Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Indiana Focused Program Integrity Review

Final Report

November 2017

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Objective of The Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Indiana 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. Due to the length of time that has lapsed since CMS's previous comprehensive program integrity review conducted in calendar year 2013, and the FFY 2013 corrective action plan (CAP) notification letter submitted to the state by CMS on December 16, 2016, that deemed all issues satisfactorily corrected, this onsite review did not include a follow up on the state's progress in implementing corrective actions for the findings previously identified.

Background: State Medicaid Program Overview

The Family and Social Services Administration (FSSA) was established by the General Assembly in 1991 to consolidate and better integrate the delivery of human services by state government. The FSSA is a health care and social service funding agency. Ninety-four percent of the agency's total budget is paid to thousands of service providers ranging from major medical centers to a physical therapist who may work with a child or adult with a developmental disability. There are six care divisions in FSSA that administer services to over one million beneficiaries.

The division within FSSA that administers Medicaid programs is known as the Office of Medicaid Policy and Planning (OMPP). The OMPP's suite of programs, called the Indiana Health Coverage Programs (IHCP), includes traditional Medicaid, risk-based managed care (RBMC), and a variety of waiver services tailored to the needs of specific populations. Indiana's RBMC programs include Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP 2.0), and Hoosier Care Connect (HCC). The state refers to these entities as managed care entities (MCEs), therefore, this term will be used throughout the report for consistency.

HIP 2.0 provides health coverage to approximately 400,000 low-income and working adults through consumer-driven health care plans. Members actively participate in their health care; in the first year, nearly 70 percent of the plans' members elected to make HIP POWER account debit card contributions to pay for enhanced services.

The HCC provides health coverage for nearly 100,000 aged, blind, and disabled members who are not dually eligible for Medicare. The program also covers many of Indiana's foster children. The HCC's MCEs provide intensive case management services for these vulnerable members.

The HHW, which includes Indiana's Children's Health Insurance Program population, serves more than 600,000 children and pregnant women. The HHW provides young children with access to well-child doctor visits during their critical developmental years. The HHW also supports early health care for pregnant women, and provides prenatal care to reduce the risk of premature and low birth weight babies in an effort to decrease infant mortality rates.
Also, Indiana's home and community-based services (HCBS) Medicaid programs assist more than 30,000 members to acquire jobs, and provide support and services as an alternative to

institutional care. These programs target specific populations that typically require an additional level of care than is standard for most members; some of these populations include: seniors, individuals with mental illness, and individuals with disabilities. The OMPP assists its sister divisions to implement and monitor these programs.

Indiana's total Medicaid expenditures in federal fiscal year (FFY) 2016 were approximately $10.4 billion. As of February 2016, approximately 1.4 million members were enrolled in Medicaid. The IHCP currently utilizes three MCEs to deliver RBMC services to more than 1.1 million of those beneficiaries or approximately 79 percent of the total Medicaid population. As of January 1, 2017, the MCEs engaged by the state are: Anthem BlueCross BlueShield (Anthem BCBS); CareSource Indiana; MDwise Inc., (MDwise); and Managed Health Services of Indiana Centene Corporation (MHS). Indiana is a Medicaid expansion state. The total MCE expenditures were approximately $4.3 billion or 41 percent of the total Medicaid spending. During FFY 2016, Indiana's Federal Medical Assistance Percentage was 66.60 percent.

Methodology of The Review

In advance of the onsite visit, CMS requested that Indiana and the MCEs 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 three-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of June 6, 2017, the CMS review team visited the FSSA and the OMPP. They conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with three MCEs and their special investigations units (SIUs). In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCEs' program integrity practices.

Results of The Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, more than 1.1 million beneficiaries, or 79 percent of the state's Medicaid population, were enrolled in three MCEs during FFY 2016. The state spent approximately $4.3 billion on managed care contracts in FFY 2016.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCEs as part of its review.

Anthem BCBS has commercial, Medicare, and Medicaid lines of business. The Anthem BCBS's Medicaid managed care programs include the HHW, HIP 2.0, and HCC RBMC programs. Anthem BCBS has staff located in the state of Indiana as well as Tampa, Florida. The 16 FTE SIU associates who are dedicated to Anthem BCBS's Indiana Medicaid plan investigate allegations of fraud.

