Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Indiana Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Indiana Medicaid Program. The MIG review team conducted the onsite portion of the review at the Office of Medicaid Policy and Planning (OMPP) and the Medicaid Fraud Control Unit (MFCU). The review team also visited the fiscal agent.

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

THE REVIEW

Objectives of the Review

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

Overview of Indiana's Medicaid Program

The Indiana Medicaid Program is called Indiana Health Coverage Programs. The OMPP is the office within the Indiana Family and Social Services Administration that administers the Indiana Medicaid program. In January 2010, the program served 1,049,234 beneficiaries. Of that total, 627,919 beneficiaries were enrolled in 3 managed care organizations (MCOs), and the remaining 421,315 beneficiaries were served on a fee-for-service (FFS) basis.

The State had 18,406 participating FFS and 24,372 MCO providers. During the State fiscal year (SFY) that ended on June 30, 2009, Indiana's Medicaid expenditures totaled approximately $5.8 billion. The Federal medical assistance percentage (FMAP) for Indiana in Federal fiscal year (FFY) 2009 was 64.26 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 73.23 percent in the first and second quarters of FFY 2009, and 74.21 percent in the third and fourth quarters.

Program Integrity Section

The State decided in SFY 2010 to bring the surveillance and utilization review (SUR) function in-house after many years of contracting the function out. The final contract ended in December 2009. The OMPP is in the process of structuring and staffing the new SUR unit that will report to the Finance Director, who is currently also functioning as the program integrity unit chief. At the time of the review, the program integrity unit was in a state of transition between having been previously largely contracted out and now staffing it with State employees. Its activities on this front were evolving. It had 2 of its 4 full-time equivalent (FTE) positions filled, while the SUR

unit had filled 7 of its 15 authorized positions. The authorized positions include auditors, investigators, and data analysts. From SFY 2006 through SFY 2009, OMPP contractors conducted an annual average of 505 preliminary investigations and 188 full investigations. The table below presents the number of investigations and overpayment amounts identified and collected for the past four SFYs as a result of administrative actions and program integrity activities, such as audits.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2006	651	248	$12,365,871	$4,690,797
2007	623	200	$ 7,078,008	$2,910,107
2008	549	255	$ 5,950,118	$1,663,820
2009	198	49	$ 8,569,857	$3,443,818

* 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.

Methodology of the Review

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

During the week of March 8, 2010 the MIG review team visited the offices of OMPP. The team conducted interviews with numerous officials from the Agency Coordination & Integration, Data Management, and Reimbursement divisions. Finally, to determine whether the MCOs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed staff from the agency component charged with managed care oversight, known as Care Programs. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of three MCOs. In addition, the team conducted sampling of provider enrollment applications, program integrity case files, and other primary data to validate Indiana's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the program integrity and SUR units, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and managed care. Indiana operates a combination Children's Health Insurance Program (CHIP). The expansion CHIP operates under the same FFS billing and provider enrollment policies as Indiana's Title XIX program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the Medicaid expansion portion of CHIP.

Unless otherwise noted, OMPP 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 OMPP provided.

RESULTS OF THE REVIEW

Noteworthy Practice

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

The State enrolls all FFS and managed care network providers through its fiscal agent

The State enrolls all FFS and managed care network providers through a contractor. By having one focal point of enrollment, the Medicaid agency ensures that all provider types are subject to the same enrollment processes in which required disclosures are made, license verifications conducted and exclusion searches performed. This standardization has eliminated essential discrepancies found in many other States, especially for providers participating in managed care networks who may be subject to different credentialing standards.

Effective Practice

As part of its comprehensive review process, the CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Indiana reported a committed partnership with MCOs and the MFCU.

Committed partnership involving State program integrity operations, MCOs and the MFCU

The State reported that the SUR and program integrity units have created a well-functioning and committed partnership with the State's MFCU, establishing a clear understanding of a standard for appropriate provider case referrals. This relationship has resulted in the MFCU accepting almost all referrals from the program integrity unit. After a case is fully developed, the SUR unit and MFCU continue communication regarding the status of the case until its conclusion. This communication takes place on an as needed basis as well as during monthly meetings. The close relationship with the MFCU has been essential in maintaining continuity of operations during the transition of SUR functions from a contractor to the State in 2010.

