Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

October 2016

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Table of Contents

Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review to determine the extent of program integrity oversight of the managed care program at the state level. CMS also reviewed Vermont's policies, procedures, and oversight of non-emergency medical transportation (NEMT). The review also included a follow up on the state's progress in implementing its corrective actions related to CMS's previous comprehensive program integrity review held in calendar year 2011.

Background: State Medicaid Program Overview

On April 15, 2005, Vermont submitted its formal proposal for the Global Commitment to Health section 1115(a) demonstration waiver to CMS. The Global Commitment to Health section 1115(a) demonstration waiver is designed to use a multi-disciplinary approach including: the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, an initiative in employer-sponsored health insurance (through December 31, 2013), and program flexibility. The initial Global Commitment to Health Demonstration was approved in September 2005. As a result, the state does not have what may be considered to be "traditional" managed care.

The Department of Vermont Health Access (DVHA) is not a traditional managed care program in the sense of a risk based capitation program with private contractors. The DVHA plans to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care through the 1115 demonstration waiver. The state Medicaid agency does not contract with any managed care organizations (MCOs) to deliver services to Medicaid beneficiaries; instead, the state administers the program through DVHA.

Under the waiver, the Agency of Human Services (AHS) is responsible for oversight of DVHA. The 1115 demonstration waiver allows the state to deliver specialized and personalized health care services to its beneficiary population. Additionally, DVHA has intergovernmental agreements (IGAs) with other state agencies to provide a variety of needed care packages to beneficiaries according to the beneficiary's specific needs. The IGAs are not considered to be contracts.

The demonstration waiver also limits the federal government's financial contribution to $13.8 billion over the 11.25 year term of the demonstration for certain eligibility populations. In any year in which the state exceeds the annual target amount, Vermont is required to develop a plan to ensure that the budget limit is not exceeded. During state fiscal year (SFY) 2014, Vermont had 222,358 active Medicaid beneficiaries and 15,133 active participating and non-participating providers enrolled in the DVHA's managed care program. For federal fiscal year (FFY) 2014, the state reported total Medicaid expenditures of approximately $1.5 billion.

Methodology of the Review

In advance of the onsite visit, CMS requested that Vermont complete a managed care review guide that provided the team detailed insight to the operational activities of the areas that were subject to the focused review. Questionnaires were completed by DVHA and NEMT brokers selected to be interviewed. A five-person team reviewed these responses and materials in advance of the onsite visit.

During the week of August 3, 2015, the team met with staff from Vermont's managed care program (DVHA as the MCO) and three of the NEMT brokers which had the most exposure and impact on the state's Medicaid program out of the eight total NEMT brokers. The team conducted interviews with numerous state agency staff involved in program integrity and managed care. In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the DVHA's program integrity practices. The review team also interviewed NEMT providers as well as state staff responsible for overseeing these providers and the operation of the NEMT program.

Results of the Review

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

Section 1: Managed Care Identified Risks

42 CFR 455.23: Suspension of payments in cases of fraud.
The Federal regulation at 42 CFR 455.23(a) requires that upon the state Medicaid agency determining that an allegation of fraud is credible, the state Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payments only in part. Under 42 CFR 455.23(d), the state Medicaid agency must make a fraud referral to either a Medicaid fraud control unit (MFCU) or to appropriate law enforcement agency in states with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.
The state is in non-compliance with this regulation
In Vermont, DVHA is a public managed care model. As such, program integrity initiates the payment suspensions, but the fiscal agent, HP Enterprise Services (HPES), completes the actions within the Medicaid Management Information System (MMIS). The DVHA is the only statewide MCO; no other MCO exists. According to DVHA, a provider payment suspension occurs when credible allegations of fraud are identified, as indicated under 42 CFR 455.23, and when a sanctionable event occurs. In the last four FFYs, DVHA has placed 28 providers on payment suspension. However, when the team examined ten of the cited providers, none were found to have been placed on payment suspension. The DVHA is required to suspend or terminate providers who had been suspended or terminated by the state Medicaid agency.
Recommendations: Verify documentation of suspensions.