MDwise is a local health plan that has been operating in the Indiana Medicaid program since 1994. MDwise administers Medicaid managed care in the state under the HHW, HIP 2.0, and HCC RMBC programs. (Effective April 1 2017, MDwise was no longer participating in the HCC program. The last date MDwise covered HCC services was on March 31, 2017.) The SIU is located in the state, and consists of four and a half full-time equivalents (FTEs) dedicated to identifying and investigating suspected fraud in the Indiana Medicaid program.

The MHS is an operating division of Centene Corporation. Centene Corporation conducts business in 30 markets nationwide. The MHS administers Medicaid managed care in Indiana under the HHW, HIP 2.0, and HCC RMBC programs. The MHS has two SIU FTEs fully-dedicated to identifying and investigating suspected fraud within the Indiana Medicaid program.

Enrollment information for each MCE as of March 2017 is summarized below:

Table 1.

	Anthem BCBS	**MHS**	**MDwise**
Beneficiary enrollment total	418,339	282,127	419,327
Provider enrollment total*	40,619	17,757	25,936
Year originally contracted	2008	1997	1994
Size and composition of SIU	174 FTEs**	6.5 FTEs**	4.0 FTEs
Number SIU FTEs fully-dedicated to state plan	16.0 FTEs***	2.0 FTEs	4.0 FTEs
National/local plan	National	National	Local

*Totals include the HHW, HCC, and HIP 2.0 RBMC programs and represent unique provider counts.
**Total FTEs include both corporate and local SIU resources utilized by the MCE for the state.
***Anthem had 3 FTEs fully-dedicated to Indiana Medicaid, along with an accumulation of additional staff equaling 13 FTEs, supporting SIU efforts in Indiana in various capacities.

Table 2.

MCEs	FFY 2014	FFY 2015	FFY 2016
Anthem BCBS	$453.3 million	$1.1 billion	$1.0 billion
MHS	$299.2 million	$583.9 million	$931.2 million
MDwise	$443.5 million	$759.1 million	$1.4 billion

State Oversight of MCE Program Integrity Activities

The Managed Care Compliance Unit within the OMPP's Quality & Outcomes Section oversees overall contract compliance and coordinates efforts with functional areas, such as provider services, pharmacy, covered services and benefits, quality management, and utilization management. The FSSA's program integrity unit (PIU) works with the Managed Care Compliance Unit to enforce contract requirements. The FSSA-PIU is the functional unit that coordinates the program integrity efforts and ensures that collaboration exists with the managed care SIUs. The OMPP is responsible for the MCE contracts; however, the FSSA-PIU is responsible for the day-to-day management of program integrity-related activities.

Indiana Medicaid contracts with Burns & Associates, Inc., as its external quality review organization. The state also contracts with Truven Health Analytics (Truven) to provide a fraud and abuse detection system (FADS). Truven submits a monthly FADS report and an annual business plan to the state. The monthly FADS report tracks the monetary progress of overpayments recovered; identified overpayments/cost avoidance measures; algorithms; policy recommendations; appeal rates; and provider audit letters sent. The state's annual business plan consists of data analysis, audit, and recovery audit contractor audits.

MCE 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 MCEs.

Indiana's MCE contract states that, "The MCE shall immediately report all suspected or confirmed instances of waste, fraud and abuse to the OMPP and the FSSA PI Unit." The MCEs promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. The MCEs are also contractually required to immediately refer all cases of suspected or known network provider fraud or abuse to both the FSSA-PIU and Indiana's Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) concurrently. The MFCU is the state agency responsible for the investigation of provider fraud in the Indiana Medicaid program. The MCE referrals are submitted to both the FSSA-PIU and MFCU simultaneously via secure email. The referral is then categorized as an "MCE referral", but does not necessarily constitute a credible allegation of fraud until verified by the state.

