# Department of Health and Human Services

# Centers for Medicare & Medicaid Services

# Center for Program Integrity

# Georgia Focused Program Integrity Review

# Final Report

# November 2018

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## Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Georgia to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. In Georgia, MCOs are referred to as care management organizations (CMOs). The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2013.

## Background: State Medicaid Program Overview

The Department of Community Health (DCH) is the single state agency charged with overseeing the Medical Assistance Plans program in Georgia. The DCH Office of the Inspector General (OIG) is the organizational unit responsible for the overall program integrity operations, although other units within the organization maintain certain delegated program integrity related responsibilities. Georgia is not a Medicaid expansion state. In 2017, Georgia's Medicaid expenditures exceeded $9.8 billion. The Federal Medical Assistance Percentage matching rate was 67.89 percent. The Medicaid enrollment increased to approximately 1.9 million beneficiaries in federal fiscal years (FFY) 2015 to 2017. Approximately 74 percent of Medicaid beneficiaries were enrolled in a risk-based managed care program, however the state's fee-for-service (FFS) program accounts for the majority of the Medicaid expenditures.

## Methodology of the Review

In advance of the onsite visit, CMS requested that Georgia and the CMOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A four-person-member review team reviewed these responses and materials in advance of the onsite visit.

During the week of April 30, 2018, the CMS review team visited the offices of the DCH/OIG. The team conducted interviews with numerous DCH/OIG officials as well as with staff from DCH's contracted CMOs. In addition, the CMS review team conducted sampling of program integrity cases investigated by the CMO special investigations units (SIUs), as well as other primary data in order to validate the state and the selected CMOs' program integrity practices.

## Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, which create risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved, particularly those from the earlier review. These issues and CMS' recommendations for improvement are described in detail in this report.

## Section 1: Managed Care Program Integrity

### Overview of the State's Managed Care Program

Georgia has approximately 1.4 million beneficiaries, or 74 percent of the state's Medicaid population, who were enrolled in four CMOs during FFY 2017. The state spent approximately $4.14 billion on managed care contracts in FFY 2017.

The DCH/OIG program integrity function is managed and directed by the Director of Program Integrity. The DCH/OIG Program Integrity Unit has 37 full-time positions of which the vast portion of their duties are to oversee Medicaid FFS, while only two FTEs are assigned to perform managed care related program integrity activities, including providing CMO program integrity oversight. For the purposes of this review, staff that work in DCH/OIGs Data Analysis and Integrity Unit (DAIU) are considered as part of the Program Integrity Unit and they support program integrity activities.

Insufficient managed care program integrity staffing levels may potentially decrease Georgia's ability to pursue investigations and other core program integrity functions within the Medicaid managed care program. It is operationally important for program integrity units to maintain sufficient staffing levels and appropriate levels of resources in order to perform the activities required to address program integrity risks to the Medicaid program.

#### *Summary Information on the Plans Reviewed*

The CMS review team interviewed three CMOs as part of its review. The selected CMOs were Amerigroup Community Care (Amerigroup), CareSource, and WellCare of Georgia (WellCare).

Amerigroup is a national, for-profit plan that is a wholly-owned subsidiary of Amerigroup Corporation. Amerigroup provides health care services in Georgia to Medicaid, PeachCare for Kids (Children's Health Insurance Program) and Planning for Healthy Babies. Amerigroup providers are credentialed by DCH's credentialing verification organization (CVO).

Amerigroup's SIU is located in Virginia Beach, VA. Approximately 23 staff perform various functions for Georgia. Only one investigator is located within the state of Georgia. The SIU does not perform any unannounced site visits as a program integrity investigative tool.

CareSource is a national healthcare managed care model headquartered in Dayton, Ohio and founded in 1989. In Georgia, CareSource's only line of business is Medicaid and their providers

are also credentialed by DCH's CVO. CareSource has a dedicated SIU located in Georgia that includes an SIU manager and a fraud manager who is responsible for program integrity activities.

WellCare is

WellCare of Georgia has multiple lines of business and has a dedicated SIU located in Tampa, Florida. There are no investigators physically in Georgia, although the plan does have a compliance person located in Georgia. Investigators will come to Georgia to conduct visits or audits along with the ability to utilize other corporate resources to aid in this process.

