Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Georgia Comprehensive Program Integrity Review

Final Report

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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 Comprehensive Program Integrity Reviews.*

The purpose of this review was to determine whether Georgia'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; and False Claims Act education and monitoring.

In 2012, Medicaid enrollment in Georgia was approximately 1,529,000 and expenditures exceeded $8.5 billion; the Federal Medical Assistance Percentage matching rate was 66.16%. Approximately 72% of Medicaid recipients are enrolled in a risk-based managed care program.

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

CMS is concerned that several issues described in this review were also identified in CMS's 2011 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 Georgia complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment, managed care, and relationship with the MFCU. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit. The review team also conducted in-depth telephone interviews with representatives from the MFCU.

During the week of September 9, 2013, the CMS review team visited the Department of Community Health's Office of the Inspector General (DCH/OIG). The team conducted interviews with numerous DCH/OIG officials as well as with staff from DCH's contracted managed care entities (MCEs), which in Georgia are called Care Management Organizations (CMOs). The team also met with representatives from Georgia's two non-emergency medical transportation (NET) brokers. Lastly, the team also conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Georgia's program integrity practices.

Scope and Limitations of the Review

This review focused on the program integrity activities of DCH/OIG but also considered the work of other components, agencies and contractors responsible for a range of program integrity functions, including provider enrollment and contract management. Georgia operates its Children's Health Insurance Program (CHIP) as both a Title XXI Medicaid expansion program and a stand-alone Title XXI program. The expansion program operates under the same billing and provider enrollment policies as Georgia's Title XIX program. The same effective practices and risks discussed in relation to the Medicaid program also apply to the CHIP expansion program. The stand-alone CHIP program operates under the authority of Title XXI and is beyond the scope of this review. Unless otherwise noted, Georgia 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 program integrity unit provided.

Medicaid Program Integrity Unit

In Georgia, the DCH/OIG is the organizational component dedicated to anti-fraud and abuse activities. The Deputy Inspector General within DCH/OIG functions as the program integrity director. At the time of the review, the program integrity unit had 75 full-time equivalent positions allocated to Medicaid program integrity functions. The table below presents the total number of preliminary investigations, MFCU referrals, and the amount of identified and recouped overpayments related to program integrity activities in the last four state fiscal years (SFYs).

Table 1

SFY	Number of Preliminary Investigations*	Number of MFCU Referrals*	Amount of Overpayments Identified**	Amount of Overpayments Collected***
2013	1345	17	Not tracked by state	$35,864,000
2012	1104	23	Not tracked by state	$20,681,000
2011	1218	15	Not tracked by state	$36,340,000
2010	802	17	Not tracked by state	$23,915,000

* 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. As the Georgia DCH/OIG does not distinguish between preliminary and full investigations, we have listed the number of MFCU referrals as a proxy for full investigations.
**The DCH/OIG does not track overpayments identified but noted that its recovery audit contractor reported over $14.3 million in overpayments identified in SFY 2013.
***The figures for overpayments collected include global settlements, which cause significant fluctuations in the annual amounts.

Results of the Review

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

Risk Area 1: Risks were identified in the state's provider enrollment practices and reporting.

Ownership and Control Disclosures

The state implemented a Medicaid web-based enrollment system where FFS providers enter ownership and control disclosures during initial enrollment and re-enrollment. While the screens in the web-based enrollment system capture most of the disclosures required by the regulation at 42 CFR 455.104, they do not specifically ask for information on individuals or corporations with ownership or control interest in the disclosing entity who also have ownership or control interests in any subcontractor in which the disclosing entity has a 5 percent or more interest as required by 42 CFR 455.104(b)(1)(iii). In addition, DCH did not collect the required ownership and control disclosures from its fiscal agent and pharmacy benefit manager.

Furthermore, the state utilizes seven different paper enrollment applications for various provider types. The state allows disclosing entities such as home health agencies to complete the individual practitioner enrollment application. This form does not solicit complete ownership, control, or managing employee disclosure information. Therefore, the state is not in compliance with the requirement at 42 CFR 455.104 to capture ownership and control information from disclosing entities.