Upon receipt of the MCE referral, the FSSA-PIU conducts an independent review of the referral and information provided. The FSSA-PIU's review includes an assessment to determine if a

credible allegation of fraud exists and if payments to the provider should be suspended. The FSSA-PIU will review the MCE referral form for completeness and to ensure all required documentation has been provided with the referral. The MCE referral and all the accompanying documents will be forwarded to the Indiana FADS vendor, Truven, for review and additional analysis. This review, along with any recommendations, is shared with the MFCU to assist in their investigation of the provider.

On a monthly basis, the MCEs submit detailed audit reports to OMPP outlining their program integrity-related activities. These audit reports specify individual provider recoupment totals, repayment schedules, and actions taken for each audit or investigation. The FSSA-PIU reviews and approves; approves with modifications; or rejects each report with specific information regarding the grounds for the rejection. During onsite interviews, the FSSA-PIU informed the CMS review team that, after receiving a referral from an MCE, they also gather information and forward a second referral to MFCU for investigation.

Anthem BCBS's PIU manages various departments, including their SIU, that engage in fraud, waste, and abuse activities. The SIU is responsible for the identification and collection of overpayments associated with resulting from fraud, waste, and abuse investigative activities. The Claims Payment Integrity Unit identifies recoveries related to claims, processing guidelines, mandates, policies, and contracts. Claims are adjusted and/or the identified overpayment is collected. Additionally, the Complex Audit Unit performs claim audits to ensure payment accuracy and adherence to both state and federal regulations. Anthem BCBS has 174 FTEs conducting program integrity-related activities at the national level; the plan dedicates 16 FTE staff associates to fraud, waste, and abuse activities for the local Indiana Medicaid plan. Some of these 16 FTEs consist of: one program integrity manager; four investigators; one education specialist; two certified professional coders; three data analysts; two investigative assistants; and one regulatory compliance consultant. Each investigator has a workload of between 20 to 40 cases. During the onsite review, three cases of suspected fraud were reported by the MCE to both the FSSA and MFCU in the last four quarters.

