Department of Health and Human Services

Centers for Medicare & Medicaid Services

Iowa Focused Program Integrity Review

Final Report

January 2022

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Iowa Focused Program Integrity Review Draft Report
January 2022

Executive Summary

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, the Centers for Medicare & Medicaid Services (CMS) set forth its strategy to safeguard the integrity of the Medicaid program.[1] State Medicaid programs are required to have fraud detection and investigation programs and oversight strategies that meet minimal federal standards. To ensure states are meeting these requirements, CMS conducts focused program integrity reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. The value of performing focused program integrity reviews include: (1) providing states with effective tools/strategies to improve program integrity operations and performance, (2) providing the opportunity for technical assistance related to program integrity trends, (3) assisting CMS in determining/identifying future guidance that would be beneficial to states, and (4) assisting with identifying and sharing promising practices related to program integrity.

This report summarizes information gathered during a focused review of the Iowa's Medicaid managed care program. The primary objective of the review was to assess the state's program integrity oversight efforts for Medicaid managed care. A secondary objective was to provide the state with useful feedback, discussions, and technical assistance resources that may be used to enhance program integrity in the delivery of these services.

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that received a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

In May 2021, CMS conducted a virtual focused review of Iowa's managed care program administered by the single state Medicaid agency, the Iowa Department of Human Services (DHS). The Iowa Medicaid Enterprise (IME) is the division of DHS that administers the Iowa Medicaid program, while the Iowa Medicaid Program Integrity Unit is responsible for program integrity oversight. This focused review helped CMS assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. CMS interviewed key staff and reviewed a sample of program integrity cases investigated by the MCOs Special Investigations Units (SIUs), as well as other primary data, to assess the state's and selected MCOs' program integrity practices. CMS also evaluated the status of Iowa's previous corrective action plan, which was developed by the state in response to a managed care focused review conducted by CMS in 2017.

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf
[2]

During this review, CMS identified a total of five recommendations based upon the completed focused review modules, supporting documentation, and discussions and/or interviews with key staff. CMS also included technical assistance resources for the state to consider utilizing for its oversight of managed care. The review and recommendations encompass the following six areas:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. MCO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspension based on credible allegations of fraud
6. Terminated providers and adverse action reporting

Overview of Iowa Medicaid

The IME is the division of DHS that administers the Iowa Medicaid program. The Program Integrity Unit (PIU) is the organizational unit responsible for the overall program integrity operations for the managed care program. The Bureau of Managed Care (BMC) has oversight responsibility for the managed care contracts.

On April 1, 2016, the DHS transitioned the majority of the existing Iowa Medicaid members to a managed care program known as IA Health Link. The IA Health Link program is administered by two contracted MCOs, Amerigroup Iowa and Iowa Total Care (ITC), which provide members with comprehensive health care services, including physical, behavioral, and long-term care services and support. The Children's Health Insurance Program (CHIP) is offered through the Healthy and Well Kids in Iowa program, also known as Hawki. Iowa offers Hawki health coverage for uninsured children of working families that meet certain income requirements.

In FY19, Iowa's Medicaid expenditures exceeded $5.2 billion, providing coverage to approximately 805,178 beneficiaries. For the same period, the managed care expenditures were approximately $2,544,323,258 (including both Medicaid and CHIP). In FY 2019, The Federal Medical Assistance Percentage (FMAP) matching rate was 59.93 percent for the Medicaid population and 94.95 percent for the CHIP population.

During the program integrity review, the two operating MCOs and one Prepaid Ambulatory Health Plan (PAHP) were interviewed: Amerigroup Iowa, Iowa Total Care, and MCNA Dental. MCNA Dental provides only dental benefits to Medicaid beneficiaries. Table 1 and Table 2 below provide enrollment and expenditure data for each MCO.