All MCOs currently participate in the same monthly meetings to discuss investigations and current fraud cases and trends. The MCOs reported that many of their case investigations are triggered by discussion in these meetings. At the time of the review, the team was told that the recent spotlight had been on problem transportation providers participating in both FFS and managed care networks. However, the value of this activity is mitigated because the State's MCO oversight staff do not regularly participate in the meetings.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations mandating certain disclosures and notification activities and has not maintained an appropriate level of oversight of provider compliance with the employee education requirements of the Federal False Claims Act.

The State does not capture all required ownership, control and relationship information from providers, the fiscal agent and MCOs.

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

The language in Indiana's provider applications does not fully meet the 42 CFR §455.104(a)(3) requirement on disclosure of ownership or control interests in other disclosing entities. In the regulations at 42 CFR §455.101, "other disclosing entity" is defined as a Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. Indiana's provider enrollment application instructs the applicant as follows, "Indicate if any persons have an ownership or control interest in any other current or prospective provider." This instruction to provider applicants does not consider affiliations with providers in delivery systems other than Medicaid.

Regarding MCO ownership, the Department of Insurance (DOI) collects ownership disclosures from MCOs at the point of contracting and OMPP reviews these disclosures. However, the

disclosures do not fully conform to the requirements of 42 CFR §455.104. Although parent and affiliate company names, some corporate information and managing employee names (key staff) are collected as part of the Request For Proposal process, the State did not present evidence that it collects the names and addresses of all MCO owners holding a direct or indirect ownership or control interest of 5 percent or the names and addresses of Board of Director members. The MCOs provide quarterly financial, ownership and related party disclosures to DOI and OMPP, however, these disclosures also do not appear to conform to 42 CFR §455.104 requirements and none of the updated information is used for the purpose of exclusion checking.

Lastly, while OMPP also collects and reviews fiscal agent disclosures as part of the contracting process, such disclosures do not contain the full range of ownership and control information required by the regulation.

Recommendations: Modify the wording in the State's provider applications to reflect the definition of "other disclosing entities" as defined in Federal regulations. Modify MCO and fiscal agent contracts to require disclosure of the name and address of those in ownership and control positions as part of the contracting process.

The State does not collect and refer all health care-related criminal conviction information.
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 at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) whenever such disclosures are made.

The OMPP does not refer criminal conviction disclosures to HHS-OIG as required in 42 CFR §455.106. In addition, the State's contract with MCOs does not require health care-related criminal conviction disclosures by providers, owners, agents, or managing employees. The MCO vendors certify in their contracts that they have no outstanding civil or criminal actions pending with the State. This statement does not include disclosures related to a history of criminal convictions nor any Federal health care crimes. The MCOs likewise reported that they do criminal background checking of employees usually at hire (with one plan requiring an annual recertification by the employee). However, this contractual certification is not the same as an ongoing obligation to disclose and does not allow the State agency to meet its disclosure collection and reporting responsibilities under the regulation.

Recommendations: Develop and implement a procedure to report applicable criminal convictions to HHS-OIG within 20 working days. Modify MCO contracts to require the disclosure of health care-related criminal convictions from providers and all affiliated parties as specified in the regulation.

Indiana does not report adverse actions taken on provider applications to HHS-OIG.
The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The OMPP does not notify HHS-OIG when it declines to enroll FFS provider applicants in Medicaid for program integrity reasons or after taking other adverse actions, such as provider terminations.

Recommendation: Develop and implement procedures for reporting any adverse actions taken on provider applications to HHS-OIG.

The State has not complied with the State Plan requirement to review provider policies and employee handbooks pertaining to the False Claim Act.
Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least $5 million annually under a State's Medicaid program have (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

The OMPP did provide the team with documentation demonstrating that it monitored provider compliance with the False Claims Act education provisions of the Social Security Act on a sample basis. However, the Indiana Medicaid provider agreement does not require employee handbooks to contain information on the Federal False Claims Act or whistleblower protections as required by the regulation.

Recommendation: Modify the State's provider agreement to require employee handbooks to contain information on the Federal False Claims Act and whistleblower protections.

