medicaid agency relies on the MFCU to assist with determinations of credible allegations of fraud, the State Medicaid agency should consider establishing an informal consultative process with the MFCU before the formal referral is made and payment suspension is imposed or good cause exception is exercised by the State Medicaid agency.
- Amend the MOU with the MFCU as needed to ensure that revised policies and procedures are in compliance with the requirements of 42 CFR 455.23.

Risk Area 2: Risks were identified in the state's provider enrollment practices and reporting practices.

Ownership and Control Disclosures

The Iowa Medicaid Portal Access (IMPA) database serves as the repository where providers and entities must enter ownership or control disclosures online during initial enrollment or re-enrollment. The application within IMPA is called Ownership Control Disclosure (OCD), and became effective May 8, 2012. The IMPA database specifically requests information on persons with a 5 percent direct or indirect ownership or controlling interest required by the regulation at 42 CFR 455.104. However, the IMPA system does not ask for the disclosure of other individuals covered under "persons with an ownership or control interest," such as officers, directors, and partners. This would be helpful given the diverse types of provider arrangements that the state encounters.

Further, the state acknowledged that it was not checking the ownership and control disclosures submitted by its MCOs and the NEMT broker to ensure that all appropriate disclosures had been made. For example, in Iowa's managed physical health care program, a review of documents

submitted by the MCO revealed that the health plan's annual submission of ownership and control disclosures was incomplete. A vice-president of the MCO was listed on the contract between the state and the plan; however, he had not been listed on the disclosures of persons with an ownership or control interest. In addition, during the interview with Iowa's statewide NEMT broker, it was discovered that the local account manager of the broker had not been named as a managing employee on the NEMT's disclosures of ownership or control interest. In addition, the disclosure information for the individuals associated with the NEMT broker did not contain each person's address, as the regulation at 42 CFR 455.104 requires.

In addition, the MCOs are required by contract to collect all required ownership and control disclosures from their network providers but neither was doing so. This is a repeat issue from the 2010 review that cited the PIHP for not collecting appropriate ownership or control disclosures.

In this review, the MCO's disclosure form, which is used for all provider types, did not capture every element which FFS providers are required to disclose under 42 CFR 455.104. Information not captured on the form included:

- The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The form only solicited disclosures "of all owners with a controlling interest of 5% or more." It did not specify that such persons could include officers, directors, or partners.
- The applicable primary business address, every business location, and P.O. Box address for corporate entities listed as having an ownership or control interest.
- The date of birth (DOB) and Social Security number (SSN) of any individual with an ownership or control interest.
- The tax identification number (TIN) of any corporation with an ownership or control interest in the disclosing entity.
- The TIN of any subcontractor in which the disclosing entity has a 5 percent or more interest.
- Whether persons listed as having an ownership or control interests are related, or whether these same individuals are related to persons with an ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more ownership or control interest.
- The name of any other disclosing entity in which an owner of the disclosing entity also has an ownership or control interest.
- The address and DOB of any managing employee of the disclosing entity.

The PIHP uses an electronic web portal for provider enrollment along with a paper form that is available to providers without electronic access. The PIHP reported that approximately 99 percent of applications are submitted through the web portal. A review of the paper form and screen shots of the web portal revealed that the PIHP was not correctly capturing all disclosure information of persons with an ownership or control interest from its providers. The forms and the web portal both solicited only the disclosure of individuals with 5 percent or more direct or indirect ownership in the disclosing entity. They did not solicit the disclosure of persons with a

controlling interest (which again could include directors, officers, and partners) or managing employees.

Also, both data collection tools did not ask for relationship information between persons with ownership or control in the disclosing entity and those with an ownership or control interest in any subcontractor in which the disclosing entity has 5 percent or more ownership. In addition, neither format solicited the name and TIN of any subcontractor in which the disclosing entity had an ownership or control interest of 5 percent or more.

Business Transaction Disclosures

The provider agreements used by both MCOs do not contain language referring to the disclosure of business transaction information although the state's contract with the MCOs requires the provider to adhere to this requirement. This issue was also cited in the previous review for the PIHP. As part of its corrective action, the state amended its contract with the PIHP in May 2011 to add provisions related to 42 CFR 455.105; however, the PIHP's standard provider agreement was not modified to include this requirement.

Exclusion Searches

The regulation at 42 CFR 455.436 requires that specific federal databases be routinely checked for providers and certain affiliated parties as a condition of provider enrollment. The State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the Excluded Parties List System (EPLS) on the System for Award Management (SAM)[1], the Social Security Administration Death Master File (DMF), and the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.