WellCare's SIU reports to the DCH/OIG about known or suspected fraud cases, but they do not investigate or resolve the suspicion without making DCH aware of the investigation. The DCH will then determine how the SIU will proceed as it relates to investigating suspected fraud cases.

Enrollment information for each CMO as of January 2017 is summarized below:

**Table 1.**

| | **Amerigroup** | **CareSource** | **WellCare** |
|---|---|---|---|
| **Beneficiary enrollment total** | 359,936 | 214,015 | 494,244 |
| **Provider enrollment total** | 31,755 | 29,361 | 26,679 |
| **Year originally contracted** | 2006 | 2017 | 2006 |
| **Size and composition of SIU** | 23* | 29** | 12*** |
| **National/local plan** | National | National | National |

*****There are 23 staff in the corporate SIU that supports Georgia's office. Of that 23, one is located in GA.
**There are 29 staff in the corporate SIU that supports Georgia's office. Of that 29, two are located in GA.
***The amount of time these out of state employees devote to Georgia equates to approximately 4 FTEs.

**Table 2.**

| **CMOs** | **FFY 20**15 | **FFY 20**16 | **FFY 20**17 |
|---|---|---|---|
| Amerigroup | $1.13 billion | $1.24 billion | $1.20 billion |
| CareSource | N/A | N/A | $142 million |
| WellCare | $1.63 billion | $1.72 billion | $1.63 billion |

*****Expenditure amounts depicted were submitted by DCH and varied only slightly from expenditure data submitted by each of the CMOs.

***State Oversight of Managed Care Program Integrity Activities***

The DCH/OIG has several issues that hinder the organization's ability to provide effective state program integrity oversight over its managed care program. The CMS review team found several risks related to program integrity in Georgia's Medicaid program that are highlighted in this report.

The CMS review team identified a lack of robust program integrity contract language that allows the state to maintain the necessary program integrity controls and oversight capabilities, while maintaining the flexibility to govern its managed care program effectively. The current contract with the CMOs has an extremely limited fraud, waste and abuse section with only a few generally outlined program integrity requirements. The state should consider enhancing/improving the program integrity contract language in order to help the state eliminate any impediments to provider auditing and collaborative audits with the CMOs.

Some of the program integrity issues that DCH might consider requiring in its managed care contracts include, but is not limited to the following: 1) Handling of provider complaints and allegations of provider fraud, waste, and abuse; 2) Handling and tracking of suspected provider fraud referrals to DCH; 3) Development and implementation of written policies and procedures on payment suspensions in accordance with 42 CFR 455.23 and/or 42 CFR 438.608(a)(8); 4) Specific language around program integrity recoupments or overpayment recoveries after all appeal rights are exhausted; 5) Collaborating and conducting joint audits and initiating routine onsite provider visits during an investigation/audit; 6) Verifying Medicaid services with beneficiaries; 7) Tracking suspected provider fraud referrals; 8) Handling of provider adverse actions to include exclusions and terminations; 9) CMO performance to include annual reviews[1] including sanctions and liquidated damages; and 10) Updated administrative appeal rights policy associated with payment suspensions in accordance with 42 CFR 455.23.

In connection to the lack of robust program integrity contract language, DCH has inadequate written policies and procedures for program integrity functions. The shortage of written policies and procedures leaves DCH vulnerable to inconsistent operations and ineffective functioning in the event DCH loses experienced program integrity or provider enrollment staff.

Moreover, DCH/OIG may want to consider requiring member complaint logs to be submitted on a monthly basis rather than a quarterly basis. The CMO should also submit to the DCH/OIG, a monthly report listing all investigations conducted that resulted in no findings of fraud, waste, and abuse and maintain a log of all incidents of suspected fraud, waste, and abuse received by the CMO regardless of the source.