Section 2: Managed Care Program Integrity

Overview of the State's Managed Care Program

The state reported that the oversight of the managed care system in Vermont is a collaborative effort between DVHA and AHS. Both DVHA and AHS share the programmatic and contractual oversight of the managed care program, while DVHA has oversight of program integrity activities related to fraud, waste, and abuse. Because the DVHA functions as the managed care entity, the state has written policies and procedures in the form of IGAs for how it will coordinate oversight of various functions and which department will be responsible for each of the specific activities.

Summary Information on the Plans Reviewed

During SFY 2014, the state had a network of 15,133 providers and 222,358 Medicaid enrollees. Providers are paid on a fee-for-service (FFS) basis. The DVHA utilizes a tiered approach to investigating fraud, waste, and abuse in its program. The DVHA's program integrity unit (PIU) consists of 11 full time equivalents whose responsibilities include ensuring that all AHS requirements are met.

Program integrity activities are supported by various DVHA functions responsible for the detection, prevention, and investigation of fraud, waste, and abuse perpetrated by their providers. Beneficiary fraud, waste, and abuse is investigated by DVHA's sister agency, the Medicaid

Fraud & Residential Abuse Unit (MFRAU: operating as the state's MFCU). The IGAs with other program areas enable the DVHA's PIU to coordinate its activities on a daily basis. The majority of fraud referrals are received through the DVHA phone line and program integrity.

Table 1.

Medicaid Enrollees SFY 2014	DVHA Contracted Providers SFY 2014	Size and Composition of PIU	Total Medicaid Expenditures for FFY 2014
222,358	15,133	11	$1.5 billion

Managed Care Program Integrity Activities

The DVHA conducts site visits to verify that providers are at the locations indicated on their state enrollment application and also conducts site visits during revalidation or as required by an ongoing investigation.

The DVHA monitors program activities through a monthly tracking tool that captures:

- The number of provider applications submitted, declined, or accepted;
- Provider investigations opened, identified dollars, and any actions taken;
- Types of improper billing behavior; and
- Recoveries identified and collected.

Investigations of Fraud, Waste, and Abuse

The DVHA is also responsible for special investigation unit functions and is required under the waiver to have the same staffing levels and positions that an MCO would have. The state's waiver also requires DVHA to report to any suspected fraud, waste, or abuse by its providers, members, employees, or subcontractors to the MFRAU. The DVHA regularly monitors the managed care program integrity activities through routine weekly or monthly updates, or through the use of quarterly reports. This allows the PIU to track activities and provides them with the opportunity to determine whether or not the same provider is under investigation by another area within the state Medicaid agency. Furthermore, it allows DVHA to manage and refer activities relative to cases involving credible allegations of fraud. The full time equivalents have a wide array of specialties which are utilized depending on the investigation in the field that arises.

Based on the memorandum of understanding (MOU), the MFRAU will review reports and allegations of fraud and abuse received from DVHA or other sources, and make a prompt determination regarding whether further investigation is warranted. The MOU is in force for a period of five years. The DVHA provides the MFRAU with copies of all reports, including the number of complaints of fraud and abuse that warrant a preliminary investigation.

Within the state Medicaid agency, fraud and abuse cases are triaged in several ways. Cases are received utilizing three avenues of referral. Primarily, referrals are received through DVHA's phone line. Referrals are also received via email or the US Postal Service on a referral form. Lastly, beneficiaries seeking to refer cases of provider fraud call the member services line, Maximus, and the referrals are directed back to PIU. Maximus calls account for about less than 1% of referrals to the state.

If calls are reported as provider-related, they are referred to DVHA. Calls reported as alleged beneficiary fraud, waste, or abuse are reported to the Economic Services Division/Department of Children and Families (ESD/DCF). One hundred percent of suspected beneficiary fraud is investigated by ESD/DCF. The state has established a $500 threshold for provider fraud cases, with very few exceptions. The DVHA indicated that the investigation breakdown is as follows: 70 percent are hotline referrals and 30 percent are via proactive data analysis.
As previously mentioned, DVHA completes a triage process prior to beginning any investigation. This triage process allows DVHA to prioritize the cases received against cases already in queue to ensure cases with the highest risk to the program are evaluated timely. The DVHA has an IGA with each of the following sister agencies: Department of Mental Health; Vermont Department of Health; Vermont Agency of Education; Department of Disabilities, Aging and Independent Living; and Department for Children and Families.