The review team found during the IME provider enrollment interview and demonstration that only provider names are searched against the LEIE and the EPLS for exclusions and debarments upon initial enrollment and monthly. While the state has begun collecting information on persons with an ownership or control interest and agents and managing employees of the provider, the state was not checking for exclusions or debarments at initial enrollment and monthly thereafter. The IME Provider Enrollment unit indicated it planned to begin matching all these affiliated parties against the required exclusion and debarment databases in September 2013 using names collected in the state's data warehouse. Although steps are being taken to correct it, this is a repeat risk from CMS's 2010 review. During the previous review the state was cited for not checking information on owners, officers, and Board of Director members against the LEIE or its CMS equivalent (known as the Medicare Exclusion Database or MED), at the time of provider enrollment. Only provider names were checked.

In managed care and other special programs, such as the NEMT and home and community based waiver programs, there was also a question as to whether the state was performing the full range of exclusion and debarment searches as required by 42 CFR 455.436. In managed care, while

[1] In July 2012, the EPLS was migrated into the new System for Award Management (SAM).

the state had procedures in place to collect the names of persons with MCO ownership or control interests, agents, and managing employees, it had not subsequently been checking the names against the required databases as stipulated in 42 CFR 455.436. In addition, at the time of contracting, since the MCO and NEMT broker were found not to have disclosed relevant parties (see earlier section on "Ownership and Control Disclosures"), its exclusion searches were by definition incomplete and not in full regulatory compliance.

In Iowa's managed care programs, the responsibility for conducting database searches on network providers and employees of the MCOs is delegated to each respective managed care plan. While the MCO does check its network providers monthly against the LEIE and EPLS, it only checks its employees annually. This runs counter to the guidance CMS provided in its State Medicaid Director Letter of January 2009, SMDL #09-001, which recommended that providers check employees against the LEIE on a monthly basis.

Provider Application Fees

The IME PI unit has not begun collecting application fees for prospective and re-enrolling Medicaid only providers covered by the regulation at 42 CFR 455.460. During interviews, the IME PI unit explained that it is required to have legislation in place to collect Medicaid application fees; therefore this is not a contractual requirement. The legislation was tentatively slated to become effective in September 2013. The new legislation would give the IME PI unit the necessary authority to collect the Medicaid application fee.

State Agency Notifications

Based on interviews and the sampling of case files, the team found that when the state agency initiates permissive exclusions, it does not provide adequate notice to the public, beneficiaries, appropriate state medical licensing boards and other relevant state agencies as the regulation at 42 CFR 1002.212 requires. The IME PI unit said it plans to address this partially by implementing a new website in mid-August 2013 which will list terminated or excluded providers. If implemented, this would satisfy the public notice element of the regulation, but would not fully address the other notification requirements. The team observed that the same shortcomings in the state's notification practices on permissive exclusions would have been reflected in its reinstatement notifications (as required by 42 CFR 1002.215) if reinstatement actions were necessary. However, no reinstatement actions were taken since the last review.

Adverse Action Notifications

The State Medicaid agency does not have clear policies or contract requirements directing the MCOs and the NEMT broker to report to it any program integrity-related adverse actions which these contractors take against their network providers. During the interviews, the MCOs indicated they were aware of the types of issues that would be reportable; however, the state indicated that nothing had been reported in the past four years. The NEMT broker was not aware of the need to report such actions, and was in the process of establishing procedures. Program integrity-related adverse actions include those related to fraud, abuse, or quality of care concerns. The State Medicaid agency is required to report such actions to HHS-OIG within 20 business days per the regulation at 42 CFR 1002.3. CMS believes MCOs should be contractually required

to report adverse actions to the State Medicaid agency so that the state can track problem providers who serve Medicaid beneficiaries or try to enter another managed care program.

Recommendations:

- Revise FFS and managed care enrollment forms, both online screens and hard copy enrollment packages, to ensure that all required ownership and control information is solicited per the regulation at 42 CFR 455.104. Develop and implement policies and procedures checking ownership and control disclosures by disclosing entities as well as brokers and contractors in the special programs for completeness.
- Ensure that all MCO provider agreements in both the capitated behavioral health and physical health programs require the submission of 455.105-related information on request.
- To prevent federal funds from going to excluded providers/entities, ensure that all persons/entities with ownership or control interests in FFS and managed care network providers and all agents and managing employees of such providers are searched at the time of enrollment or reenrollment and on an ongoing monthly basis against the LEIE (or MED) and EPLS.
- Ensure that the required identifying information on providers and other affiliated parties is housed in a database which can be matched against the LEIE and EPLS at the required intervals.
- Monitor managed care plans to make sure they are collecting the full range of disclosures and searching them at the contractually required intervals for exclusions and debarments. Monitor managed care plan compliance with the guidance in State Medicaid Directors Letter #09-001 which calls for MCOs to search their employees for exclusions on a monthly basis.
- Develop and implement policies for collecting application fees from appropriate Medicaid-only providers once the state has obtained the legislative authority to do so.
- Develop and implement policies and procedures to ensure that all parties identified by the regulation are notified of a state-initiated exclusion consistent with 42 CFR 1002.212.
- Develop a contractual provision requiring MCOs to report program integrity-related adverse actions taken against network providers to the State Medicaid agency and monitor plan compliance with this requirement.