Table 1. Summary Data for Iowa MCOs

Iowa MCO Data	Amerigroup Iowa	MCNA Dental	Iowa Total Care
Beneficiary enrollment total	349,770	113,702	269,741
Provider enrollment total	27,759	465	28,440
Year originally contracted	2015	2016	2019
Size and composition of SIU	5 local/339 corporate	22	4
National/local plan	Local	National	National

Table 2. Medicaid Expenditure Data for Iowa MCOs

MCOs	FY 2017	FY 2018	FY 2019
Amerigroup Iowa	$1,034,539,181.24	$1,436,216,404.90	$2,020,468,080.72
MCNA Dental	$7,862,068	$18,344,551	$20,558,714
Iowa Total Care	$0.00*	$0.00*	$493,296,464
Total MCO Expenditures	$1,042,401,249	$1,454,560,956	$2,534,323,258

Iowa Total Care's MCO contract with the state started on July 1, 2019.

Results of the Review

CMS evaluated the following six areas of Iowa's managed care program:

1. State Oversight of Managed Care Program Integrity Activities
2. Provider Screening and Enrollment
3. MCO Investigations of Fraud, Waste, and Abuse
4. Encounter Data
5. Payment Suspensions Based on Credible Allegations of Fraud
6. Terminated Providers and Adverse Action Reporting

CMS identified six areas of concern with Iowa's managed care program integrity oversight that may create risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible through implementation of a corrective action plan. These areas of concern and CMS' recommendations for improvement are described in detail below.

1. State Oversight of Managed Care Program Integrity Activities

The IME administers the state's Medicaid managed care program. The IME is a collection of specific units, each having an area of expertise within the Medicaid program.

Overall, the State Program Integrity team, the Bureau of Managed Care (BMC), the Medicaid Fraud Control Unit (MFCU), contractors, and other associated departments collaborate to provide comprehensive oversight of program integrity in managed care. Each entity meets with the State Medicaid Agency (SMA) and the MFCU on a monthly basis. The DHS, IME, and PIU have a Memorandum of Understanding with the MFCU to protect and preserve the integrity of the Iowa Medicaid program; **however, there is no intra-agency agreement between the BMC and IME outlining administrative roles and responsibilities.** During the review, the BMC provided a document detailing the program integrity related communications between MCOs and the IME.

The IME also contracts with IBM Watson Health to conduct program integrity activities on behalf of the state. The contractor is responsible for data analytics, audits and investigations, managed care oversight, monthly provider surveillance, and financial accountability. The contractor's activity is overseen by state staff. The Iowa PIU is comprised of a combination of state employees and IBM staff. The PIU's state employees consists of: one Program Integrity Director, one Program Integrity Manager, and one Program Integrity Specialist. The other 20 positions are staffed by the contractor and include: one Account Manager, one MCO Program Integrity Subject Matter Expert (SME), one Audits and Investigations Manager, one Quality Assurance Manager, one Data Analytics Manager, one Senior Financial Analyst, one MCO Program Integrity Oversight Specialist, one Audit Manager, two Clinical Reviewers, two Audit Analysts, one Medical Director, three Investigators, two Data Analysts, one Data Analytic SME, and one Encounter Data Specialist.

In Iowa, MCOs are contractually required to have specific administrative and management arrangements or procedures in place, including a mandatory compliance plan that is designed to guard against fraud, waste, and abuse. Compliance plans are required to be provided by the contract operational start date, and annually thereafter. The MCOs must also have written internal controls designed to prevent, detect, reduce, investigate, and report known or suspected fraud, waste, and abuse activities, in accordance with the requirements at 42 CFR 438.608.

Additionally, Iowa's contract requires all MCOs to submit a monthly Program Integrity Activity Report outlining the MCO's program integrity activities for the previous calendar month and a quarterly audit report. The quarterly report is required to be a detailed audit report that outlines the MCO's program integrity-related activities, as well as identifies the MCO's progress in meeting program integrity-related goals and objectives. The audit report specifies individual provider recoupment, repayment schedules, and actions taken for each audit or investigation.