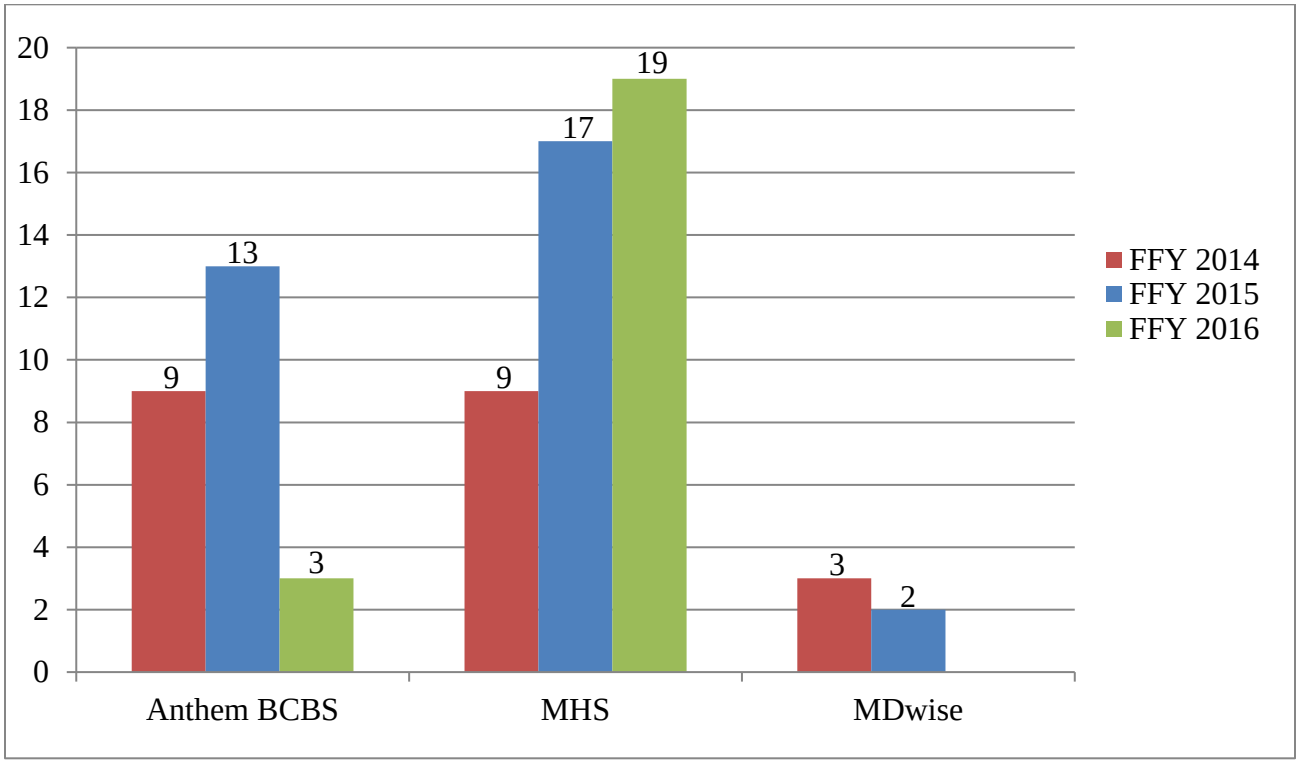
The MHS has two SIU FTEs dedicated to identifying and investigating suspected fraud within the Indiana Medicaid plan; one of these positions is located in Indiana. The two FTEs consist of an SIU manager and an SIU investigator. The SIU investigator has an estimated caseload of 130 cases; the SIU investigator is located at Centene Corporate Headquarters in St. Louis, Missouri. The MHS utilizes 18 additional SIU support staff members located at their corporate headquarters; these national positions are partially dedicated to identifying fraud, waste, and abuse within the Indiana Medicaid plan. Support staff from Centene's SIU consists of: registered nurses, licensed practical nurses, certified professional coders, and supervisory personnel who assist investigators by providing various analytical and investigative support functions. The MHS estimated that each of the 18 additional FTEs dedicate approximately 25 percent of their time to conducting program integrity activities for the Indiana Medicaid plan, which is the equivalent of six and one-half FTEs. The SIU at the corporate headquarters is also tasked with identifying suspected fraud within their Medicare and Health Insurance Marketplace plans. During the onsite review, MHS stated its intent to hire two additional SIU investigators by the end of calendar year 2017; these positions will be based locally in Indiana. In addition, MHS utilizes the resources of Centene Corporation to process claims and identify fraud and

abuse. Claims submitted for reimbursement are edited through Verscend's *Fraud Finder Pro* (FFP), a software that profiles providers prior to issuing payments. Fraud Finder Pro identifies providers that are billing at least two and one-half standard deviations above those of their peers. The MHS also utilizes an electronic case tracking system, *CaseShield,* provided by Healthcare Fraud Shield (HCFS). In the last four quarters, 19 provider investigations of suspected fraud were reported concurrently to both the FSSA and MFCU.

MDwise's SIU is staffed by four and a half FTEs who are dedicated to identifying and investigating suspected fraud within the Indiana Medicaid plan. The four and a half FTEs consist of one SIU manager and three SIU investigators, an extern comprising a quarter FTE, and a Chief Compliance Officer/General Counsel comprising a quarter FTE. All claims, with the exception of pharmacy claims, are processed through a central claims repository managed by Evolent Health. *PostShield*, a product from HCFS, is a claims edit tool that performs line-by-line analytics on claims as they are processed for payment. *PostShield* assigns risk scores to each claim line, each overall claim, each member, and each provider listed on the claim. In addition, MDwise utilizes an electronic case tracking system, *CaseShield,* also provided by HCFS. During the onsite review, no cases of suspected fraud were reported by the MCE to FSSA and MFCU in the last four quarters.