Vulnerabilities
The review team identified six areas of vulnerability in the State's program integrity practices. These involved the current state of program integrity/SUR operations and a general lack of MCO oversight. Additional issues include the failure of MCOs to verify billed services with beneficiaries, collect required disclosure information from network providers, notify OMPP of adverse actions taken on provider applications, and conduct complete searches for excluded individuals and entities within their networks. They also include the failure to ensure that managing employee information is captured during the provider enrollment process.

Limited effectiveness of program integrity/SUR operations.
Under the regulation at 42 CFR § 455.13, the State Medicaid agency must have methods and criteria for identifying suspected fraud cases and investigating those cases, and to have procedures for referring suspected cases of fraud to law enforcement officials. The Indiana State agency was in a state of transition from outsourcing its program integrity activities to bringing them back within the agency. However, the review team found a number of marked weaknesses in OMPP's current transitional situation. Key examples of these include the following:

Lack of policies and procedures
The State has no written policies and procedures for program integrity functions and is currently using SUR policies and procedures utilized by a previous SUR contractor that have yet to be formally approved. The absence of written policies and procedures leaves the State open to legal challenge of its processes and vulnerable to inconsistent operations and ineffective functioning in the event the State loses experienced program integrity or SUR staff.

For example, the State did not have procedures for reporting providers with Medicaid-related criminal convictions to HHS-OIG, although the regulation at 42 CFR 1002.230 requires the Medicaid agency to do so within specified timeframes unless the MFCU has already provided such notice. There are also no policies, procedures or contract requirements directing MCOs to transmit to the State agency information on convictions obtained during a network provider's recertification. The State agency would therefore be unable to refer such information to HHS-OIG as required in the regulation.

During the sampling of case files, the team likewise observed poor and inconsistent documentation, which highlights the need for policies and procedures in the department. For example, the case files on MFCU referrals did not show the actions the State took after a case was returned to the State from the MFCU.

Low staffing levels
During a 2005 CMS review of the State's program integrity functions, the CMS review team found the State contracted its SUR functions to a private entity that employed 27 FTEs to execute these functions. In addition, the State also contracted with a private entity to provide professional accounting, consulting, data management, and billing and reimbursement analysis services. This accounted for an additional six FTEs.

The State decided in early SFY 2010 to transition SUR functions "in house." As noted in the program overview, the Medicaid agency has authorized 15 FTEs for SUR and 4 FTEs for program integrity work, of which 7 SUR positions are currently filled by contractors and 2 of the program integrity positions are vacant. This is a significant decrease in staff dedicated to program integrity and SUR functions in the past 5 years while the number of Medicaid beneficiaries in the State has increased by approximately 227,000 beneficiaries or 27 percent. The State indicated that it is in the process of developing a policy and procedure manual to reflect the recent changes to SUR functions and program integrity operations. However, the State had no previous policy and procedure manual for program integrity even when SUR functions were executed by a contractor.

During a time of major program integrity transition and a significant influx of Medicaid beneficiaries, the State also does not have a dedicated program integrity director to exercise overarching control of the program integrity and newly assumed SUR functions. Prior to the MIG review, the State was unable to submit review materials in a timely fashion. Although the program integrity unit has established some strong partnerships, during the review, the team observed a disconnect in the interaction among Medicaid agency components. For example, after the transfer of a designated point of contact out of the program integrity unit, managed care case referrals ceased to be received by the unit. The review team believes that a significant overhaul of the program integrity/SUR program will require a dedicated program integrity director position.

Limited audits and productivity
A decrease in program integrity operations is evidenced in a decline of prepayment review activities resulting in referrals to the MFCU. Over the past four SFYs the number of such referrals decreased from seven in 2006 to zero in 2009. The MFCU referrals based on post-payment provider reviews have also decreased progressively over the past 4 SFYs from 21 in 2007 to 14 in 2009. Overall, cases that were sent to the MFCU in the past 4 SFYs have declined from 21 in SFY 2007 to 6 in SFY 2008 and 11 in SFY 2009. The number of actual post-payment reviews has also decreased from 68 desk audits and 194 field audits in SFY 2008 to 5 desk audits and 19 field audits in SFY 2009. The State indicated to the team that its data analysis activities are currently only resulting in provider self audits. The absence of desk and field audits raises concerns about the State's effectiveness in identifying overutilization and fraud and abuse in the Medicaid program. The State also mentioned at the time of the review that one of its key data mining programs was not functioning, which further limits the State's ability to routinely conduct surveillance of providers.