The appropriate collection of ownership and control information were issues previously identified in the 2008 and 2011 CMS reviews and remain uncorrected.

Exclusion Searches

A critical element of Medicaid program integrity is the assurance that individuals or entities do not receive payments when they are excluded or debarred from receiving such payments. For this reason, the regulation at 42 CFR 455.436 requires that, for any provider enrolled as a participating provider by the state, the State Medicaid agency 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, and the National Plan and Provider Enumeration System upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.

Since the state's provider enrollment applications and the web portal application screens do not solicit the full range of ownership and control disclosures (as described in the section on Ownership and Control Disclosures on page 4), the state is unable to search these parties for exclusions. Further, the frequency of the database searches undertaken is also not consistent with the regulatory requirements. The state does not search the LEIE and EPLS on a monthly basis as required for persons with ownership and control interests, agents and managing employees of the FFS provider as well as those disclosed by CMOs.

During interviews, the state indicated that it performs exclusion searches on any person with an ownership or control interest or who is an agent of the NET broker upon contracting and annually thereafter against the LEIE. However, the searches do not include managing employees or agents, nor do they check any names against the EPLS. The state is also not conducting monthly checks of the LEIE or EPLS.

Inadequate Safeguards in Place to Ensure Payments Are Not Made to Excluded or Debarred Individuals or Entities in Managed Care

The federal managed care regulation at 42 CFR 438.610 prohibit MCEs from knowingly having a director, officer, partner, or person with a beneficial ownership of more than 5 percent of the entity's equity who is debarred, suspended, or excluded, or from having an employment, consulting, or other agreement with an individual or entity for the provision of items and services that are significant and material to the entity's obligations under its contract with the state where the individual or entity is debarred, suspended, or excluded. CMS issued guidance to states through a series of State Medicaid Director Letters and a best practices document on this topic that provided states direction on screening for excluded individuals and entities. [2] The guidance

[1] In July 2012, the EPLS was migrated into the new System for Award Management (SAM).
[2] CMS, State Medicaid Director Letter, SMDL #08-003 (June 12, 2008), available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd061208.pdf.
CMS, State Medicaid Director Letter, SMDL #09-001 (January 16, 2009), available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD011609.pdf.

also communicated that while states may delegate many provider enrollment or credentialing functions to CMOs for managed care network providers, the state remains responsible for ensuring that excluded or debarred parties do not receive Medicaid funds.

Since federal regulations prohibit payment for items or services furnished by excluded individuals and entities, it is imperative that this first line of defense in combating fraud and abuse be conducted accurately, thoroughly, and routinely.

Georgia's contracts with the CMOs and NET brokers do not require the collection of disclosure information from network providers pursuant to 42 CFR 455.104 nor were the CMOs and NET brokers collecting the full range of disclosures from network providers. The disclosure form thereby potentially limits the ability of the contractors and the state to identify all relevant affiliated individuals or entities.

Further, the DCH and its CMOs and NET brokers could not demonstrate that they had a process in place that was thorough or frequent enough to verify that they do not have a relationship with an individual or entity that has been debarred, suspended, or otherwise excluded from participating in a contract paid with federal funds at the CMO or NET network provider level.

Criminal Offense Disclosures

The regulation at 42 CFR 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs since the inception of those programs for each person with ownership or control interest in the provider, or who is an agent or managing employee of the provider. Such information must be furnished at the time providers apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made within 20 working days from the date it receives the information.

The 2011 review found that the state's individual FFS provider enrollment application did not solicit the appropriate health care-related criminal conviction information from persons with ownership or control interests or agents and managing employees. The 2013 review found that the state partially addressed this issue. However, the state's web based enrollment system continues to be out of compliance in that it does not solicit health care-related criminal conviction information on agents as part of the enrollment process.