Table 3 lists the number of referrals that Anthem BCBS, MHS, and MDwise's SIU made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by Anthem BCBS is low, compared to the size of the plan; during FFY 2016 the referrals to the state and MFCU decreased to only three. Also, the referrals from MHS were low compared to the size of the plan; however, the MCE did demonstrate a gradually increasing trend in referrals reported during the three FFYs reviewed. The trend for MDwise's overall referrals was determined to be either low or nonexistent, when compared to the size of the plan; during FFY 2016 no referrals were reported by the MCE. Cumulatively, the state and MFCU reported accepting three referrals from Anthem BCBS and five referrals from MDwise during the three FFYs reviewed. The state and MFCU also reported 48 referrals accepted from MHS during the three FFYs reviewed; however, the MCE reported a cumulative number of only 45 referrals forwarded during this same timeframe.

Table 3.



MCE Compliance Plans

The state does require its MCEs 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 MCE's compliance plan and communicates approval/disapproval with the MCEs. The state of Indiana requires its Medicaid MCEs to submit an annual program integrity compliance plan that describes in detail how the MCE will detect provider and member fraud and abuse. The state's program integrity reviewers conducted a series of calls with each MCE to discuss their annual program integrity compliance plan and provide feedback. The FSSA-PIU dedicated two reviewers who examined each MCE's plan to determine compliance with the MCE contract. The most recent review took place in Fall 2016.

The review of the compliance plan revealed minimal issues, such as grammatical errors. All of the MCEs provided the review team with 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

Indiana Medicaid receives full encounter data from the MCEs. The state and FSSA-PIU often include encounter data for informational purposes when developing FFS audits, algorithms, and investigating providers.

During the onsite interviews, the state mentioned that the quality of the encounter data is in the process of being improved. Therefore, the FSSA-PIU has not traditionally performed data mining or direct recoupment based on encounter data. The FSSA-PIU also stated that it has only audited and/or investigated FFS provider claims. Each MCE has their own SIU to conduct these audits, while program integrity improvements are being made to enhance the quality of MCEs' encounter data. The FSSA-PIU has been tasked with identifying the most efficient way of auditing providers across all of the MCE and FFS programs. The FSSA-PIU anticipates initiating these more comprehensive audits by mid Fall 2017. The FSSA-PIU utilizes Truven's DataProbe and J-SURS systems to data mine and run fraud, waste, and abuse analytics against Medicaid claims data.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not require MCEs to return to the state any overpayments recovered from providers as a result of MCE fraud and abuse investigations or audits. The state does require the MCEs to report on overpayments recovered from providers as a result of MCE fraud and abuse investigations or audits. Overpayment recoveries by the MCEs are not verified by the state. Overpayments submitted by the MCEs are reflected in the encounter claims submissions either in the form of a voided and resubmitted claim, or through recoveried "pay-and-chase" third party payments. Such reductions are included in the base data used to establish future capitation rates.

In cases involving waste or abusive provider billing, or service practices including overpayments identified by the FSSA-PIU, the FSSA may recover any identified overpayment directly from the provider, or may require the MCE to recover the identified overpayment and return the monies to the state Medicaid agency, as directed by the FSSA-PIU.

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

Table 4-A.

FFY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2014	107	63	$961,193	$1,745
2015	131	55	$1.9 million	$310,896
2016	108	47	$4.9 million	$303,345

*The MCE defines preliminary investigations as investigative leads it has received. Leads may or may not develop into full investigations.

Anthem BCBS promptly performs a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. The MCE's SIU classifies preliminary investigations as

"leads". These leads originate from complaints, tips, or referrals from other sources to the SIU, and require assessment. As part of that preliminary investigation, Anthem BCBS may employ a prepayment and/or post-payment review of claims. To ensure a prompt investigation occurs, all suspect allegations must be forwarded to the SIU within 24 hours upon identification or suspicion of possible fraud and abuse. Some of the information forwarded to SIU includes all pertinent provider/member information, claims detail, and areas of concern. The SIU tracks cases through the Corporate Investigations Management System (CIMS). CIMS is a proprietary database that allows tracking and reporting of case information. Anthem BCBS provides the results of its preliminary investigation to the FSSA-PIU or to another agency designated by the FSSA-PIU. Anthem BCBS will not contact the subject of the investigation without prior written approval from the agency to which the incident was reported or its designee, as required by contract. Full investigations will have the status of "conditionally closed", when a case is neither actively being worked nor has been resolved. On a quarterly basis, Anthem BCBS submits a detailed audit report to OMPP which outlines the contractor's program integrity-related activities, including detailed overpayment amounts identified or recouped.