Finally, the DCH/OIG and the CMOs should meet more frequently to actively engage around subjects centered on investigations, referrals and reporting of suspected fraud, waste, and abuse by providers. This would include increased training sessions and educational meetings between the DCH and the CMOs on Medicaid program integrity. There appears to be an opportunity for

[1] The DCH currently has no program integrity monitoring tool or checklist to review CMO program integrity performance nor is it a contract requirement to have such a monitoring tool.

educating the CMOs on the differences between how the CMOs view aberrant providers relative to their private lines of business versus how it should be viewed for their Medicaid line of business. Emphasis should be placed on how the CMOs investigate and resolve provider fraud, waste, and abuse along with the consequential actions that should be taken. During a sampling of provider investigative case files conducted by the CMOs, the review team found several of the sample cases where providers were terminated by the CMOs for business reasons rather than for credible allegations of fraud.

### *MCO Investigations of Fraud, Waste, and Abuse*

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral and reporting of suspected fraud, waste, and abuse by providers and CMOs.

Georgia's CMO contract states that the CMOs program integrity program, "shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of fraud, waste and abuse in the administration and delivery of services under this contract."

The CMOs do not make referrals directly to the MFCU according to DCH/OIG. The review team was unable to ascertain the accuracy of the referral process without any formalized referral system in place and some of the CMOs indicated they made referrals directly to the MFCU. The CMO contract itself is not specific and does not describe the reporting mechanisms or the units that are involved in case handling. The contract does not provide information about who the information is to be reported to and the time frames for reporting the information, although in practice the CMOs are providing the referral.

The only reporting information in the contract is as follows: "The CMOs shall submit quarterly reports of fraud, waste, and abuse activity to DCH, which is then sent to the OIG for review". The contract does include language that defines where the CMO submits reports of suspected provider fraud, waste, or abuse on a quarterly basis. The review team discussed the need for more frequent reporting time frames for the identification, investigation, referral and reporting of suspected fraud waste and abuse. Monthly reports will allow the DCH/OIG to oversee program integrity in the managed care program more effectively.

Amerigroup informed us that their SIU uses prepayment review to evaluate claims to ensure the documentation supports the services billed. The decision to place the provider on prepayment review is specifically related to fraud, waste and abuse. Amerigroup indicated that the "provider will remain on a prepay edit until an accuracy rate of 75 percent or higher for three consecutive months is attained or the provider has a low estimated savings." The Amerigroup corporate policy says that the provider must receive an accuracy rate of 90-95 percent in order to be removed from prepay. So, it appears that either Amerigroup is not following their own corporate policy or the standard has been lowered for Georgia. The review team was unable to ascertain if either of these was the situation.

Amerigroup indicated they placed 34 providers on prepayment review for 2017. Prepayment reviews are specific to the code(s) that are billed. They do not look at the overall billings by the

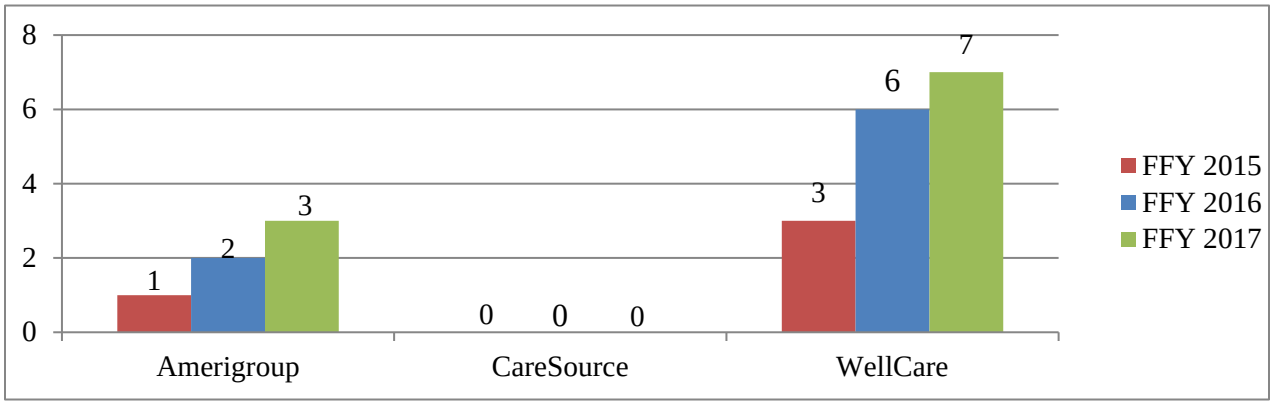
provider. Amerigroup did not provide us with the total savings generated from the prepayment review.