Risk Area 3: Risks were identified in the state's program integrity oversight in FFS and managed care.

Work Plan

The IME PI unit does not have a written work plan either in published form or as an internal plan for assigning staff and contractor work. Developing a written roadmap of the review activities that the unit plans to carry out during the fiscal year and outlining strategic goals would help to guide the unit's endeavors in combating Medicaid fraud and abuse.

In the absence of a written work plan, it is unclear whether or not the state gives sufficient priority to high risk provider types or high risk services and whether adequate program integrity

resources are being used to oversee the MCOs and other special programs, such as the home and community based services (HCBS) waiver, self-directed personal care services, and NEMT programs.

Program Integrity Oversight in Managed Care

The IME PI unit utilizes a data warehouse which houses all of the state's policies and procedures for staff and contractors. The policies and procedures in the areas of FFS program integrity and provider enrollment are quite detailed and comprehensive. However, the review team noted an absence of directives for staff on how to carry out oversight of program integrity activities in the managed care programs. During the onsite interview, the state referenced administrative rules and managed care contracts as guidance documents, but these were sometimes not specific enough to ensure the completion of certain critical monitoring tasks.

For example, there are no policies and procedures on how to use managed care encounter data for program integrity purposes, such as mining for anomalies and aberrancies that can identify fraudulent or abusive network providers. Policies and procedures to monitor the MCO reporting of adverse actions and the collection of full ownership and control disclosures from network providers were also absent. In addition, the state has not developed a methodology for monitoring its MCO's recoupment activities and ensuring that managed care program integrity recoveries are factored into an adjusted capitation rate.

In Iowa, when the MCO recovers an overpayment, the state does not collect any funds. Because the state considers the MCO's baseline costs to be included in the capitation rate, the plan is permitted to keep all recoveries. The state indicated that it expects the MCO to factor recoveries into the rate calculations of future contract periods. However, it does not audit or monitor this process to ensure that such adjustments are made, and the team found no policies or procedures directing staff on how to do this. In contrast, capitation rate adjustments are addressed in the statewide managed behavioral care program. Any recoveries made by Iowa's PIHP are placed in a claims fund which will go to the PIHP after each fiscal year's capitated payments are fully reconciled. However, in the behavioral health delivery system, there is no systematic oversight to ensure that the PIHP is in fact aggressively moving to recover suspected overpayments.

In general, the absence of written policies and procedures leaves the state vulnerable to inconsistent operations and ineffective functioning in the event the state loses experienced program integrity or managed care staff. In addition, where program integrity oversight of the MCOs falls short, such as in the situation discussed above, this may have been prevented if written policies and procedures had been in place to guide staff in performing the oversight functions.

Recommendations:

- Develop an annual written work plan (whether as an internal or public document) that outlines the state's proposed future review activities and strategic objectives.
- Develop and implement policies and procedures for monitoring MCO compliance with all program integrity-related contract requirements.

Noteworthy Practices

As part of its comprehensive review process, the CMS review team identified two practices that merit consideration as noteworthy or "best" practices. CMS recommends that other states consider emulating this activity.

The state utilizes innovative database searches to identify ineligible or excluded providers and beneficiaries as well as overpayments

The IME PI unit performs regular data matching with a number of databases beyond those prescribed specifically in federal regulations. These matches have resulted in the identification of ineligible beneficiaries, excluded parties working inappropriately in health care positions, and overpayments made to deceased beneficiaries and providers. The additional sources which Iowa uses for data matching purposes include Department of Corrections (DOC) claims data, Iowa Workforce Development (IWD) employment files, and Department of Public Health (DPH) Death Statistics files.

a. **Department of Corrections (DOC) Matches:** The IME PI unit has had a data exchange agreement with the Iowa DOC since 2008. The IME PI unit matches paid claims data from the MMIS on a monthly basis against monthly feeds of DOC data. The purpose of these data matches is to identify improper payments to beneficiaries who are incarcerated and whose care should not be covered by Medicaid during their period of incarceration. The IME PI unit has recovered over $200,000 in Medicaid overpayments since the DOC-MMIS matches began. The majority of the recoveries are capitation claims.