The DVHA tracks their investigations in monthly reports which are reviewed by the staff and a compliance committee. The committee includes nurses, data analysts, auditors, and compliance team members. For FFYs 2012 through 2014, the state identified a total of 452 investigations of potential fraud and abuse.

Table 2.
Number of Investigations Referred by Plan. (Based on referral received date, as cases are in various stages throughout each of the FFY's.)

FFY 2012	FFY 2013	FFY 2014
157	153	142

Meetings and Trainings

The DVHA meets bi-monthly with MFRAU to review any open cases on network providers and their status. The meetings may also include other issues, such as training for both DVHA and the MFRAU on program integrity issues and upcoming fraud trends. Over the past three years, DVHA staff has attended training at: the Annual Invitational Meeting for the Vermont Healthcare Fraud Enforcement Task Force; the National Association for Medicaid Program Integrity Annual Conference; the Criminal and Civil Standards in Medicaid Fraud; Health Care Fraud and Program Integrity; and the Healthcare Fraud Prevention Partnership. In addition, DVHA staff has had representation at many Medicaid Integrity Institute courses and/or webinars.

Encounter Data

The DVHA does not have traditional capitated providers. The Department functions as a managed care FFS program which does not rely on encounter data. The DVHA has access to the databases to review for program integrity and audit reviews. The DVHA does utilize a capitated payment structure to pay its NEMT brokers on a per member/per week basis (PMPW). This is the only program where capitated rates are paid. The state Medicaid agency is in the process of procuring a new MMIS, but does not anticipate that it will go live before 2018 or 2019. The new MMIS system is being designed to address many of the areas related to fraud, waste, and abuse. The request for proposal process has yet to be completed.

Overpayment Recoveries, Audit Activity, and Return on Investment

The DVHA's PIU is primarily responsible for collecting overpayments; however, some overpayments are collected from the Vermont Restitution Unit. The DVHA's program integrity policies and procedures address overpayment recoveries at length. Overpayments made to a Medicaid provider may be treated as resulting from fraud only if DVHA has referred a provider's case to the MFRAU or appropriate law enforcement agency. The MFRAU provides DVHA with written notification of acceptance or denial of a case.

The DVHA had a total of 452 investigations from 2012 through 2014, with most investigations remaining open for 60 to 90 days. The DVHA does not consider a case closed until it receives notification that the MFRAU has concluded their investigation.

The overpayment recoveries during SFY 2015 were much lower when compared to past SFYs. The PIU expressed its dedication to the recovery process, as well as taking a proactive approach to preventing overpayments from occurring. The DVHA attributed the decrease in recoupments to additional cost savings achieved through various claims editing and cost avoidance activities. The state's waiver directs DVHA to document overpayments as well as cost avoidance.

Overall, the trend regarding overpayments has continued to improve over the past several SFYs resulting in the need to recoup lower amounts directly resulting from greater cost avoidance measures instituted by the DVHA. Please refer to the chart below:

Table 3.

SFY	Program Integrity Recoupments
2012	$3.3 million
2013	$1.4 million
2014	$1.8 million
2015	$898 thousand

In Table 3, program integrity recoupments have experienced a notable decrease during SFY 2015, in comparison to prior periods. The state Medicaid agency attributes the SFY 2015 decrease in recoupments to a previous reduction in staffing levels, which has since been increased. In addition, the state also maintains that cost avoidance measures in place, such as claims editing, have resulted in a significant reduction in overpayments, leading to the need to

recoup less monies. However, the state did not provide documentation related to the savings achieved through the use of claims edits or other cost avoidance activities. Also, the DVHA indicated that Vermont does not have a recovery audit contractor (RAC). The DVHA is exempt from the RAC requirements; however, it still conducts RAC-like reviews internally.

