Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Indiana Comprehensive Program Integrity Review

Final Report

January 2015

Reviewers:
Mark Rogers, Review Team Leader
Michael Berry
LaShonda Mazique
Debra Tubbs
Joel Truman, Review Manager

Table of Contents

Executive Summary and Introduction

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

The purpose of this review was to determine whether Indiana'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 anti-fraud and abuse activities. 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; False Claims Act education and monitoring; managed care oversight at the state level; and program integrity activities conducted by managed care organizations (MCOs).

The review of Indiana's program integrity activities found the state to be in compliance with many of the program integrity requirements. However, the review team identified a number of vulnerabilities and instances of regulatory non-compliance in both the state's fee-for-service (FFS) and managed care programs, thereby creating a risk to the Medicaid program. The risks are related to program integrity oversight of MCOs, managed care contracting process and provider enrollment practices and reporting, and payment suspension procedures in cases of a credible allegation of fraud. Several of the issues described in this review were also identified in CMS's 2010 review and are still uncorrected. CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review are satisfactorily resolved as soon as possible. These issues and CMS's recommendations for improvement are described in detail in this report.

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/disclosures, 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 an in-depth telephone interview with representatives from each of the three MCOs and the MFCU.

During the week of September 23, 2013, the CMS review team conducted onsite interviews with the Indiana Family and Social Services Administration's (FSSA) Office of Medicaid Policy and

Planning (OMPP) and the fiscal agent. The review team studied the state's managed care contracts to determine whether the MCOs were complying with contract provisions and other federal regulations relating to program integrity. The team met separately with the OMPP's Care Programs Unit to discuss managed care oversight and monitoring, and with staff from the Indiana Department of Administration (IDOA) to discuss managed care contract disclosure monitoring. The team also conducted sampling of provider enrollment applications, program integrity cases, 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 Unit (PIU) within FSSA's recently established Division of Operations, but also considered the work of other components and contractors responsible for a range of program integrity functions, including surveillance and utilization review and provider enrollment. Indiana operates its Children's Health Insurance Program (CHIP) as a stand-alone program. The stand-alone CHIP operates under the authority of Title XXI and is beyond the scope of this review. Unless otherwise noted, Indiana 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 FSSA provided.

Medicaid Program Integrity Unit

In Indiana, the Medicaid program is called Indiana Health Coverage Programs, and the PIU is the organizational component dedicated to fraud and abuse activities. The PIU had 19 full-time equivalent (FTE) positions allocated to Medicaid program integrity functions in state fiscal year (SFY) 2013, of which 6 were vacant. In addition, the state contracts with a fraud and abuse detection contractor to run data analytics, issue draft audit findings, and calculate and recover overpayments.

The table below presents the total number of preliminary and full investigations, and the amount of identified and recouped overpayments related to program integrity activities in the last four complete SFYs.

SFY	Number of Preliminary Investigations*	Number of Full Investigations*	Amount of Overpayments Identified	Amount of Overpayments Collected**
2010	19	19	$ 68,493	$1,085,920
2011	118	118	$938,175	$1,442,669
2012	186	186	$2,443,617	$1,620,169
2013	268	268	$3,163,407	$2,653,710

*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. In Indiana, a standardized Credible Allegation of Fraud tool is used to conduct all investigations from intake to final disposition (see page 9 below); therefore the state does not make a distinction between preliminary and full investigations.

**Recoupments do not include global settlements. However, for the years listed (and most clearly in SFY 2010 and 2011), the amounts recouped include overpayments identified in previous years.

Results of the Review

The CMS review team found a number of risks related to program integrity in the Indiana Medicaid program. These issues fall into three areas of risk as outlined and discussed below. To address them, Indiana should improve oversight and build more robust program safeguards.

Risk Area 1: Risks were identified related to the state's oversight of managed care.