The table below shows the cumulative amount reported by MHS for the past three FFYs.

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2014	0*	2	$8,077	$8,077
2015	0*	2	$843	$843
2016	0*	4	$70,119	$3,891

*Additional detail requested from the MCE regarding amounts reported; however, the source of the data (the plan's compliance director) is no longer employed by MHS.

The CMS review team requested additional details from MHS regarding the total overpayments identified and recovered for each of the FFYs reviewed. According to the MCE, the director of compliance who was responsible for providing these overpayment details resigned shortly after the CMS onsite review. As a result, MHS was unable to locate the origin of the information provided to the CMS review team or respond to questions regarding a noted recovery trend of 100 percent of all overpayments identified during both FFYs 2014 and 2015, and the subsequent changing trend of only less than six percent recovery of the total monies identified as overpaid to providers demonstrated in FFY 2016. During onsite interviews, both the MHS and FSSA acknowledged the need for the plan to hire two additional investigators to perform program integrity activities for the MCE. Both the FSSA and MHS informed the CMS review team of their awareness of the necessity of additional staffing for the plan, and that the MHS has agreed to create these two positions which are critical to the performance of fraud, waste, and abuse activities.

In addition, the CMS review team was unable to obtain an explanation as to how the eight full investigations conducted during the time period reviewed did not originate from the initiation of any preliminary investigative activity conducted by the MCE; the reporting of zeroes served as an indicator quantifying no activity by the plan in this category. From the results reported in the

table above, the number of full investigations and overpayments recovered by MHS were found to be low in comparison to the size of the managed care plan; however, attempts by the CMS review team to obtain additional information from the MCE regarding the trends noted were unsuccessful.

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

Table 4-C. MDwise's Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified**	Total Overpayments Recovered
2014	*	86	$11.9 million	$900
2015	*	108	$4.7 million	$592
2016	*	167	$4.5 million	$0

*The MCE did not track preliminary or full investigations separately until the third quarter of FFY 2016, upon the implementation of a new case tracking management system.
**Prior to FFY 2017, the SIU only tracked the total amount of all MCE payments to the suspected provider/provider group in a two to three year time frame; the amount reported is neither an exact calculation nor derived from an extrapolation of a statistically valid random sample (SVRS).

MDwise implemented a new case tracking management system in the third quarter of FFY 2016, and began to track both preliminary and full investigations separately; no distinction in investigation type existed in the previous tracking system. In addition to the new tracking system, and upon the hire and completion of training of a new SIU manager and an additional investigator, all unresolved cases from the old tracking system were analyzed. Any unresolved cases deemed worthy of continued investigation were migrated to the new tracking system based upon the allegation, previously collected data, and/or current trends. During onsite interviews, MDwise attributed the low amount of recoveries to the high number of vacancies and staffing turnover. MDwise acknowledged the urgency of hiring additional staff and informed the CMS review team that they were currently engaged in the interview process to fill positions critical to the performance of program integrity activities. As a result of low staffing, the SIU stated that it did not have an adequate number of investigators to identify any new aberrant billing trends during the three FFYs reviewed. MDwise stated that they do refer suspected fraud to both the FSSA-PIU and MFCU immediately; however, the MCE's SIU was unable to pursue any identified overpayments, since the overpayments identified were related to providers currently under investigation by the MFCU.

As previously mentioned, the state does not require MCEs to return overpayments recovered to the state. However, the MCEs are required to report to the state any overpayments recovered from providers as a result of MCE fraud and abuse investigations or audits. Reporting of MDwise's program integrity activities should have served as an alert to the state regarding the low volume of investigations and overpayment recovery efforts attributed to MCE's understaffing issues. MDwise's explanation for zero recoveries in FFY 2016 was accredited to the length of time that the SIU manager position remained vacant. Also, MDwise anticipates the addition of financial categories to be included for FFY 2017 cases. These categories would include initial suspect dollars that represent the total dollar amount of claims meeting criteria for

potential fraud, waste, and abuse. In addition, the dollars at risk would be included for either the estimated overpayment based upon the extrapolation of a SVRS, or an exact calculation of overpayment based upon the affected claims contained in the claims data universe.