Provider Terminations

The DVHA is required to suspend or terminate providers who have been suspended or terminated by the state Medicaid agency and to terminate any providers who have been terminated from Medicare, another federal health care program, or another state's Medicaid or CHIP. These provisions are consistent with, though not identical to, existing federal FFS requirements on terminating providers for cause across the Medicare, Medicaid, and CHIP programs, and reporting adverse actions that relate to fraud or abuse. In addition, the state reported that it does communicate terminations to the US Department of Health and Human Services-Office of Inspector General (HHS-OIG), other states, and plans. The DVHA has a process in place that requires its PIU and their fiscal agent to notify the state within two business days of taking any action against a provider for program integrity reasons including, but not limited to, denials of credential and recredentialing applications, suspensions, and terminations.

The DVHA indicated that most of the providers chose to disenroll from the program when they attempt to collect overpayments or the investigation resided with the state's MFCU, otherwise known as the MFRAU; in these instances, most providers prefer to pay back overpayments and disenroll from the program. The DVHA is not documenting the providers that disenroll. Without documentation, this may allow a provider to enter other states with a clean background and/or not have to disclose that they even provided services in the state of Vermont.

Regarding personal care attendants (PCAs) and payment suspensions/good cause exceptions under 42 CFR 455.23, Vermont Medicaid does not enroll PCAs in the traditional sense; therefore, termination does not apply to these providers. To date, all PCA providers found to have credible allegations of fraud have chosen to stop providing care to Medicaid beneficiaries. As a result, actual payment suspensions are not enforced since claim submissions for services have stopped. Since these PCAs are not enrolled providers, no disenrollment occurs. If a PCA is convicted, the provider's information is placed in the TIBCO file, so that other federal and state entities are aware of this conviction. The DVHA has had 6,178 providers disenrolled or terminated over the last three year period.

Table 4

MCO	Providers Disenrolled or Terminated in the Last 3 Completed FFYs	Providers Terminated for Cause in the Last 3 Completed FFYs
DVHA	6,178	6

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must 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 HHS-OIG'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 the Provider Enumeration System (NPPES) upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.

The state's 2015 contract requires the DVHA to have provisions in their fraud, waste, and abuse compliance plans to check their provider files, including atypical providers, against both the LEIE and the EPLS on the SAM website as part of credentialing and recredentialing, and at least monthly thereafter. The contract further stipulates that NEMT brokers should conduct monthly exclusion checks of their own owners, agents, and managing employees on a monthly basis.

Additionally, the contract also indicates that DVHA's fiscal agent, HPES, must check network providers against the SSA-DMF or the NPPES as part of the credentialing and recredentialing process. These databases are part of the additional screening requirements implemented in FFS under the Affordable Care Act at 42 CFR 455.436.

The DVHA recredentials their providers every two years. The DVHA checks its providers and affiliated parties against the LEIE and EPLS upon credentialing and recredentialing and monthly thereafter. There is also a check of the SSA-DMF and the NPPES at the time of credentialing or recredentialing.

The DVHA required HPES to include provisions regarding conducting checks of their provider files including checking both the LEIE and EPLS (SAM), as part of the credentialing and recredentialing of a provider. The HPES will also be automating the monthly checks beginning September 2015, when it rolls out its new automated platform. However, due to lack of HPES resources, the exclusions of owners, agents, and managing employees are not being currently done.

Section 3: Non-Emergency Medical Transportation

The DVHA is designated as the single state agency that is responsible for the oversight of NEMT services. The state of Vermont has a total of eight NEMT brokers; however, three were selected for review based on their impact to the Medicaid program. The selected NEMTs are as follows: Special Services Transportation Agency, Rural Community Transportation, and Marble Valley Regional Transit.

Upon enrollment, transportation providers are screened and have a criminal background check, drug screen, and a driver history abstract. The transportation brokers must check the adult registry, before they enroll a driver.

