Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Georgia Comprehensive Program Integrity Review

Final Report

January 2012

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Table of Contents

Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Georgia Medicaid Program. The onsite portion of the review was conducted at the offices of the Georgia Department of Community Health (DCH). The MIG review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the DCH Office of Inspector General (DCH-OIG), which is responsible for Medicaid program integrity in Georgia. This report describes four effective practices, eight regulatory compliance issues, and eight vulnerabilities in the State's program integrity operations.

The Review

Objectives of the Review

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

Overview of Georgia's Medicaid Program

The DCH administers the Medicaid program. As of January 1, 2011, the program served a total of 1,672,205 beneficiaries, 1,133,544 of whom were enrolled in three care management organizations (CMOs). In the State fiscal year (SFY) ending June 30, 2010, total Medicaid expenditures were $7,516,818,753. The State had 84,670 providers participating in the Medicaid program; of these, the CMOs reported a duplicative total of 41,173 enrolled in managed care.

Program Integrity Section

In Georgia, DCH-OIG is the organizational component dedicated to anti-fraud and abuse activities. In SFY 2010, the DCH-OIG had 51 full-time equivalent positions allocated to Medicaid program integrity functions. None of these were vacant at the time of the review. The table below presents the number of preliminary and full investigations, the amount of overpayments identified and total recoupments in the past four SFYs. The amount of overpayments collected does not include global recoveries.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected***
2007	1,657	3	not tracked	$ 9,801,681
2008	1,346	22	not tracked	$17,196,804
2009	2,068	167	not tracked	$11,814,637
2010	1,657	218	not tracked	$11,153,130

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. Preliminary investigations in 2010 decreased significantly due to reallocation of investigation staff to the MMIS certification project.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the Medicaid Fraud Control Unit or administrative or legal disposition.
***The amount of overpayments collected spiked in SFY 2008 due to the fruition of several projects that began in prior years.

Methodology of the Review

In advance of the onsite visit, the review team requested that Georgia 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 the MFCU. A three-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of June 20, 2011, the MIG review team visited the DCH-OIG and MFCU offices. The team conducted interviews with numerous DCH officials as well as with staff from the MFCU. To determine whether the CMOs were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team also reviewed the State's managed care contract. The team conducted in-depth interviews with representatives from three CMOs and met separately with DCH staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity case files, and other primary data to validate Georgia's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of DCH-OIG, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care contract management, non-emergency medical transportation (NEMT), and provider training. Georgia's Children's Health Insurance Program operates under Title XXI of the Social Security Act and was, therefore, not included in this review.

Unless otherwise noted, DCH-OIG 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 provided.

Results of the Review

Effective Practices

As part of its comprehensive review process, the CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Georgia reported a three-day readmit project, realignment of the provider enrollment function, review of dual-eligible claims, and program integrity staff's involvement with managed care.

Three-day readmit project

The DCH-OIG Program Integrity Section's (PI Section) Hospital Team identified hospital claims with readmissions within three days of discharge for the same or related problem. The hospital manual defines these readmissions as the same admission for reimbursement purposes. Affected hospitals were given the opportunity to self-disclose and if the disclosure was within $1,500 of the amount identified through the data run, the self-disclosure was accepted. If the hospital did not self-disclose or the self-disclosure was not accepted, the full amount identified by the data was collected. This project collected $1,500,000.

Realignment of the provider enrollment function under program integrity

In order to maximize program integrity operations, DCH realigned the provider enrollment function under the DCH-OIG. As of February 2011, provider enrollment operations moved from the Office of General Counsel to the DCH-OIG where DCH's program integrity function also resides. This change permits a more direct involvement in monitoring the enrollment of providers wanting to enter the Georgia Medicaid program. The new manager of provider enrollment will have a dedicated investigator to perform on-site reviews prior to enrolling durable medical equipment suppliers and high-risk providers. In addition, policies are being developed to accommodate the new Patient Protection and Affordable Care Act provider enrollment requirements.

Utilizing a contractor to identify overpayments from dual-eligible claims

The DCH utilizes a contractor to provide experienced resources to help identify, correct and prevent inappropriate payments to providers. The contractor performs global analysis and special studies of claims paid through the Medicaid Management Information System (MMIS). Data mining, exploratory data analysis, and computerized algorithms are used to identify inappropriate payments based on MMIS adjudication, provider compliance, billing errors, fraud and abuse or other causes.