Overall, overpayments identified and recovered are low. Discussions with the CMS review team indicated that overpayments identified/recovered and program integrity-related investigations are anticipated to increase, once this additional investigative staff is hired. In addition, both the state and the MCE will have access to, and be routinely reporting and evaluating, both investigation and recovery activities. The oversight, tracking, review, and evaluation of MCE information would no longer be the sole responsibility of one internal employee.

Payment Suspensions

In Indiana, Medicaid MCEs are not contractually required to suspend payments to providers at the state's request. However, the MCE contracts require the plans to comply with all applicable federal, state, and local laws, rules, regulations, and ordinances and, consequently, the OMPP-PIU has had no issues with MCEs suspending payments based on Indiana Medicaid's direction. The state of Indiana is required to have this provision in its contract by January 1, 2018. The state acknowledged the contract will be amended in the future to include this provision to be in compliance with 42 CFR 455.23. The FSSA has a process to ensure that the MCEs suspend upon a credible allegation of fraud, although it is not currently stipulated in the contract.

Anthem BCBS does not institute a provider payment suspension, unless directed by the state. Also, Anthem BCBS does place providers on prepayment review. The decision to place a provider on a prepayment review is solely related to suspected fraud, waste, and abuse issues. Investigators monitor the claim and medical record submissions of provider placed on prepayment review, and determine if the provider should continue to remain on prepayment review. The provider will remain on a prepayment edit until the accuracy rate of 75 percent or higher for three consecutive months is achieved, or the provider has a low estimated savings.

Both MDwise and MHS may institute a provider payment suspension without direction from Indiana Medicaid; however, they also have the option to place a provider on prepayment review. MDwise will keep a provider on prepayment review for a minimum period of six months and until the provider has achieved 85 percent accuracy in claim submission for at least three consecutive months. The MHS placed 41 providers on prepayment review during FFY 2016. As previously mentioned, FFP software profiles providers prior to processing payments. When a provider is billing differently than their peers by at least two and one-half standard deviations, FFP flags the claim/provider for review prior to payment. The Verscend team will then conduct a mini-review and make a recommendation back to MHS's SIU team. The SIU team reviews the recommendation and any additional information. If the team member is unable to determine an explanation regarding the provider's billing pattern, medical records may be requested or a retrospective review to be opened. A retrospective review allows the SIU team to request additional records for review and to evaluate a variety of inconsistencies. Medical records submitted will be reviewed by the SIU clinical review team which is comprised of registered nurses, licensed practical nurses, and certified professional coders. The codes billed must be clearly documented to warrant payment. Once the provider is placed on prepayment review, a letter is mailed to that provider informing them of this status. If a provider is denied payment,

the SIU clinical review team will send a letter requesting additional documentation for review. The SIU will review 20 services of the particular code in question that has been placed on prepayment review.

During FFY 2016, the FSSA-PIU instituted payment suspensions against five providers. Prior to the current program integrity-related language in the MCE contracts, the FSSA-PIU only issued these suspensions against FFS providers. Although the new program integrity contract language did not become effective until January 1, 2017, the FSSA-PIU issued payment suspensions on two providers in December 2016; the FSSA-PIU requested that the MCEs also implement payment suspensions on these providers in their networks. The FSSA-PIU received confirmation from all of the MCEs that these suspensions were in place, shortly following the state's notifications of credible allegation of fraud determinations against the five providers.