Not utilizing sampling and extrapolation
State policy in Indiana allows the use of sampling and extrapolation. However, the State does not make use of these potentially effective statistical methods when reviewing provider payments. The OMPP employs prepayment reviews to monitor problem providers and uses payment withholds to stem the flow of dollars out of the program while deciding whether to refer problem providers to law enforcement. Large-scale State-initiated provider audits are not currently undertaken due to staff limitations. This prevents Indiana from identifying and recouping as much in likely overpayments as accepted statistical procedures would suggest it is due.

Not utilizing permissive exclusion authority
The Medicaid State Plan reserves the right to exclude problem providers on a discretionary basis, using the permissive exclusion authority permitted under 42 CFR §1002.210. However, this program integrity tool is also not currently being utilized by the State. The OMPP has initiated no permissive exclusions in the past four SFYs. Thus the State is not as proactive in excluding problem providers from the Medicaid program as it has the authority to be.

***Recommendations*:** Develop policies and procedures to define provider review strategies, case documentation expectations, and reporting requirements to help make the program more effective and consistent in operations. Expand provider review techniques and exercise the authorities available to maximize program oversight, identify program integrity issues and overpayments, and proactively exclude aberrant providers from the program. Continue fulfilling program integrity and SUR staffing goals and assign a dedicated program integrity director to lead and integrate integrity operations within OMPP.

Not capturing managing employee information on provider enrollment forms.
Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency."

Although Indiana requests managing employee information on its provider enrollment applications, which are processed by a contractor, there is no quality control process to assess whether appropriate managing employee information is actually provided. During a walkthrough of the provider enrollment process in which the team observed two actual enrollments, the team noticed that only a single managing employee disclosure was sufficient for a hospital or group application to be considered complete. The hospital application (for a not-for-profit facility) showed the president of the hospital as the only managing employee at the facility. Similarly, a group practice application showed no managing employees listed in the section where such individuals would be recorded, along with persons with ownership and control interests and related parties. Only a contracted billing agent was listed in another section of the application. The review team was told there is no policy on calling providers to determine if applications are complete or if the listing of one or zero managing employees seems implausible. As a result, the State would have no way of knowing if excluded individuals are working for health care entities in responsible positions, such as billing managers and department heads.

***Recommendations*:** Modify the State's enrollment procedures and provider applications to require information on the full range of managing employees. Maintain such information in a database where it can be used to search for exclusions at the point of initial enrollment and periodically thereafter.

Not conducting complete searches for individuals and entities excluded from participation in Medicaid.
On June 12, 2008, CMS issued a State Medicaid Director Letter (SMDL #08-003) providing guidance to States on checking providers and contractors for excluded individuals. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own staff and subcontractors for excluded parties, including owners, agents, and managing employees. The Indiana State agency does not conduct exclusion searches that are fully consistent with this guidance.

The OMPP has a provider enrollment contractor that enrolls all FFS and managed care providers into Indiana's Medicaid program and searches every name disclosed in an application for a possible HHS-OIG exclusion at the time of enrollment. The contractor also does monthly searches of a provider database for exclusions by comparing it with CMS' Medicare Exclusion Database (MED). However, as noted above, there are no procedures for verifying whether the information provided on managing employees is complete, and the team found some gaps in the provision of ownership and control information as well. For example, rendering physician applications do not contain a section for ownership and control disclosures at all. A rendering physician must be attached to a group practice and does not perform any billing activities. Since the application does not ask for any ownership and disclosure information, it would not be possible for the Medicaid agency to search for excluded individuals who may be associated with an individual rendering services.

In addition, the database which the provider enrollment contractor uses to identify excluded parties through a comparison with the MED does not contain owners, directors and managing employees. While OMPP has access to limited MCO information on ownership and control (including quarterly updates) as well as data on fiscal agent ownership, the available names of owners, directors, agents, subcontractors and managing employees are not entered into a searchable database. Therefore, exclusion searches conducted after the point of provider enrollment or MCO and fiscal agent contracting are incomplete.