In Indiana, Medicaid managed care is administered by the Care Programs Unit within the Office of Medicaid Policy and Planning. The Medicaid agency operates two different managed care programs. The larger of these is a mandatory enrollment program for low income families, children, and pregnant women called Hoosier Healthwise, which operates under the waiver authority of Section 1932(a) of the Social Security Act and a Section 1115 demonstration waiver. The state also runs a smaller Section 1115 demonstration waiver program called the Healthy Indiana Plan (HIP). This provides health insurance for otherwise uninsured low income persons between the ages of 19 and 64 using a Health Savings Account approach. Based on the state's review guide responses, 70 percent of Indiana's Medicaid beneficiaries were enrolled in a managed care program, and total enrollment in the two programs was just over one million beneficiaries as of January 1, 2013. Indiana's managed care program consumed $1.562 billion, or 19.6% of total state Medicaid expenditures during fiscal year 2013 with services delivered by approximately 6000 providers.

The PIU has no direct oversight of MCOs. It receives MCO reports from the Care Programs Unit and attends monthly meetings with representatives from the MCOs, Care Programs Unit, and the MFCU where program integrity issues and potential provider fraud cases are discussed. However, its involvement in the state's Medicaid managed care programs is generally limited.

The Care Programs Unit is responsible for programmatic oversight for managed care. All MCOs are contractually required to submit an annual Program Integrity Plan that describes in detail the manner in which the MCOs will detect fraud and abuse. Care Programs Unit staff conduct monthly onsite visits to review the MCOs' compliance with the Program Integrity Plan along with other contract related topics; however, based on site visit agendas furnished by the state, their reviews are more closely related to the MCOs' general operations and have little relation to program integrity. The areas reviewed during their visits include quality of care initiatives, call center operations, behavioral health and wraparound services. The team did note an agenda topic related to debarred individuals but nothing related to anti-fraud and abuse activities.

The Care Programs Unit is also responsible for performing an annual review of each MCO's Program Integrity Plan which, according to the state, is completed during the onsite visits. However, there is no indication from reviewing the site visit agenda that the Program Integrity Plans are specifically reviewed. None of the MCOs has received feedback from the state regarding their compliance with the Program Integrity Plan to indicate whether they adequately address program integrity requirements.

In addition, while each MCO is required to submit monthly and quarterly reports detailing its preliminary investigations, the Care Programs Unit staff does not provide feedback or follow-up

to ensure that MCOs are following through on the investigations reported or pursuing them with appropriate due diligence. The periodic reports are prepared on an aggregate level, are not given to the PIU in a timely or consistent manner, and generally do not identify problem providers. In response to a CMS request for sample reports, two MCOs provided reports that were more than a year old and one MCO could not provide any reports. If and when such reports are completed, they appear to be done to fulfill a contract requirement but contain little useful information from a program integrity perspective.

The CMS review team also noted that the Hoosier Healthwise contract contains no provision requiring MCOs to verify with beneficiaries whether services billed by providers were actually received. This was an issue found during the 2010 review. The practice of direct verification, if established to target certain high risk services, is an example of another oversight safeguard that could impede the flow of improper payments within the managed care program.

During the review State staff acknowledged the need to develop more rigorous oversight policies and to improve the communication links across MCOs, Care Programs Unit, the PIU, and the MFCU in the interest of conducting more effective program integrity oversight.

Recommendations:

- Develop and implement policies and procedures to facilitate stronger PIU oversight of managed care program integrity activities and improve communications among all key stakeholders. Require MCOs to report detailed program integrity activities directly to the PIU. Ensure that Program Integrity Plans and required reports detailing active investigations are submitted timely. Develop and implement policies and procedures to ensure that follow-up actions are taken to address issues identified in these reports.
- Develop a process to verify with Hoosier Healthwise enrollees whether services billed by providers were received.

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

Ownership and Control Disclosures

The state's fiscal agent is responsible for the enrollment of all Indiana Medicaid providers including waiver, managed care, and pharmacy benefit network providers. During the 2010 CMS review, the team found that the language in Indiana's provider applications did not fully meet the requirements of 42 CFR 455.104(a)(3) for the disclosure of ownership or control interests in other disclosing entities owned or controlled by the enrolling providers. Managed care entity disclosures did not fully conform to the requirements of the regulation and fiscal agent disclosures did not contain the full range of ownership and control information required by the regulation. Although Indiana subsequently modified the language in its provider enrollment application to address these issues, the changes made did not encompass revised language in the regulation at 42 CFR 455.104 that took effect on March 25, 2011. In addition, the 2013 review found that the state was still not collecting full disclosures for fiscal agents and MCOs.