CareSource has only been reviewing trends for one year, since becoming a Georgia Medicaid provider a little over a year ago. CareSource has not reached the point where any cases have been referred to the state for suspicious activity. Over the past year, the CMO has been primarily engaged in provider education activities as they continue to analyze the claims data for trends. In the event of an actual case, CareSource stated that cases might come in various ways, which would then be triaged by the SIU manager to various staff. The case then goes to intake where it is triaged to a claims analyst in the unit. If supported, the case would then get forwarded for full investigation. They must obtain permission from the state before they can investigate. If fraud is suspected, it will be referred to the state and they will refer to the Medicaid Fraud Control Unit.

WellCare conducts periodic assessments to determine how best to focus its SIU efforts. These assessments include any identified or reported fraud schemes or trends, identified outliers or other data that dictates a targeted response or preventive action by the CMO. Once a referral is received, the matter is entered into the secure Compliance 360 data base by the SIU. The referral will be preliminarily assessed by the intake team, to confirm that the matter concerns potential fraud, waste, and abuse. The SIU will pursue reactive and proactive investigations to either validate the allegations or determine them unfounded.

Table 3 lists the number of referrals that Amerigroup's SIU, CareSource's SIU and WellCare's SIU made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by each of the CMOs is low, compared to the size of the plan. The level of investigative activity by the CMOs has not changed over time.

**Table 3.**




As illustrated above, the CMOs referred relatively few cases of suspected fraud during the review period. The review team noted incidents where some of the CMOs may have referred a suspected credible allegation of fraud case to the state; however, when it came down to terminating the provider, the CMO opted not to terminate the provider for cause. This allows the provider to maintain a clean record with no impediments to becoming a participating provider in any Federal program.

The low volume of CMO provider case referrals was of particular concern to the review team. This was also a concern in the state's previous 2013 comprehensive review report. As depicted in table 3 above, WellCare had the most referrals, however, the number of referrals are low for the size and amount of years the CMO has been operating in Georgia. The DCH/OIG should incorporate a specific referral policy and procedure that provides a description of the CMOs internal procedures for the SIU to identify and report possible acts of fraud, waste, and abuse by providers to DCH.

Moving forward, the DCH/OIG should consider utilizing a customized Georgia fraud referral form for reporting purposes. The referrals should include an investigative report identifying the following: (1) allegation; (2) the relevant statutes and regulations violated or considered; (3) the results of the investigation; (4) the covered conduct, i.e., time period at issue; (5) the estimated identified overpayment; (6) a summary of the interviews conducted; (7) the encounter data submitted by the provider during the time period at issue; and (8) all supporting documentation obtained associated with the investigation.

### *MCO Compliance Plans*

The state does require its CMOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608.

The state does have a process to review the compliance plans and programs. As required by 42 CFR 438.608, the state does review the CMOs compliance plan and communicates approval/disapproval with the CMOs.

The DCH/OIG did not review the compliance plans during the review period. However, DCH/OIG informed the review team of its intent to review the compliance plans moving forward. The contract specialist at DCH was responsible for ensuring the compliance plans were submitted in accordance with the CMO contract. The review of the compliance plan revealed no issues. All of the CMOs provided a copy of their compliance plans that have been submitted to the state. A review of these plans revealed they were in compliance with 42 CFR 438.608.

### *Encounter Data*

The DCH collects encounter data from each of the CMOs electronically on a weekly basis. Myers and Stauffer (contracted with DCH) validates the data and makes adjustments based on their analysis. The validated and corrected data is utilized by the department's actuaries for capitation rate setting. The data is used for capitation payment analysis, financial activities and cash disbursement auditing.

The DCH/OIG analyzes the validated encounter data for aberrant practices or trends and refers that information back to the CMO in order for the CMO to conduct further analysis and/or investigation. The encounter data is not utilized by the DCH/OIG to proactively identify improper claims that may have been paid inappropriately to managed care providers or for conducting any internal audits of the encounter data to identify possible credible allegations of fraud.