Lastly, OMPP contracting and procurement staff indicated that HHS-OIG's List of Excluded Individuals/Entities (LEIE) is not checked at all during the procurement of both the fiscal agent and managed care contracts, while the Excluded Parties List System, which the General Services Administration maintains, is only searched for contractors. This means that even though the identity of owners, directors and other principals may be available to the State in contract documents, they are not searched for exclusions as part of the procurement process.

***Recommendations*:** Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information to ensure that provider enrollment and contracting staff conduct complete exclusion searches using the LEIE or MED at the time of provider enrollment, re-enrollment, and at least monthly thereafter. Refer for guidance as needed to SMDLs #08-003 and #09-001, which can be found on the CMS website.

Not verifying whether managed care services billed by providers were received.
While the State meets the requirements of 42 CFR § 455.20 by sending explanations of medical benefits to FFS beneficiaries, information obtained by the MIG review team during interviews with three MCOs and a care management organization which works with the Aged, Blind and Disabled under a primary care case management arrangement indicated that the MCOs are not performing direct beneficiary verification of services. A review of the contract between the State agency and MCOs revealed that Indiana does not require this. The MCOs reported to the team that they perform routine and ongoing data mining and claims audits; however, they do not use direct beneficiary verification strategies.

***Recommendation*:** Require MCOs to develop and implement a method for verifying with beneficiaries whether billed services were received.

Not providing sufficient oversight over MCOs.
Although OMPP requires annual compliance plans from the MCOs and program integrity projects are beginning to be incorporated into the Quality Improvement Workplans of the MCOs, OMPP does not require the reporting of ongoing program integrity activities (audits and investigations) from plans. The OMPP requires only the immediate reporting of suspected fraud and abuse incidents. In addition, the reporting of program integrity activity is reviewed by managed care staff from Indiana Care Programs and not the program integrity unit.

During interviews, the plans uniformly reported that they conduct surveillance activities, such as investigations, audits, and data mining and are in the process of expanding these. However, the MCOs do not systematically share information on the status of investigations of specific providers or problem areas with the State. For example, in the year preceding the review, 1 MCO reported that it investigated 18 cases but reported none to the State. A second MCO indicated that it investigated 16 cases and reported all of them. Since 2008, a third MCO reported investigating four cases but filed no reports because its contract only requires the immediate reporting of suspected fraud or abuse. Additionally, several cases reported by MCOs originated with the MFCU and might not otherwise have been reported.

All of this has hindered Indiana from being able to "red flag" issues or providers early on and ensure that MCOs are proactively looking for fraud, waste and abuse. It has limited the State's ability to develop program integrity strategies targeting patterns of fraud that cut across the FFS and managed care delivery systems. In addition, Care Programs has not been attending the monthly MFCU/MCO/program integrity meetings. The review team was told by a supervisor from this component that Care Programs would begin attending the monthly meeting as a result of the CMS review.

***Recommendations*:** Require MCOs to routinely report ongoing program integrity audit and investigation activities to the program integrity unit. Require managed care oversight staff to attend the monthly MFCU/MCO/program integrity meetings.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications.
The OMPP does not require MCOs to report adverse actions taken against providers either as a matter of policy or contract. Although plans provide the State agency with monthly provider data files for the purpose of updating provider network lists, this information is not flagged for terminations "for cause", nor does it include enrollment denials. The lack of systematic and required reporting may make it easier for problem providers to find a way into other MCOs and the FFS program undetected. The failure of MCOs to notify the Medicaid agency of adverse actions taken for program integrity reasons also precludes the Medicaid agency from reporting such actions to the HHS-OIG, as the regulation at 42 CFR § 1002.3(b) would require in the FFS program.

Recommendations: Require contracted MCOs to notify the State agency when they deny providers credentialing or take other adverse actions against enrolled providers for program integrity-related reasons. Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers enrolled or applying to participate in the program.

CONCLUSION

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

- a common platform for enrolling all FFS and managed care network providers, and
- a committed partnership among the SUR unit, MCOs and the MFCU.

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

However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, six areas of vulnerability were identified. In particular, we are concerned about the overall effectiveness of the State's program integrity operations. The CMS encourages OMPP to closely examine each area of vulnerability that was identified in this review.

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

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

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