NEMT Federal Database Checks

- Special Services Transportation checks the LEIE and the EPLS (SAM) on the driver upon enrollment. However, the transportation broker conducts no ongoing monthly searches of the LEIE and the EPLS which is a requirement under CFR 455.436. In addition, the NPPES and the SSA-DMF are not being checked upon initial enrollment.

- Rural Community Transportation does not check any of the excluded databases that are required under CFR 455.436. The LEIE and EPLS are not being checked upon enrollment and monthly. Also, the NPPES and the SSA-DMF are not being checked upon initial enrollment. The team was told that they check the adult and child registry upon enrolling a driver. They were unaware of the exclusion databases that they are required to check under CFR 455.436.

- Marble Valley Transportation does not check any of the excluded databases that are required under CFR 455.436. The LEIE and EPLS are not being checked upon enrollment and monthly. Also, the NPPES and the SSA-DMF are not being checked upon initial enrollment. The team was told that they check the adult and child registry upon enrolling a driver. They were unaware of the exclusion databases that they are required to check under CFR 455.436.

NEMT Ownership and Control Disclosures

The three transportation brokers interviewed are not capturing all the required ownership and control disclosures from their drivers, as required in the contractual agreement with the state application.
The Vermont NEMT network contract and provider application does not capture all required ownership and control interest disclosures. Specifically, neither the contract nor the application requires the date of birth of each person with ownership and control interest.

NEMT Business Transaction Disclosures

The three transportation brokers interviewed are not adequately addressing business transaction disclosures in network contracts**.** Specifically, neither the network transportation contracts nor the provider agreements require network transportation providers to disclose certain business transaction information as required in the contractual agreement with the state application.

Section 4: Effective Practice

Explanation of Medical Benefits (EOMBs)

Prior to 2012, the state's fiscal agent was responsible for managing the EOMB process. The fiscal agent was required to disseminate 1,200 EOMBs per quarter. The state felt that the EOMB was not providing an adequate description to accurately communicate services to beneficiaries.

Once the state brought the process in-house, they changed the focus of the EOMB process. The state places pictures of items on EOMBs to provide better references for beneficiaries to verify

services. The state now reports a return rate of 60 percent to 80 percent, and the work now provides many productive cases.

Recommendations for Improvement

- The state should verify that its fiscal agent, HPES, is checking the required federal databases for exclusions of owners, agents, and managing employees at the required intervals.

- Develop and implement policies and procedures for initiating provider exclusions. CMS recommends that Vermont continue to improve its ability to analyze encounter data reported for its limited capitated providers and perform state-initiated data mining activities to assist in identifying fraud, waste, and abuse issues with its network providers.

- The state should ensure that the disenrolled providers are documented. This documentation would prevent a provider from entering other states with what appears to be a clean background and/or without disclosing that they ever provided services in the state of Vermont.

- The state should verify documentation regarding providers suspended due to credible allegations of fraud to ensure that the suspended providers do not continue to receive Medicaid payments, unless the agency has good cause to not suspend payments or to suspend payments only in part.

- In accordance with waiver requirements, the state should provide documentation in support of any savings achieved through claims editing and/or cost avoidance activities that have resulted in a decline in overpayments.

- The state should amend the NEMT contract to require the appropriate collection and maintenance of disclosure information for disclosing entities and regarding any person with a direct or indirect ownership interest of 5 percent or more; or who is an agent or managing employee of the disclosing entity; or who exercises operational or managerial control over the disclosing entity.

- The state should ensure that the NEMT brokers search the LEIE; EPLS; SSA-DMF; and the National Plan & Provider Enumeration System upon enrollment, reenrollment, credentialing, or recredentialing of network providers, and check the LEIE and EPLS monthly thereafter for the names of any person with an ownership or control interest, or who is an agent or managing employee.

Section 5: Status of Corrective Action Plan

Vermont's last CMS program integrity review was in March 2011, and the report for this review was issued in September 2011. During the 2011 program integrity review, the team identified three regulatory compliance issues and three vulnerabilities. At the time of the August 2015 focused review, the team found one area of concern from the 2011 program integrity review remains unresolved. The findings of this review are described below.