Business Transaction Disclosures

The regulation at 42 CFR 455.105(b) requires that, upon request, providers furnish to the state or HHS information about certain business transactions with wholly owned suppliers or any subcontractors. Georgia contractually requires business transaction disclosure information to be

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CMS, *Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment,* available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/bppedisclosure.pdf.

submitted by the CMO on an annual basis. However, the contract does not include a statement requiring the CMOs to disclose the specified business transaction information to the Secretary or the Medicaid agency within 35 days of the date of a request. This is a regulatory finding that was noted in the 2011 review and remains uncorrected.

Additionally, the NET program is vulnerable because neither the NET broker contracts nor the provider agreements require network transportation providers to disclose certain 455.105-related information upon request. The absence of this requirement in network provider agreements could hinder the state agency or broker in undertaking future investigations or audits related to potential fraud or abuse.

Verification of Provider Licenses

The regulation at 42 CFR 455.412 requires the state to have a method for verifying that a provider is licensed in accordance with state laws. States must check that the license has not expired and that there are no limitations on the license. Georgia requires in-state FFS providers to submit a hard copy or digital copy of their license to the fiscal agent for verification. The fiscal agent has an electronic feed with the Secretary the of State's office, medical boards and licensing boards to verify the license. However, the state indicated that out-of-state provider licenses are not verified by its fiscal agent. Providers are required only to attest on the application that there are no restrictions or sanctions against the license. While a license expiration date is checked, the state does not check with out-of-state licensing boards to determine if the provider has limitations or restrictions on their license.

National Provider Identifier

The regulation at 42 CFR 455.440 requires the state to require all claims for payment for items and services that are ordered or referred to contain the NPI of the physician or other professional who ordered or referred such items or services. At the time of the review, the state's paper claim forms did not capture the NPI number for ordering and referring providers. The state indicated that it expected to implement a new process in which the NPI will be captured on claim forms during SFY 2014.

Notifications of Adverse Actions to HHS-OIG

CMS's 2011 review found that the state was not notifying HHS-OIG of adverse actions taken on provider applications for participation in the Medicaid program as required by 42 CFR 1002.3(b)(3) because of difficulties in establishing an HHS-OIG contact. The state has since begun making notifications and at the time of the review said it was reporting FFS provider terminations, exclusions, settlements involving withdrawal from the Medicaid program, payment suspensions and payment withholds to the HHS-OIG. However, the state did not have a process for reporting providers whose applications were denied for program integrity reasons.

While Georgia's CMOs reported the same types of adverse actions to the state, reporting practices in the NET program were less consistent. Georgia's NET contract does not require the NET brokers to report adverse actions during credentialing of transportation providers to the

state. One of the two NET brokers did not report any adverse actions to limit a provider's participation in the Medicaid program to DCH/OIG. Although the second NET broker reported for-cause provider terminations to the state, it was unaware that other adverse actions taken to limit provider participation in the Medicaid program should be reported, including enrollment denials. By keeping the state informed of these actions the state will be able to provide HHS-OIG with an accurate overview of adverse actions cutting across both FFS and alternate delivery systems.

Notice of Exclusion

The regulation at 42 CFR 1002.212 requires the state to provide notice of permissive exclusions 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. While Georgia notifies appropriate licensing boards and state agency components when it undertakes permissive exclusions, state staff indicated they do not issue notifications to the public when they terminate FFS providers, as the regulation also requires. The state should also notify the public when a provider has been reinstated.

Recommendations:

- Collect the full range of ownership and control disclosures from FFS providers, the fiscal agent, and pharmacy benefit manager during the enrollment and contracting processes. Modify the state's web based enrollment system to solicit the full range of health care-related criminal conviction disclosures from providers.
- Develop and implement a process to ensure that neither the state nor its CMOs and NET brokers are affiliated with any individual or entity prohibited from receiving federal funds. At a minimum, either the state and/or the CMOs and NET brokers should search providers and any person with an ownership or control interest or who is an agent or managing employee of the network provider against the LEIE, EPLS, NPPES, and Social Security Administration Death Master File during the enrollment process and against the LEIE and EPLS monthly thereafter. Perform these same searches on all of the individuals and entities disclosed by the FFS providers, CMOs, NET brokers, and network providers. If the state chooses to delegate this task to the CMOs and NET brokers for network providers, CMS suggests these activities be required by contract.
- Develop policies and procedures to implement the provider enrollment and screening requirements as described in the 42 CFR 455 Subpart E as they relate to the verification of out of state provider licenses and the inclusion of ordering and referring provider NPIs on all claims where required.
- Modify the CMO and NET broker contracts to require business transaction disclosures upon request in accordance with the requirements of 42 CFR 455.105. Amend the NET contract and develop procedures to ensure that all adverse actions and provider terminations in the alternate delivery systems that are based on fraud, integrity, or quality concerns are reported to state agency and then to HHS-OIG.
- Ensure that proper notifications are provided when the state agency terminates or reinstates providers in accordance with 42 CFR 1002.212.

Risk Area 2: Risks were identified in the state's program integrity controls over the NET program

The CMS review team noted that DCH/OIG does not have program integrity policies and procedures in place to ensure that the state's two NET brokers perform adequate fraud detection and investigation. One broker performs no proactive data analysis to look for aberrant billing patterns or suspected fraud that would result in a referral to DCH/OIG. This is substantiated by its failure to generate any fraud referrals over the past 4 SFYs. This broker had no guidelines for applying intermediate sanctions and did not have a special investigations unit (SIU) for the purpose of investigating fraud and interacting with DCH/OIG on suspected fraud cases. Furthermore, this broker has never classified provider activity as fraudulent and primarily provides education to its transportation providers when overpayments or incorrect billings are identified. In addition, neither the broker's contract with the state nor any internal policies required it to verify the receipt of Medicaid services with the beneficiaries in its districts.

The other NET broker did not have a mandatory compliance plan that met the requirements of 42 CFR 438.608, nor was it a requirement of its contract with the state. However, it did have an SIU and a work plan along with policies and procedures on how to implement the plan. The presence of an operational SIU permitted this broker to provide more extensive program integrity oversight and to put an active fraud referral system in place. As noted in the noteworthy practices section, the second NET broker also utilized innovative provider tracking and monitoring techniques to help detect and prevent fraud, waste and abuse from occurring. The review team observed that many of the operational differences between the two NET brokers were primarily due to the absence of overall policies and procedures for state monitoring of program integrity in the NET program. During interviews with DCH/OIG staff, the state acknowledged this limitation and indicated it was in the process of initiating quarterly transportation collaborative meetings to enhance program integrity oversight and improve reciprocal communications with all transportation partners.

Recommendations:

- Develop and implement state-level policies and procedures for overseeing program integrity activities in the NET program.
- Incorporate guidelines or standards into the NET contract which brokers must follow in terms of baseline expected program integrity activities. At a minimum monitor the NET brokers for compliance with minimum SIU staffing levels, case tracking and reporting systems, and provider sanctions taken as a result of investigations.
- Amend the state's contract with the NET broker to include a compliance plan as required by 42 CFR 438.608.
- Consider the development of metrics to evaluate the performance of NET brokers on key program integrity performance indicators, such as overpayments recovered and fraud referrals developed.

Risk Area 3: Risks were identified in the state's payment suspension practices and annual reporting.

The regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, it must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment only in part. DCH/OIG defines the cases that it initially sends to the MFCU as possible fraud cases and awaits the MFCU's determination as to whether a credible allegation of fraud exists. If the MFCU indicates that a credible allegation of fraud exists, the state immediately files a written good cause exception request on every case per the terms of the memorandum of understanding between DCH and the MFCU. The review team sampled 10 cases that were referred to the MFCU, which subsequently determined that a credible allegation of fraud existed. A good cause exception was issued for each of these cases and therefore, no payments were suspended. The state indicated that it had serious reservations about suspending payments because this automatically triggered an administrative hearing[3], which could rule against the state and undermine the MFCU's case. The DCH Inspector General indicated that he preferred to put providers suspected of fraud on prepayment review where appropriate because this did not trigger appeal rights in Georgia.