The PIU and the BMC are responsible for obtaining and reviewing the compliance plans. During the review, it was noted by the review team that all three MCO/PAHPs had compliance plans that met the minimum requirements outlined in 42 CFR 438.608.

The PIU and the BMC also confirmed that the MCOs have historically complied with the contractual requirements set forth by the state and federal regulations pertaining to compliance with 42 CFR 438.608.

The State's PAHP MCNA reported that their SIU unit and manager (for this review period) were located in their headquartered Fort Lauderdale, Florida location. The SIU manager and staff *continue to* perform program integrity SIU operations out of the Florida location. Two of their Provider Relations Staff are located in Iowa and serve in an "as needed capacity" for PI medical record pick-up and review and provider onsite visits. No Special Investigative Unit staff are located in Iowa.

Iowa's 2019 MCNA contract states in section 1.7 (Additional Program Integrity Requirements), "The contractor should ensure that the SIU Manager is dedicated full-time to the Contractor's Iowa Medicaid product lines and required to be located in Iowa." Although the requirement had not been met at the time of review (May 2021), as of July 1, 2021, the State had ensured that all MCOs have met all contractual SIU staffing requirements.

Recommendation #1: The State should ensure MCOs meet all contractual SIU staffing requirements.

2. Provider Screening and Enrollment

To comply with 42 CFR 438.602(b), 42 CFR Subpart B, 42 CFR Subpart E, and Section 5005(b)(2) of the 21st Century Cures Act, all providers furnishing services to Iowa's Medicaid members, including providers participating in an MCO provider network, are required to be screened and enrolled with IME before they can be credentialed with an MCO.

In Iowa, the Provider Services Manager (PSM) provides oversight of the providers services functions. This includes, but is not limited to, the provider services helpline, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing provider manual and education materials, and developing provider outreach programs. The PSM also closely coordinates with other key state and MCO Contract Managers to ensure that all MCO provider services operations are in alignment with the terms of the contract.

Additionally, in accordance with 42 CFR 438.214, MCO/PAHPs must comply with a number of provider contracting requirements, including:

- The State must ensure, through its contracts, that each MCO or PAHP implements written policies and procedures for selection and retention of network providers and that those policies and procedures, at a minimum, meet the requirements of this section.
- Credentialing and re-credentialing requirements.
- Consistent with 42 CFR 438.12, network provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- MCO/PAHPs are not permitted to employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

MCOs/PAHPs are also required to develop and implement written policies and procedures, subject to SMA review and approval, related to provider credentialing and re-credentialing, for any work plan required by the contract. These policies and procedures must include standards of conduct that articulate the MCO/PAHP's understanding of the requirements and that direct and guide compliance with all applicable federal and state standards related to provider credentialing, including those required in 42 CFR Part 438 and Part 455, Subpart E, which include the following: a training plan designed to educate staff in the credentialing and re-credentialing requirements; provisions for monitoring and auditing compliance with credentialing standards; provisions for prompt response and corrective action when non-compliance with credentialing standards is detected; a description of the types of providers that are credentialed; methods of verifying credentialing assertions, including any evidence of prior provider sanctions; and prohibition against employment or contracting with providers excluded from participation in federal health care programs. MCOs/PAHPs are also required to ensure that the credentialing process provides for mandatory re-credentialing at a minimum of every three (3) years.

CMS did not identify any recommendations regarding Iowa's provider screening and enrollment process for Medicaid.

3. MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13-17, the state has an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and the MCOs. Iowa's Medicaid MCO contract stipulates this requirement in the following section: "The Contractor shall report possible fraud or abuse activity to the Agency. The Contractor shall initiate an immediate investigation to gather facts regarding the possible fraud or abuse. Documentation of the findings of the investigation shall be delivered to the Agency of the identification of suspected fraud or abuse activity as defined by the Agency. In addition, the Contractor shall provide reports of its investigative, corrective, and legal activities concerning fraud and abuse to the Agency in accordance with contractual and regulatory requirements. The Contractor and its subcontractors shall cooperate fully in any Agency reviews or investigations and any subsequent legal action. The Contractor shall implement corrective actions in instances of fraud and abuse detected by the State agency, or other authorized agencies or entities. The Contractor shall report to the Agency the following information monthly and in the manner required by the Agency: (1) the number of complaints of fraud and abuse made to the Agency that warrant preliminary investigation, and (2) for each complaint which warrants investigation: (a)the name and ID number; (b) source of complaint; (c) type of provider; (d) type of provider; (e) nature of complaint; (f) approximate dollars involved; (g) disposition The Contractor must have in place policies and procedures for ensuring protections against actual or potential fraud, waste, and abuse. The Contractor must have a formal comprehensive Iowa Medicaid Program Integrity Plan, reviewed and updated annually, to detect, correct, and prevent fraud, waste, and abuse; and supports correction and prevention efforts. All fraudulent activities or other program abuses shall be subject to the laws and regulations of Iowa and/or Federal government."

The Iowa MCO contract also outlines coordination of program integrity efforts. The contract states that "[t]he Contractor shall coordinate any and all program integrity efforts with IME personnel, Iowa Department of Public Health] IDPH personnel, and Iowa's Medicaid Fraud Control Unit

(MFCU), located within Iowa Department of Inspections and Appeals." The contract specifies that, at a minimum, the MCOs shall:

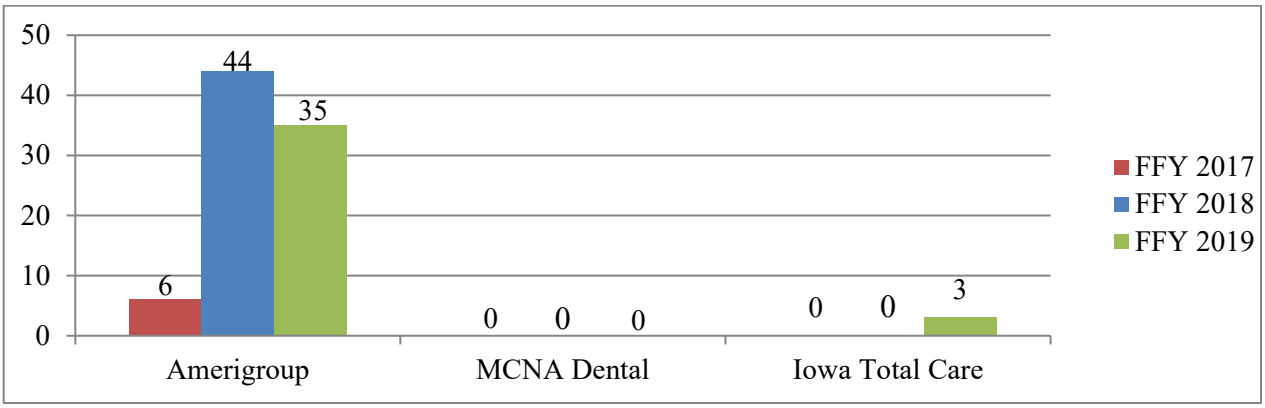
- Meet no less than two times each month and as otherwise required with the SMA PI Unit, IDPH staff, and MFCU staff.
- Provide any and all documentation or information upon request to the SMA, the MFCU, HHS-OIG, or the US Department of Justice related to any aspect of the MCO contract, including, but not limited to, contract, policies, procedures, subcontracts, provider agreements, claims data, encounter data, provider records, and report on recoupment actions and receivables.
- Coordinate PI activities with other contractors as directed by the SMA.

In accordance with 42 CFR 455.14, if the SMA or the MCO receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, the SMA and the MCOs must conduct a thorough preliminary investigation to determine whether there is sufficient basis to warrant a full investigation by MFCU. A thorough preliminary investigation by the SMA and the MCOs includes interviewing the tip reporter, beneficiaries and others; reviewing claims data and provider records; gathering statutory, regulatory, and policy guidance; informal consultation with other agencies and law enforcement; and any other steps necessary to evaluate whether a credible allegation of fraud exists. The MCOs report their investigations to the state on a monthly basis. Reports are due 30 calendar days after the last date of the prior month. These reports are currently submitted through a SharePoint site.