Terminated Providers and Adverse Action Reporting

The state MCE contract states, "The Contractor shall be responsible for meeting all provider screening and enrollment requirements described in 42 CFR 455 Subpart E. The Contractor is prohibited from contracting with providers who have been excluded from the Federal Government or by the State's Medicaid program for fraud or abuse. The Contractor shall be responsible for checking the lists of providers currently excluded by the State and the Federal Government every thirty (30) calendar days." The state requires all providers to be enrolled through the FFS program, prior to contacting with the MCEs. The MCEs retain the right to cancel contracts with their network providers. Enrollment terminations are the responsibility of the state. Upon termination of a provider, the MCEs are notified and they must cancel current contracts with the terminated provider. The MCE contract states, "In accordance with 42 CFR 438.10(f), the Contractor must make a good faith effort to provide written notice of a provider's disenrollment to any member that has received primary care services from that provider or otherwise sees the provider on a regular basis. Such notice must be provided within fifteen (15) calendar days of the Contractor's receipt or issuance of the provider termination notice."

When advanced notice of provider disenrollment is available, " disenrollment data shall be submitted within five (5) business days prior to the effective disenrollment date. When advanced notice is not feasible, including, but not limited to, in the event of provider death or exclusion due to fraud or abuse, the Contractor shall submit the disenrollment within five (5) business days of the provider's termination effective date." During the onsite interviews, the state indicated that they were actively uploading all providers terminated for cause to the TIBCO MFT portal.

Table 5.

MCE	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
Anthem BCBS	2014 2015 2016	2,063 2,474 2,848	2014 2015 2016	3 24 13
MDwise	2014 2015 2016	142 240 199	2014 2015 2016	4 5 28
MHS	2014 2015 2016	1,354 2,538 5,194	2014 2015 2016	3 20 8

Overall, the number of providers terminated for cause by both of the plans appears to be low, compared to the number of providers in each of the MCE's networks and compared to the number of providers disenrolled or terminated for any reason.

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. 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); 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.

On a monthly basis, the OMPP (working through its fiscal agent) reviews all enrollment data against the required databases to identify providers who have been sanctioned or excluded. The following databases are checked at the time of provider enrollment/revalidation and monthly: NPPES, OIG/LEIE, SAM/EPLS, SSA-DMF, and TIBCO.

Recommendations For Improvement

- The state should ensure that it is allocating sufficient resources to program integrity oversight and that its MCEs build PIUs/SIUs with sufficient resources and staffing commensurate with the size of their managed care programs to conduct the full range of program integrity functions including the review, investigation, referral, and auditing of provider types where Medicaid dollars are most at risk. The state should also evaluate the number of MCE staff physically located in the state, therefore, enhancing the ability to conduct fraud, waste, and abuse activities locally.
- The state should develop written policies and procedures, or an interagency agreement that outlines which state unit will be responsible for the various program integrity-related oversight functions
- The state should work with the MCEs demonstrating low volumes of referrals to develop specific program integrity training to cultivate and enhance the quality of case referrals from the MCEs. Also, the state should provide more frequent feedback to the plans regarding the cases that they refer to the state. The state should ensure that all SIU staff are receiving appropriate training in identifying and investigating potential fraudulent billing practices by providers.
- The state should continue efforts to improve its ability to analyze encounter data reported by the MCEs and perform state-initiated data mining activities in an effort to identify fraud, waste, and abuse issues with MCE network providers. In addition, the state should develop written policies and procedures to oversee the collection and validation of the encounter data reported by the MCEs.
- The state should consider amending the current MCE model contract to include language regarding returning overpayments by the MCEs resulting from MCE fraud and abuse investigations and/or audits. Also, the state should develop written policies and procedures concerning the overpayment recoveries oversight process.
- The state should contractually require MCEs to suspend payments to providers against whom an MCE or the state can document a credible allegation of fraud. The payment suspension requirements at 42 CFR 455.23 should be consulted, when drafting this provision. The state should provide training to its MCEs on the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23, and should further require the reporting of plan-initiated payment suspensions based on credible allegations of fraud. In addition, the state should develop written policies and procedures to monitor payment suspensions within its managed care program.

Section 2: Status of Corrective Action Plan

Indiana's last CMS program integrity review was in September 2013. Per the FFY 2013 CAP notification letter submitted to the state by CMS on December 16, 2016, Indiana was found to be in compliance with no additional action or review of outstanding items required by the onsite team.

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:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems 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 (Select State) 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. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html
- 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.

Conclusion

The CMS focused review identified areas of concern 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 Indiana to build an effective and strengthened program integrity function.