   Effective December 2012, the IME PI unit also implemented a monthly match of Medicaid waiver providers with offenders identified from the DOC data. The purpose of this data match is to identify already screened and enrolled Medicaid providers who were later charged with or convicted of a criminal activity.

b. **Iowa Workforce Development (IWD) Matches:** On a quarterly basis, the IME PI unit compares the SSNs of Iowa-based excluded providers/individuals from the MED against the state's Workforce Development database to identify excluded providers/individuals who may be working illicitly in the health care field. The IWD database matches were also identified as an effective practice during the 2010 program integrity review of Iowa. Since the last review, the IME PI unit reported that it found approximately 26 matches using this process between December 9, 2010 and September 30, 2012. Of these, 18 matches led to recoveries totaling over $1.5 million.

   The IME PI unit has also used the IWD database to identify individual personal care and respite providers enrolled in the MMIS with the highest amount of Medicaid reimbursement. These outliers were then matched against IWD records to identify which providers also had other types of full-time employment. The matches revealed 12 potential cases, with seven referrals to the MFCU.

c. **State Death Statistics File and DMF Matches:** The IME PI unit also uses data file matching to ensure that the member identification numbers (IDs) of deceased Medicaid beneficiaries and providers are not being used to file claims for Medicaid reimbursement.

Beneficiary matches are accomplished by comparing the MMIS paid claims file to both the Iowa Department of Public Health's Death Statistics File and the DMF. Through the file matching process, the IME PI unit recovered the following amounts in FFY 2010-2012:

FFY 2010	$150,624
FFY 2011	$116,969
FFY 2012	$ 85,587

The IME PI unit undertakes similar matches of the MMIS paid claims and provider files against the above two databases to determine if Medicaid payments are flowing to a deceased provider's ID. The unit will recover and report any payments uncovered. It will also notify both the IME Provider Enrollment unit and the Managed Care Contracts Manager of providers identified as deceased so that the former can terminate the provider in the fee-for-service (FFS) Medicaid program and the latter can notify the MCOs to do the same.

Notwithstanding the additional database searches, the review team found some weaknesses in the state's collection of required disclosure information and required federal database searches. These are discussed in the second risk area above.

Individual Consumer Directed Attendant Care Provider Enrollment Process

The state requires that all individual consumer directed attendant care (CDAC) providers be enrolled with the State Medicaid agency in the same manner as FFS providers. In addition to the exclusion searches required by federal regulations, the state agency conducts background checks to see if the applicant has a criminal, adult dependent abuse, child abuse, and/or sex offender history. The direct enrollment of CDAC providers affords the state a chance to hold care-giving individuals directly accountable for fraud and abuse in the Iowa's self-directed HCBS waiver program, while the thoroughness of the background and exclusion checks helps ensure that problem attendants will not be able to resurface in the program at a later time.

Effective Practices

As part of its comprehensive review process, CMS also invites each state to self-report practices that it believes are effective and demonstrate its commitment to program integrity. CMS does not conduct a detailed assessment of each state-reported effective practice. Iowa reported that it conducts regular meetings to discuss program integrity issues throughout the IME PI unit and that it has made several useful enhancements to its beneficiary lock-in program.

The program integrity unit takes part in a series of regular meetings that ensure discussion of the program integrity issues throughout the IME

The IME PI unit has organized several different types of regularly occurring meetings which help to ensure that program integrity issues are discussed throughout the agency. The meetings include:

- **Provider Adverse Action Meeting:** Comprised of representatives from all sections of the agency. Meetings are held bi-weekly to discuss issues with problem providers and consider actions that may be appropriate to deal with them.
- **Waiver Provider Meeting:** Implemented in February 2012 between the program integrity unit and the IME component which oversees HCBS waiver programs (called the HCBS Quality Assurance unit). The bi-weekly meetings are comprised of key staff from both units and the DHS' Long Term Care policy staff. The goal of the meeting is to regularly discuss issues each unit is addressing to ensure concerns are dealt with collaboratively and in a consistent manner. Ongoing discussions have allowed the two units to join together and perform unannounced onsite reviews and work together to gather the necessary information for determining if providers have quality and/or integrity issues. The collaborative efforts of the Waiver Provider Meeting has resulted in 42 providers referred to the MFCU, 27 providers terminated or no longer providing services, and identified overpayments of approximately $3.7 million.
- **Managed Care Meeting:** The program integrity Director and contractor, MCO representatives, and members of the MFCU meet bi-weekly to discuss problem providers in the FFS program and managed care delivery systems. The parties confer about fraud and abuse cases and reach a consensus on which cases should be referred to the MFCU for prosecution. The State Attorney General frequently attends and provides opinions on where administrative actions or fraud referrals are appropriate.