While CMS encourages states to communicate frequently with the MFCU and does not limit who a state may consult with in order to determine that an allegation of fraud is credible, the regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the state must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. The use of alternate sanctions, such as prepayment review, may be part of a good cause exception but should be documented as such in the case files.

In addition, the team noted that the state has not provided HHS with any summary data on payment suspensions and good cause exceptions filed as part of the annual report required under 42 CFR 455.23(g).

Recommendations:

- Refine current payment suspension practices to ensure that DCH/OIG determines whether an allegation of fraud is credible. As soon as DCH/OIG determines there is a credible allegation of fraud, it should refer the case to the MFCU and suspend payment unless there is a basis to exercise good cause not to suspend. In determining whether there is good cause, DCH/OIG must consider each case referred to the MFCU on its own merits and not routinely exercise good cause in every case. This will help the state agency to identify where it can safely suspend Medicaid payments to potentially fraudulent providers without jeopardizing further investigation of those providers.

[3] See sections 404, 505 and 506 of the Georgia DCH's Medicaid provider manual, dated July 1, 2011, at https://advocacy.gha.org/Portals/1/Documents/Advocacy/Finance/Policies.pdf.

- Report annual summary payment suspension and good cause exception information to CMS via its web portal. More information on this process is located in the Technical Assistance Resources section of this report on page 12.

Noteworthy Practices

As part of its comprehensive review process, the CMS review team has identified two practices that merit consideration as a noteworthy practice. CMS recommends that other states consider emulating these activities.

Use of contractors to monitor improper payments within Georgia's Medicaid fee-for-service and managed care programs

The state has made optimal use of contractors to audit parts of the Medicaid program that state staff cannot necessarily cover on a regular basis. This has enabled the state to identify more improper payments in both the FFS and managed care programs over the last few years than would have been possible using only state employees. Georgia's Recovery Audit Contractor (RAC) is a contractor of long-standing with the state which currently performs a number of RAC and non-RAC functions. For example, it has developed a novel approach called "benefits testing" which looked for vulnerabilities in payment systems that could be exploited by providers, but would not be caught by existing MMIS edits and audits. The contractor reported over $14.3 million in overpayments identified in state fiscal year 2013 and nearly $5.1 million in recoveries. Its data analysis and audit activity cover both the managed care and FFS program in Georgia. Besides conducting systematic reviews to identify duplicate Medicaid beneficiaries in both programs, the contractor regularly identifies managed care enrollees who are capitated in the incorrect rate cohort. The contractor also reviews CMO encounter data for accuracy and completeness before it goes into the MMIS. CMOs whose encounter data does not meet a 99 percent standard of accuracy are penalized by the state.

Operating as a RAC, the contractor uses encounter data to perform data mining on managed care providers. According to Georgia state law, CMOs can only look back one year at a network provider's claims for irregularities, but the Medicaid agency and its agents can go back five years. When the RAC identifies network providers with billing issues, it notifies the CMOs. If they do not complete an audit and recoup funds within a one year period, the RAC can take over the audit and pursue it for over an additional look-behind period of four years. The RAC also conducts comprehensive audits of the Georgia CMOs and takes part in regular quarterly meetings with the State agency, CMOs and MFCU. The sum total of these activities help provide the state with significantly more oversight of payment, data reporting and rate-setting practices in the managed care program than might be available through the efforts of state staff alone.