***Overpayment Recoveries, Audit Activity, and Return on Investment***

The state does not require CMOs to return to the state or report on overpayments recovered from providers as a result of CMO fraud and abuse investigations or audits.

The state's model contract language does not require the CMOs to return or report overpayments to the state. Therefore, CMOs do not return any overpayments to the state. However, the state requires the CMOs to offset overpayment recoveries on their financial report for rate setting purposes. At the time of the review, DCH/OIG did not recover any overpayments or track overpayment recoupments made by the CMOs, which the CMOs are contractually obligated to recover. The CMS team was unable to obtain any information from the state that described the process for ensuring this information is being reported and that it was being reported accurately.

The table below shows the respective amounts reported by Amerigroup for the past three FFYs.

**Table 4**

| FFY | Preliminary Investigations | Full Investigations | Total Overpayments Identified | Total Overpayments Recovered |
|---|---|---|---|---|
| 2015 | 30 | 36 | $772,896.00 | $79.899.98 |
| 2016 | 44 | 71 | $209,816.00 | $22,120.56 |
| 2017 | 9 | 67 | $545,788.27 | $26,498.09 |

Amerigroup's recoveries for Table 4-A are significantly less than the monies they identified. The SIU manager, informed the CMS team that as of July 2017, they could no longer extrapolate claims data and that resulted in lower recovered amounts. However, the SIU manager indicated that when negotiating to recover overpayments from investigations, Amerigroup would attempt to collect at least 70 percent of the amount identified. In reviewing their recoveries for the last three FFYs, Amerigroup was well under the suggested 70 percent. For 2015, Amerigroup collected 10.2 percent of its identified overpayment amount. For 2016, Amerigroup collected 10.5 percent of its identified overpayment amount. Finally, for 2017, Amerigroup only collected 5 percent of the identified overpayment amount.

In FFYs 2016 and 2017 Amerigroup's full investigations were noted to be significantly higher than the preliminary investigations. in 2016 and 2017, rather than the preliminary investigations or leads being higher. Amerigroup explained that investigators have the option to open full investigations without it first being a lead or preliminary investigation. Thus, all full investigations have not necessarily been preliminary investigations.

CareSource started operations in 2017, and primarily utilized provider education as a program integrity tool. Accordingly, CareSource did not have any recoveries to report for the timeframes for this report.

WellCare was unable to provide the review team with any recoveries for the review period as the CMO contract does not require them to report this information

***Payment Suspensions***

In Georgia, Medicaid CMOs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is not any contract language mirroring the payment suspension regulation at 42 CFR 455.23. This is a repeat risk from 2013 and remains uncorrected.

The regulation at 42 CFR 455.23(a) requires that when the State Medicaid agency determines that there is credible allegation of fraud, 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 DCH is reluctant to suspend payments and a good cause exception is issued for all referred cases and therefore, no payments were suspended during this review period. As was the state's position in 2013, the state indicated having reservations about suspending payments because this automatically triggered an administrative hearing, which could rule against the state and undermine the MFCU's case.

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 CMS with complete summary data on payment suspensions and good cause exceptions filed as part of the annual report required under 42 CFR 455.23(g). A review of the payments report shows that Georgia does not report the number of payment suspensions or the dollar amount associated with the payments suspensions. Based upon information collected by the review team all of the managed care referrals were given a good cause exception not to suspend.

***Terminated Providers and Adverse Action Reporting***

The CMO contract does not address terminated providers and adverse action reporting. Therefore, the CMO is not required to provide written notice of termination to the state and there are no timelines for this procedure. However, the state expressed that the CMOs do provide this information. The review team found evidence during a sampling of case files that this information is not being provided as efficiently as possible. When termination or adverse action information is shared with the state, the state reports that it shares this information with other plans and the expectation is that each plan would act on the information. It was also noted, that

before taking any action themselves, plans rely on the state to notify them of actions taken at the state level against providers.