The network of meetings which IME PI unit sponsors has helped considerably to bring program integrity considerations and concerns to the forefront in all parts of the state agency. It has also helped Iowa's MCOs become more proactive in fraud and abuse detection. This notwithstanding, the review team found a number of issues relating to managed care disclosures, reporting, database searches and general oversight during the course of the review. These are discussed in the program integrity oversight and provider enrollment risk areas above.

Enhancements to Beneficiary Lock-In Program

The IME's Member Services Unit (MS unit) administers the state's beneficiary lock-in program. Since the last review, enrollment in the program has increased by nearly 16 percent (to 1561), and cumulative program savings exceeded $19 million as of March 31, 2013. The successful expansion has been triggered by an automation of the lock-in review process and by educating providers on the lock-in program. Medicaid beneficiaries placed in the lock-in program are enrolled with one primary care physician (PCP) to coordinate all of their medical care, one pharmacy to monitor their medication use, and one hospital for emergent needs that cannot be treated by their PCP.

Whereas Iowa's lock-in program previously focused on prescription drug overutilization, the IME MS unit realized that significant savings could be achieved by curbing overutilization of other services. Accordingly, it developed a separate algorithm to identify the non-emergent use of emergency rooms as well as the overuse of other services.

Iowa also makes use of a special Medical Health Education Program (MHEP) before resorting to the lock-in. The MHEP seeks to educate beneficiaries at the first signs of service overutilization

about the appropriate way to use Medicaid services. In addition, the IME's MS unit does extensive outreach to providers through one-on-one presentations, information on the Medicaid website, informational bulletins, and annual provider training. Iowa Medicaid now receives multiple lock-in referrals on a monthly basis from physicians, pharmacies, and hospitals, as well as referrals from the drug utilization review program and the Iowa DHS.

Technical Assistance Resources

CMS offers the following technical assistance resources to assist Iowa in strengthening its program integrity operations:

- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in RISS for information provided by other states including best practices and managed care contracts.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and assistance as needed to conduct exclusion searches and training of managed care staff in program integrity issues.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. More information can be found at http://www.justice.gov/usao/training/mii/
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Work with the assigned CMS State Liaison to discuss program integrity issues and request technical assistance as needed.
- Access the CMS website at www.cms.gov/medicaidintegrityprogram. The website is frequently updated and contains resources for states including annual program integrity review summary reports, educational toolkits developed by CMS for training purposes, and other guidance documents. The summary reports contain information on noteworthy and effective program integrity practices in states.
- Work with the MFCU to update and strengthen the current interagency MOU to account for current regulatory requirements on payment suspensions. CMS staff can assist Iowa in identifying other states with appropriate model MOUs.

Summary

Iowa applies several noteworthy and effective practices that demonstrate program capabilities and the state's commitment to program integrity. CMS supports Iowa's efforts and encourages it to look for additional opportunities to improve overall program integrity. However, the identification of significant areas of risk and numerous findings of non-compliance with federal regulations is of concern and should be addressed immediately. CMS is also particularly concerned about uncorrected, repeat problems that remain from the time of the agency's last comprehensive program integrity review.

We require the state to provide a corrective action plan (CAP) for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific problems identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will occur and identify which area of the state is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. Please provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

CMS looks forward to working with Iowa to strengthen the effectiveness of its program integrity function.

Official Response from Iowa
February 2015

Iowa Department of Human Services
Terry E. Branstad, Governor | Kim Reynolds, Lt. Governor | Charles M. Palmer, Director

February 13, 2015

Peter Leonis
Director of Field Operations North
Investigations and Audits Group
Center for Program Integrity
Centers for Medicare & Medicaid Services
via email @
Peter.Leonis@cms.hhs.gov

Dear Mr. Leonis:

I received the Iowa Comprehensive Program Integrity Review Final report from August 2013 and my staff and the MCOs have developed Corrective Action Plans (CAPs) for each of the identified risk areas. The attached CAPs address how the Iowa Medicaid Enterprise and/or the MCOs will ensure that the identified risks are mitigated, as well as timeframes for the correction, along with specific steps that will occur.

Iowa is committed to improving all of its Medicaid program integrity procedures and processes, and the information contained in the report is 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 Rocco Russo Jr., Program Integrity Director for the Iowa Medicaid program. His contact information is (515) 256-4632 or rrusso@dhs.state.ia.us.

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

Sincerely,

Julie Lovelady
Interim Medicaid Director

JL/rr