1. ***The state's fiscal agent is not conducting monthly exclusion searches of providers enrolled in the Medicaid program***

   Status at time of the review: Not Corrected

   The state submitted documentation regarding this risk; however, it was discovered that in practice the state's fiscal agent indicated that it had entered into agreement with a large provider, under a streamlined recertification process, to conduct its own exclusion searches and was unaware as to whether these checks were being completed. According to 42 CFR 455.436, the state must check on a monthly basis specific exclusion databases. It is the state's responsibility to conduct exclusion searches of providers enrolled in the Medicaid program. At the time of the review, the fiscal agent pointed out that the practice will no longer take place as of September 1, 2015.

2. ***The State does not capture information on ownership and control interests in subcontractors and from its fiscal agent.***

   Status at time of the Review: Corrected

   The enrollment application was modified to require and now collects the full ownership and control disclosure information specified in the regulation at 42 CFR § 455.104. A document was provided under addendum A; this document amendment was implemented by Vermont's fiscal agent, HP Enterprise Services. The DVHA also requires ownership and control disclosures from HP Enterprise Services, in accordance with 42 CFR § 455.104(c), and included that requirement in the contract amendment.

3. ***The State does not require all providers to submit business transaction information upon request.***

   Status at time of the Review: Corrected

   The enrollment agreement was modified to meet the full requirements specified in 42 CFR § 455.105(b). The document was provided to the review team and listed as addendum B. This document amendment was implemented by HP Enterprise Services.

4. The State does not request health care-related criminal convictions from agents of the provider.

Status at time of Review: Corrected

The enrollment application has been modified to require the full range of health care-related criminal conviction disclosures required by 42 CFR § 455.106. The document was listed as addendum C. The amendment was implemented by HP Enterprise Services.

5. Not allowing minimum criteria set forth in CMS guidance for fraud referrals.

Status at time of Review: Corrected

Based on the CMS Performance Standards for referrals of suspected fraud from a single state agency, a MFCU referral must contain at least the minimum elements set forth in this guidance document. Effective March 25, 2011, compliance with the referral performance standards is required as part of the regulation at 42 CFR § 455.23. The DVHA submitted an updated referral form which details the requirement for the fraud referrals to the MFCU.

6. Inconsistencies in processing provider enrollment applications.

Status at time of Review: Corrected

All applicable policies and procedures regarding the handling of provider applications have been reviewed and, if necessary, modified to ensure clarity and consistency. Training has been provided for State and fiscal agent staff on the policies in effect. A policy and procedure was developed regarding review of provider applications which indicate adverse actions or previous program integrity issues.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Vermont 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 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 Vermont 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.
- 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 Vermont review the effective and noteworthy practices in program integrity and consider emulating these practices as appropriate.
- 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

CMS supports Vermont's efforts and encourages it to look for additional opportunities to improve overall program integrity. The CMS focused review identified areas of concern and an instance 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 plan should identify those corrections as well.

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

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Agency of Human Services

November 1, 2016,

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Re: Response to the October 2016 Vermont Focused Program Integrity Review Report

Dear Mr. Majestic:

Thank you for the opportunity to respond to the October 2016 Vermont Focused Program Integrity Review Report. Please find our responses enclosed.

As noted in our response, there were several inconsistencies that were resolved during the October 21, 2016 conference call with CMS. Since the Department of Vermont Health Access (DVHA) is not a traditional managed care program in the sense of a risk based capitation program with private contractors; and, the State Medicaid agency does not contract with any managed care organizations (MCOs) to deliver services to Medicaid beneficiaries, quarterly reports detailing the number of provider investigations and suspected fraud referrals by MCOs will not be provided, as requested in the Report cover letter.

We look forward to working with you to continue to enhance our Program Integrity efforts.

Respectfully,

Steven M. Costantino, Commissioner

cc: Laurie Battaglia, Division of State Program Integrity Director
Jackie Garner, CMCHO Consortium Administrator
Richard McGreal, DMCHO Associate Regional Director
Jason Turner, MFCU Director
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