**Table 5:**

| MCOs | Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs | | Total # of Providers Terminated For Cause in Last 3 Completed FFYs | |
|---|---|---|---|---|
| Amerigroup | 2015<br>2016<br>2017 | 766<br>368<br>1960 | 2015<br>2016<br>2017 | 374<br>247<br>1036 |
| CareSource | 2015<br>2016<br>2017 | 0<br>0<br>0 | 2015<br>2016<br>2017 | 0<br>0<br>0 |
| WellCare | 2014<br>2015<br>2016 | 1086<br>1572<br>1209 | 2014<br>2015<br>2016 | 90<br>18<br>14 |

Overall, the number of providers terminated for-cause by the plans appear to be low, compared to the number of providers enrolled with the CMOs and compared to the number of providers disenrolled or terminated for any reason.

In addition, the CMOs do not seem to have a clear understanding of what constitutes a for-cause action versus a not for-cause action. The for-cause termination totals for Amerigroup appear to be the result of definition and terminology differences. The bulk of these cases do not involve issues of integrity, quality or fraud. Accordingly, the CMS review team determined that additional education is warranted in order to ensure provider adverse actions are handled appropriately.

***Federal Database Checks***

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. DHHS-Office of Inspector General's List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

The DCH is compliant with conducting all required federal database checks. The DMF, LEIE, and SAM are checked automatically prior to enrollment and reenrollment as well as on a monthly basis. The NPPES is currently checked manually upon enrollment and reenrollment.

## Recommendations for Improvement

- Refine the fraud, waste, and abuse section of the general CMO contract incorporating the key elements of program integrity operations, as well as the requirements expected to be performed in order to meet all program integrity federal regulations for the Medicaid managed care program. The fraud, waste, and abuse section of the contract should lay out more specific program integrity requirements in order to avoid misunderstandings due to generalities and ambiguity.
- Develop a monitoring tool that is linked to the fraud, waste, and abuse section of the contract and its requirements. At a minimum, implement an annual review of each CMO in order to assess compliance with meeting all contract program integrity requirements.
- Develop, compile, implement, and update as necessary, written policies and procedures addressing all program integrity functions. This would also include a referral policy.
- Given the limited number of provider investigations and referrals by the CMOs along with the low number of overpayments and terminations that the CMOs reported, the state should ensure that both the DCH/OIG and its CMOs are allocating sufficient resources to the prevention, detection, investigation and referral of suspected provider fraud.
- The DCH/OIG should obtain feedback from the MFCU regarding the quantity and quality of CMO referrals reviewed and develop a strategy for improving CMO referrals.
- The DCH/OIG, in conjunction with the MFCU when possible, should work with the CMOs to develop and provide program integrity training on a routine basis to enhance case referrals from the CMOs. The state should ensure that CMO staff, primarily the SIU and/or compliance officer, is receiving adequate training in identifying, investigating, referring, and reporting potential fraudulent billing practices by providers.
- The DCH/OIG should implement proactive audits of validated managed care claims encounter data.
- Review the regulations at 42 CFR 455.23 completely and refine current payment suspension policies and procedures 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.
- Amend the general CMO contract language to ensure the appropriate actions are taken by CMOs to suspend, exclude or terminate providers from its Medicaid program in coordination with DCH/OIG when there is cause to do so.
- Review and address any state laws that conflict with the regulation at 4455.23 regarding payment suspensions. Consequently, assess whether the state's MOU with the MFCU should be revised to incorporate any necessary improved case referral and payment suspension procedures that complies with the regulation at 42 CFR 455.23. Conduct relevant training to all contracted entities that refer directly to the MFCU on any new procedures, as required.

## Section 2: Status of Corrective Action Plan

Georgia's last CMS program integrity review was in September 2013, and the report for that review was issued in December 2014. The report contained three risk areas with eleven recommendations. During the onsite review in May 2018, the CMS review team conducted a thorough review of the corrective actions taken by Georgia to address all issues reported in calendar year 2013. The risk areas from the 2013 Georgia comprehensive review report have all been satisfied by the state, with the exception of the risks surrounding the lack of payment suspensions, which remains uncorrected from the 2014 report.

## 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:

- 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.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Georgia are based on its identified risks include those related to managed care. 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.
- 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 Regional Information Sharing Systems (RISS) as tool to identify effective program integrity practices.
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.
- Access the Toolkits to Address Frequent Findings: Payment Suspension Toolkit website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html.

## Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a 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 provide any supporting documentation associated with the CAP 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 the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

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