The regulations at 42 CFR 455.104 require, among other elements, that disclosure information on corporate ownership include the primary business address, every business location in the state, and P.O. Box address. In Indiana, all facility providers must complete the Indiana Health Coverage Programs *Hospital and Facility Provider Enrollment and Profile Maintenance Packet*. This would require a corporation to provide a primary business address in the section entitled "Legal Name and Home Office Address". However, the application form does not specifically require the corporation to provide an address for every business location and a P.O. Box address, where applicable, to comply with the requirements of the regulation.

According to the current regulation at 42 CFR 455.104, managed care organizations and fiscal agents must also submit complete ownership and control disclosures. These organizations would include Indiana's Medicaid MCOs and a pharmacy benefit administrator, the contracts for both of which are administered by the IDOA. The IDOA provided the team with a copy of its boilerplate contract titled *Professional Services Contract.* The contract does not solicit any of the disclosure information from managed care organizations or the pharmacy benefits administrator as required by 42 CFR 455.104.

Moreover, the state provided the team with a copy of the most current amended version of its main fiscal agent contract and the most recent fiscal agent Request for Proposals. Neither document required the fiscal agent to submit any of the disclosures required by 42 CFR 455.104.

Exclusion Searches

The regulation at 42 CFR 455.436 requires that 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 (DMF), and the National Plan and Provider Enumeration System upon enrollment and reenrollment. State agencies must also check the LEIE and EPLS no less frequently than monthly.

At the time of the 2010 CMS review, the state was collecting incomplete managing employee disclosures and did not collect ownership and control disclosures on individual network provider enrollment applications. In addition, the state did not have a process in place to conduct monthly exclusion searches of all of the required parties. The state has since taken corrective action and now collects disclosures for all enrolling billing providers and houses that information in a searchable database. However, the modified enrollment form for ordering and referring providers does not collect the full range of disclosures that must be subject to federal database searches, so the information necessary to perform these checks is incomplete.

With regard to MCO contracting, the IDOA determines what names are checked, which databases are checked, and the frequency. The IDOA does not collect any of the disclosure

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

information needed for the database checks that are mandated by 42 CFR 455.436, nor is the information maintained in a searchable database. In addition, the agency does not search the LEIE at the point of contracting and monthly thereafter. This issue was also identified during the 2010 CMS review. Concerning debarment checks, the IDOA indicated that they search the entity name against the EPLS at the time of contracting, but they do not perform monthly searches, nor do they check other names that may be disclosed during contract procurement. Additionally, the DMF is not checked during contract procurement.

Criminal Offense Disclosures

A similar risk was identified in the managed care program with regard to capturing health care-related criminal conviction disclosures from MCOs. The IDOA's *Professional Services Contract* does not require the MCOs to disclose information required by the regulation at 42 CFR 455.106, including:

- any person with an ownership or control interest in the MCO or who is an agent or managing employee of the MCO; and
- has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX programs as required by 42 CFR 455.106.

This risk likewise applies to the modified enrollment form for ordering and referring providers, which also does not request the provider to disclose all information required by 42 CFR 455.106.

Notifications to HHS-OIG and State Agency Exclusion Notifications

The state does not notify HHS-OIG when it suspends, disenrolls or terminates, or declines to enroll a provider for program integrity reasons as required by 42 CFR 1002.3. This issue was previously identified during the 2010 CMS review. During interviews, PIU staff indicated that they have reached out to HHS-OIG to determine what type of adverse action information it must provide. But the actual reporting process has not begun.

Indiana's MCO contract requires plans to notify the state on a quarterly basis of providers who have been disenrolled. However, based on interviews with the plans, the MCOs are not consistent in the types of action they report or the manner in which reports are provided. In addition, the contract does not require—and plans are not reporting on—actions taken to deny provider enrollment or credentialing for program integrity reasons. Failure by the plans to report providers that were denied enrollment on fraud and abuse grounds represents a potential risk to the program. The absence of such reporting increases the risks that such providers may acquire billing privileges in FFS Medicaid and the other MCOs. It also prevents the state from being able to call these adverse actions to the attention of HHS-OIG.