Additionally, the state provides educational guidance on the quality and quantity of referrals at the bi-annual meetings. It has also facilitated MFCU-led educational opportunities. Additional education and guidance are provided at monthly MCO-PI meetings, as well as at monthly MCO-MFCU-PI meetings. Further, if MCO referrals are inadequate, the state returns the referrals to the MCO with an explanation of why the referral is being rejected.

All referrals submitted by the MCOs are submitted to IME for quality review before being sent to the MFCU. The CMS review team confirmed that each of the MCO/PAHPs interviewed have SIUs. The SIU staffing levels reported by all three plans ranged between four to 22 full-time employees dedicated to the Iowa Medicaid program. The program integrity efforts of two of the three reviewed SIUs appear to be adequate in terms of provider referrals and investigations.

Figure 1. Number of Investigations Referred to the State by Each MCO



*ITC MCO contract started July 1, 2019.

As stated previously, the MCO provider case referrals of the reviewed SIUs appear to be adequate for Amerigroup and ITC; however, MCNA Dental had no provider case referrals in FYs 2017-2019.

Additionally, although two of the three MCOs reviewed referred 88 cases to the state between FY17-2019, **the review team observed that the MFCU rejected a substantial portion of the MCO referrals. Specifically, during the review period, the MFCU only accepted 21 case referrals related to MCO investigations, an acceptance rate of just 23 percent.**

Overall, the amount of overpayments identified and recovered by two of the three MCOs appears to be low. Further, although MCOs may not be required to return overpayments from their network providers to the state, the state must obtain a clear accounting of any recoupments in order for these dollars to be accounted for in the annual rate-setting process. Without these adjustments, MCOs could be receiving inflated rates per member per month.

Table 3-A. Amerigroup's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	22	69	$44,269.33	$0.00
2018	79	63	$166,134.01	$13,410.91
2019	182	105	$83,576.15	$67,836.16

Table 3-B. MCNA Dental's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	0	0	$0.00	$0.00
2018	2	0	$0.00	$0.00
2019	5	2	$2,482.87*	$1,016.90*

**These figures have been adjusted to correct the amounts reported in 2020; the original submission reported $3,421.48 in overpayments identified, captured in that amount was $939.21 that was requested for recoupment on 10/1/2019 (FY 2020) and not in FY 2019 thus reducing the overpayments identified in FY 2019. Additionally, the original submission reported $40.00 in overpayments recovered, the original submission did not capture two (2) payments from a payment plan of $488.45 each, $976.90 in total. The corrected overpayments recovered in FY 2019 are $1,016.90.*

Table 3-C. Iowa Total Care's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	0	0	$0.00	$0.00
2018	0	0	$0.00	$0.00
2019	51	25	$0.00	$0.00

Recommendation #2: The state, in conjunction with the MFCU when possible, should work with the MCOs to develop and provide program integrity training to staff on a routine basis, to enhance case referrals from the MCO. The state should ensure that MCO staff, primarily the SIU and/or compliance officer, is receiving adequate training in identifying, investigating, referring, and reporting potential fraudulent billing practices by providers.

Recommendation #3: The state should ensure that its MCOs are being proactive in identifying and collecting over-payments and are accurately reporting all over-payments to the state. The state should ensure that the MCOs develop and maintain the appropriate overpayment identification /collection/reporting policies and procedures.

4. Encounter Data

The IME PIU analyzes claims data using algorithms from the annual work plan. These algorithms are broadly designed to identify issues such as outlier billing patterns, payments for non-covered services, fraudulent billing, overutilization of services, incorrect program capitation payments, and duplicate billing. While IME's PIU prioritizes algorithms from the work plan, it also performs ad hoc reporting and runs supplemental algorithms. These functions are performed through Data Probe, an IBM web-based analytic application.