Use of innovative monitoring and tracking technology by transportation broker

One of Georgia's two NET brokers has made innovative use of technology by distributing mobile mini tablets with customized proprietary software to all assigned drivers. The software enhances the contractor's ability to detect, deter, and prevent fraud activities within the broker's

contracted coverage area. Essentially, the broker receives information from the tablet's software system on drop off points in its database, which allows the broker to determine if specific patients are using rides to go to non-authorized sites, like supermarkets. The customized capabilities of the software allows for a series of baseline reports to be electronically generated as part of the pickup and drop-off process. The mini tablets are geo-coded so their location is always known, which allows the broker to automatically track how close or far vehicles and drivers are from the designated pickup location. The software technology also time stamps all trips so the broker knows if a provider is claiming to be in two places at once. The software is also capable of performing signature analysis. Therefore, it is capable of comparing the electronic signatures of all drivers who sign off after completing Medicaid trips. The mini tablets also have built-in security features to safeguard all collected information. Once the broker receives each day's entries, all the information is wiped clean from the tablets. Furthermore, if a driver's mobile tablet is ever lost or stolen, it can be automatically wiped clean.

At the time of the review, the broker reported that many drivers found the technology to be user-friendly and appreciated the efficient paperless process used for submitting invoices. Georgia's use of mini tablets, along with innovative transportation software, results in reduced risks to the Medicaid program and potentially increases the state's assurance that eligible beneficiaries are receiving quality health care from participating providers. Notwithstanding the benefits of this technology, the review team identified a number of issues with provider enrollment practices as well as monitoring and oversight in the state's NET program. These are discussed in Risk Areas 1 and 2 above.

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. The state reported a program integrity staff that is actively involved with its managed care program.

Program integrity staff involvement with managed care

Georgia's CMOs seek guidance from DCH/OIG staff before proceeding with investigations of suspected fraud and abuse in the managed care program. Because of this practice, the state is able to determine if the provider is being investigated by another entity before initiating an investigation. DCH/OIG staff also hosts quarterly meetings with the three CMOs and the RAC to discuss and review information on fraud and abuse issues. These meetings discuss problem providers who operate in both the FFS program and managed care delivery systems. The quarterly meetings which the state sponsors have helped to bring program integrity considerations and concerns to the forefront in all parts of the state agency. It has also helped Georgia's CMOs become more proactive in fraud and abuse detection.

Technical Assistance Resources

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

- Access the Regional Information Sharing Systems and use the program integrity review guides as a self-assessment tool to help strengthen the state's program integrity efforts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute, such as the *Medicaid Provider Enrollment Seminar* which can help address the risk areas such as those related to provider enrollment which are outlined in Risk Area 1. 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 to help strengthen program integrity efforts.
- To facilitate annual reporting of payment suspension information to CMS, please follow these steps:
    - Go to: www.medicaid.gov
    - Select the "State Resources" tab near the top of the page
    - Select the "Medicaid and CHIP Program Portal" option
    - Medicaid Model Data Lab will appear as an option, select "Enter" on the right
- Access the Medicaid Integrity Program's Support and Assistance webpages at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/index.html . The website is frequently updated and contains resources for states including annual program integrity review summary reports, best practices reports, and educational toolkits developed by CMS for training purposes.

Summary

The instances of non-compliance with federal regulations should be addressed immediately. CMS is also concerned about uncorrected, repeat risks 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 risk areas 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 take place and identify which area of the State Medicaid agency is responsible for correcting the issue. We are also requesting that the state should 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 Georgia to strengthen the effectiveness of its program integrity function.

Nathan Deal, Governor | **Clyde L. Reese III, Esq., Commissioner**

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January 12, 2015

Mark Majestic, Director
Investigations & Audits Group
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, MS AR 18-50
Baltimore, MD 21244-1850

Dear Mr. Majestic:

Attached is Georgia's Corrective Action Plan for the FY 2013 Program Integrity Review that was conducted by the Medicaid Integrity Group in September 2013.

We appreciate the efforts of CMS and their staff who conducted the review. The recommendations outlined in their report have assisted us in enhancing our internal controls to help reduce fraud, waste, and abuse.

Should you need additional information or assistance, please do not hesitate to contact me.

Sincerely,

Clyde L. Reese III, Esquire
Commissioner

cc: Donald E. Pollard, Jr., Esq., Inspector General
Lynnette Rhodes, Deputy Director, Medicaid Division
Heather Bond, Deputy Director, Medicaid Division

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