The team also found an issue with the state's adherence to the public notification procedures required by the regulation at 42 CFR 1002.212. When Indiana terminates a provider for cause, it does not have procedures in place to notify beneficiaries, the state medical licensing board, the public, other state agencies, and others in accordance with this regulation. The PIU indicated

that it did not believe the regulation applied to such actions because the regulation referred to provider "exclusions," a term not addressed in the Indiana Administrative Code. The review team indicated that CMS regards terminations and exclusions,[2] when undertaken by a State Medicaid agency, to be subject to the same regulatory requirements at 42 CFR 1002.212. Only exclusions undertaken by HHS-OIG fall under a different authority in that they are law enforcement rather than administrative actions. Therefore, future termination actions undertaken by the state should be accompanied by the full range of mandatory notifications. Moreover, the same notifications should be made when and if the state reinstates terminated providers under the companion regulation at 42 CFR 1002.215(b).

Business Transaction Disclosures

The review team found that the IDOA's contract with the MCOs titled *Professional Services Contract* does not require the disclosure of business transaction information from MCOs that is required under 42 CFR 455.105. This is also a risk for the ordering and referring providers as the modified application forms or provider agreement do not contain any of the language required by this regulation.

Recommendations:

- Modify IDOA's Professional Services Contract and all provider enrollment and contracting applications to ensure complete and accurate disclosure information is provided to meet the requirements of 42 CFR 455.104, 455.105, and 455.106. Ensure that every disclosed party affiliated with providing services in the state's Medicaid program is checked against the EPLS, LEIE, and DMF during the enrollment process and further ensure that the LEIE and EPLS is checked monthly.
- Work with HHS-OIG to develop a process for the state and MCOs to report adverse actions when a provider is denied enrollment, dis-enrolled, suspended or terminated for quality of care or program integrity reasons. Additionally, develop a process to provide the proper notifications when providers are excluded or terminated from the program and when they are reinstated or re-enrolled.

Risk Area 3: Risks were identified in the state's procedures to suspend payments in cases involving a credible allegation of fraud.

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.

During the onsite review, the team examined 15 case files that were referred to the MFCU since March 25, 2011. One of these cases was referred to both the state and the MFCU by an MCO. The case file had no record of the date of payment suspension or good cause exception. After

[2] For reporting purposes, CMS refers to state actions in accordance with this regulation as "terminations" whether the state calls them "terminations" or "exclusions".

the review, the state provided additional information indicating that the state suspended payments 19 days after determining a credible allegation of fraud and an additional $7,126 was paid.

Upon completion of the on-site review, the team sampled an additional six cases that were referred to the MFCU. The state provided evidence of payment suspension or the filing of a good cause exception following the determination of a credible allegation of fraud and subsequent referral to the MFCU. However, in three cases, there was a delay ranging from 10 to 21 days in the time taken to suspend payments or file a good cause exception after the accompanying MFCU referral was made. This resulted in approximately $102,000 in additional Medicaid program payments that were potentially at risk.

Recommendations:

- Ensure that in the absence of a written good cause exception, provider payments are suspended after determining an allegation of fraud is credible in accordance with the requirements at 42 CFR 455.23. Update and strengthen the state agency's policies and procedures to reflect this process.

Noteworthy Practice

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

The state utilizes an innovative risk assessment tool entitled "Credible Allegation of Fraud Tool", or CAF tool to identify and evaluate fraud.

The Indiana State Medicaid agency in collaboration with its Fraud and Abuse Detections System contractor has developed a comprehensive set of tools to evaluate provider allegations including fraud. According to the state, the CAF tool includes three components: a preliminary investigation assessment, risk assessment, and credible allegation of fraud assessment. The tools help to increase the state's efficiency and consistency in reviewing provider integrity allegations by utilizing an objective systematic approach to determine the most appropriate course of action that does not inappropriately single out providers.

The CAF tool utilizes 29 criteria for determining whether a provider's past and present billing activity rises to the level of a credible allegation of fraud. It further takes into consideration a variety of background checks and risk factors. Each criterion is given a weighted score to arrive at a composite assessment score. Some categories are considered high risk and some categories require a mandatory score. Based on the overall score or the score of a high risk category, a recommended approach of action is determined.

When an allegation against a provider is received, the state evaluates and determines if it rises to the level of fraud. If provider fraud is not initially believed to be associated with the allegation, the preliminary investigation assessment tool is used. This may result in no action against the provider, or it may lead to a full risk assessment with or without pre pay review. The state processes more serious allegations through the risk assessment tool. This again could result in

no action or lead to a pre-pay review, an audit (self, desk or field), or a MFCU referral. All proposed audits are first vetted through the MFCU.