MCO data is regularly reviewed for potential overpayments using algorithms jointly performed for fee-

for-service (FFS) claims and MCO encounter claims. Various MCO financial reports are submitted on a monthly, quarterly, and annual basis within the Iowa Medicaid program. These reports contain insight into the medical loss ratios, solvency, and overpayment recoveries for each of the MCOs. The Medicaid Management Information System (MMIS) encounter data, which is used as the basis for rate development, is validated and benchmarked against the reported financials to ensure the base data used for rate setting is complete and only appropriate costs are included within the base. Historically, network adequacy evaluations for the MCOs have been performed as part of the rate-setting process as well. These evaluations are conducted by reviewing MCO encounter data at the provider level and comparing various metrics, such as provider-member ratios and service utilization levels between the members enrolled with each managed care plan, and can serve as an additional mechanism to identify aberrant provider or beneficiary activity that might indicate potential overpayments.

The IME receives detail-level encounter data from the MCOs. Institutional and professional claims are submitted using the EDI 837 transaction set and format. This data format is used to submit claims in accordance with Health Insurance Portability and Accountability Act (HIPAA) requirements. Pharmacy point of sale claims are submitted using the National Council for Prescription Drug Programs (NCPDP) post adjudicated claim transaction format. As per the state contract with the MCOs, all adjudicated claims encounter data is required to be submitted by the 20th day of the following month. However, the encounter data can be received and processed by the MMIS as frequently as daily. All encounter data processed by the MMIS is transferred and loaded to the data warehouse on a weekly basis. Post-processing monitoring ad-hoc analysis is developed by the Encounter Data Officer and Encounter Data Specialist in T-SQL scripts. Examples of this ad-hoc analysis for data accuracy include but are not limited to:

- Accuracy of key data elements
- MMIS encounter reject monitoring
- Timeliness of submission monitoring
- Potential duplicate analysis
- Analysis based on IME policy

Any issues identified in the encounter data are communicated to the MCOs during weekly encounter data project conference calls. This conference call also serves as a platform for planning for remediation of known data issues.

Additionally, as a method of measuring the completeness of the encounter data, a monthly encounter claim reconciliation is performed with the MCOs. The PIU also uses encounter data to conduct preliminary investigations analyzing billing claims data for abnormalities.

CMS did not identify any recommendations regarding Iowa's use of encounter data for Medicaid oversight.

5. Payment Suspensions

In Iowa, Medicaid MCOs are contractually required to suspend payments to providers at the state's

request; the MCO contract requires plans to suspend payments to a network provider on notice that the state determined a credible allegation of fraud in accordance with 42 CFR 455.23. Suspension of payments must be implemented immediately and applies to any and all Medicaid claims (fee-for-service and managed care based) submitted by the provider. The state reviews all allegations of fraud referrals. If the state determines the allegation has indicators of reliability that fraud exists, the state sends the referral to MFCU for investigation and issues a credible allegation fraud suspension notice, unless requested through a good exception to not suspend by the MFCU or if the state determines it is in the best interest of the state to not suspend. The suspension notice is sent to a distribution list, which includes the MCOs and PAHPs, directing the plans to suspend payments to the provider until further notice by the state.

The state does not allow the managed care plans to suspend providers without the direction of the state. However, the plans can place a provider on prepayment review without the state's permission.

The MCOs and the PAHP must report payment suspension action on the monthly report to the state. The state ensures compliance through oversight monitoring conducted through monthly reports. The information presented in these reports is validated by conducting desk reviews and/or onsite audits to assess compliance with the MCO/PAHP's contractual obligation under this provision.

All three MCO/PAHPs reviewed were observed to have a suspension policy in place and to comply with the terms of their contract. **As such, CMS did not identify any recommendations regarding Iowa's payment suspension policies and processes.**

6. ***Terminated Providers and Adverse Action Reporting***

During the review, it was observed by the review team that two of the three MCO/PAHPs are not conducting the appropriate databased checks, as specified by the Iowa MCO contract. The MCO contract states that "[t]he Contractor is prohibited from subcontracting with providers who have been excluded from participation by the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) under section 1128 of the Social Security Act, or by the Agency from participating in the Iowa Medicaid program for fraud or abuse. The Contractor shall ensure that a reimbursed Consumer Choice Option provider is not an excluded entity. The Contractor shall be responsible for checking the lists of providers currently excluded by the State and the federal government every thirty (30) calendar days. The Contractor shall check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the System for Award Management (SAM), the Medicare Exclusion Database (the MED), and any such other databases as the Secretary of DHHS may prescribe. Upon request by the Agency, the Contractor shall terminate its relationship with any provider identified as in continued violation of law by the Agency." **The review team was informed during the MCO interview portion of the review process that two of the three MCOs did not check the Social Security Administration's Death Master File as contractually required.**

Additionally, Iowa's MCO contract creates specific requirements intended to safeguard the integrity of the provider enrollment process. MCOs are contractually required to implement in their provider enrollment process an obligation for providers to disclose the identity of any person described in 42 CFR

1001.1001(a)(1), as well as other permissible exclusions that would impact the integrity of the provider's enrollment. MCOs are required to submit these disclosures to the SMA and to adhere to any directives provided by the SMA on whether or not to permit the applicant to be a provider in the program. Specifically, the MCO is not permitted to enroll a provider if the SMA or MCO determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services program, or if the SMA or MCO determines that the provider did not fully and accurately make any disclosure pursuant to 42 CFR 1001.1001(a)(1).

MCOs are also contractually required to comply with all requirements for provider disenrollment and termination as required by 42 CFR 455.416. The IME loads terminated providers to CMS' Data Exchange System (DEX), which

Recommendation #4: The State should ensure that all MCOs are meeting Iowa's contractual data base requirements and following all federal database check requirements, outlined in 42 CFR 438.602(d).

Table 4. Provider Terminations in Managed Care

MCO	Total # of Providers Disenrolled or Terminated in Last 3 Completed FYs	Total # of Providers Terminated for Cause in Last 3 Completed FYs	Total Enrolled Providers as of FY19
Amerigroup Iowa	2017 73 2018 196 2019 664	2017 5 2018 6 2019 5	27,759
MCNA Dental	2017 24 2018 58 2019 71	2017 0 2018 0 2019 0	465
*Iowa Total Care	2017 0 2018 0 2019 1237	2017 0 2018 0 2019 19	28,440

Footnote: Terminations numbers in column one consists of non FWA terminations. Termination numbers in the second column consist only of FWA and/or "for cause" types of terminations executed by the state.

**** Iowa Total Care executed their contract with IME July 1, 2019.***

The number of providers terminated for-cause by the plans appears low, compared to the number of providers enrolled with the MCOs.

Recommendation #5: The state should consider increasing their oversight of "for cause" terminations, to ensure their PI contractor and MCOs are appropriately and effectively, identifying and reporting

outlier providers, for potential FWA termination, to the state.

Status of Iowa's 2017 Corrective Action Plan

Iowa's last CMS program integrity review was in June 2017, and the report for that review was issued in January 2018. The report contained six recommendations. During the virtual review in May 2021, the CMS review team conducted a thorough review of the corrective actions taken by Iowa to address all issues reported in calendar year 2017. The findings from the 2017 Iowa focused PI review report have all been satisfied by the state.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Iowa to consider utilizing:

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Provider Requirements website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Provider-Requirements to address site visit requirements.
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCU.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address Overpayment and Recoveries.
- 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 the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- 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 training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Conclusion

CMS supports Iowa's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified six areas of concern and instances of non-compliance with federal regulations that should be addressed immediately.

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

CMS looks forward to working with Iowa to build an effective and strengthened program integrity function.