If the original allegation suggests fraud, or if the preliminary investigation or risk assessment tools indicate possible fraud, the state will make use of the CAF portion of the tool. Program integrity staff indicated that they use the CAF portion of the tool on 95 percent of provider allegations.

Notwithstanding the usefulness of a standardized set of tools using multi-factored analysis in evaluating Medicaid fraud and abuse cases, the team found compliance issues with the actions taken by the state in cases involving CAFs. These issues are discussed in Risk Area 3.

Effective Practice

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 2010 CMS review identified the centralized enrollment of all FFS and managed care network providers as a noteworthy practice. The state has continued to use a standard enrollment process for all provider types that is not found in many other states. The practice has been expanded to include the Affordable Care Act requirement to enroll ordering, prescribing, and referring providers where they are also checked for current licenses and against federal databases for exclusions and debarments. Notwithstanding the advantages of this practice, the team identified issues with the provider enrollment process as outlined in Risk Area 2.

Technical Assistance Resources

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

- Consult CMS's Medicaid Payment Suspension Toolkit at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html to develop a payment suspension process that is consistent with federal regulations and guidance. CMS can also refer Indiana to states that are further along in this process to address the areas of non-compliance identified is Risk Area 3.
- Access the Regional Information Sharing System (RISS) to find appropriate provider enrollment applications and provider agreements to assist in complying with the full range of current disclosure requirements and consider posting requests for states to share their provider enrollment packets to correct deficiencies described in Risk Area 2.
- Use the review guides and other state review information posted in RISS as a self-assessment tool to help strengthen the state's program integrity oversight of MCOs.
- 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 Indiana based on its identified risks include those related to provider enrollment and oversight of managed care. More information can be found at http://www.justice.gov/usao/training/mii/training.html.

- 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.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Indiana review the noteworthy practices on provider enrollment and disclosures and the effective practices in program integrity and consider emulating these practices as appropriate. The state should also review effective practices related to the handling of terminated providers to address the issues identified in Risk Area 2.

Summary

Indiana applies noteworthy and effective practices that demonstrate program capabilities and the state's commitment to program integrity. CMS supports Indiana's efforts and encourages it to look for additional opportunities to improve overall program integrity. The risks identified in this report, particularly those that remain from the time of the agency's last comprehensive program integrity review in 2010 should be addressed immediately.

We require the state to provide a corrective action plan (CAP) for each of the areas of concern 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. 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 Indiana to build an effective and strengthened program integrity function.

Official Response from Indiana
March 2015

Michael R. Pence, Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

John J. Wernert, M.D., Secretary

March 25, 2015

Peter Leonis
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Center for Program Integrity
Investigations and Audits Group
233 N. Michigan Ave Chicago IL 60601

Dear Director Leonis,

FSSA Program Integrity welcomes the opportunity to your respond with our proposed corrective action plan based on the findings stated in the "Comprehensive Program Integrity Review Final Report" letter delivered on January 9, 2015. We first reached out to LaShonda Mazique, State Investigations and Audits Lead for general guidance as we were preparing our proposed corrective action. Using the information from tat meeting and the Corrective Action Plan Development Tool, FSSA Program Integrity developed our proposed corrective action plan.

Our response is attached and has been prepared addressing the three "Risk Area's" that were identified in the following format:

Element
Finding/Vulnerability
Responsible Party
Action Plan
Policy/Procedure Development
Contract or Regulatory Development
Training

Completion Date
System Enhancements
Internal Controls/Audits

Indiana FSSA was appreciative of the extension of time granted in responding to this detailed audit. With that time we were successful in securing the above-referenced information for the items flagged as the "Risk Areas" in this CMS report. As laid out in our response, Indiana will be implementing several structural changes. We also listed the time frame that we will need to make those changes that we will implement should our response be approved by CMS.

We look forward to any guidance that CMS can give in regards to the implementation or altering of this proposed corrective action plan.

Sincerely,

Michael Barnes
Chief Compliance Officer

Attachment

cc: Joseph Moser, Medicaid Director
John McCullough, Program Integrity Director