A special study reviewed Medicare prior payments for four hospitals. The claim analysis showed that the providers improperly reported Medicare payments, causing the State to pay full Medicaid reimbursement with no reduction. This study involved more surveillance and utilization review-type work than normal because crossover claim analysis looks at the relationship between Medicare and Medicaid claims. Errors are not extrapolated, but are used to search out all claims that may have a similar error. The contractor works

closely with the PI Section to identify and confirm the errors and develop a list of affected providers. The result of this financial study covering SFYs 2007-2011 resulted in recovery of $6,377,917 in SFY 2011. The MFCU is working on cases where the impact is more than $100,000 per provider and issuing penalties when appropriate.

Program integrity staff involvement with managed care
Georgia's CMOs seek guidance from program integrity staff before proceeding with investigations of suspected fraud and abuse in the managed care program. In doing so, the State is able to determine if the provider is being investigated by another entity before initiating an investigation. Program integrity staff hosts quarterly meetings with the three CMOs to discuss and review information on fraud and abuse issues. However, other issues with managed care are discussed in the Vulnerabilities section of this report.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to suspending payments when referring cases to the MFCU, collecting ownership and control, business transaction and criminal conviction disclosures, checking Federal databases for exclusions and debarments, and the reporting of adverse actions to the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG). Issues also include having administrative procedures to initiate provider exclusions and monitoring provider compliance with the False Claims Act.

The State has not implemented the new provisions of the regulation to suspend payments in cases of credible allegations 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 payment only in part; and 42 CFR § 455.23(d) requires that the State Medicaid agency make a fraud referral to either a MFCU or to an 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 CMS released an Informational Bulletin and Frequently Asked Questions to States on March 25, 2011. In addition, CMS has provided States numerous opportunities, including national teleconferences and sessions during two Medicaid Integrity Institute courses, to learn more about the payment suspension regulation since it became effective on March 25.

The State is conducting preliminary investigations and has referred one case to the MFCU based on a credible allegation of fraud since March 25, 2011. The referral meets the standards of the U.S. Department of Health and Human Services (HHS) Secretary's referral performance standards. However, the State did not suspend payments to the provider as required and did not have a good cause exception not to suspend payments.

Recommendations: When an investigation determines there is a credible allegation of fraud, suspend payments to providers or document a good cause exception not to suspend. Refer such cases to the MCFU and comply with the notification requirements of the regulation.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Repeat Finding)

Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or managed care entity (MCE), must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and managed care entities prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

The language in the State's fee-for-service (FFS) provider enrollment forms does not fully meet the disclosure requirements of the regulation. For example, in-State and out-of-State entity enrollment forms do not request complete ownership or control interests of subcontractors in which the disclosing entity has direct or indirect ownership of 5 percent or more as required by § 455.104 (a)(1). These forms also do not request the relationship of individuals with entity and subcontractor ownership or control interests as required in § 455.104(a)(2), or the name of any other disclosing entity in which the enrolling entity also has an ownership or control interest. This is uncorrected from the 2008 CMS program integrity review.

The DCH also does not collect disclosure information throughout its contracting process for persons with ownership or control interests, subcontractors and other disclosing entities related to NEMT broker programs and CMOs. In addition, similar disclosure information is not collected for Georgia's fiscal agent and pharmacy benefit manager as required under 42 CFR § 455.104(c). This issue remains uncorrected from the 2008 CMS review.

As of March 25, 2011, State agencies must capture SSNs and DOBs and enhanced address information for all persons with an ownership or control interest in providers seeking enrollment in a State Medicaid program. Georgia's enrollment applications for in-State and out-of-State entities request the DOB of the owners and business managers. However, neither of the applications requests the SSN of owners and the in-State application does not ask for the SSN of business managers. The CMO, NEMT, and fiscal agent contracts also do not require the

address, SSN, DOB or Employer Identification Number for individuals with ownership or controlling interest in those entities.

Recommendations: Develop policies and procedures for the appropriate collection of disclosures from disclosing entities, fiscal agents, pharmacy benefit managers, CMOs, or NEMT brokers regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities, fiscal agents, pharmacy benefit managers, CMOs, or NEMT brokers. Modify disclosure forms as necessary to capture all disclosures required under the revised regulation. The MIG made a similar recommendation in its 2008 review report.

The State does not adequately address business transaction disclosure requirements in its contracts. (Uncorrected Partial Repeat Finding)

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors.

The State relies on a blanket statement in the FFS provider agreements requiring the disclosing entities to comply with disclosure requirements specified in 42 CFR Part 455, Subpart B. However, the DCH contracts with NEMT brokers do not have a provision to provide business transaction information upon request. This is uncorrected from the 2008 CMS review.

Georgia contractually requires disclosure information to be submitted by the CMOs on an annual basis. However, the contract does not include a statement requiring the CMOs to disclose the specified business transaction information to the Secretary or the Medicaid agency upon request. The contract also contains no reference to the 35-day period to submit business transactions as required in the regulation.

Recommendation: Revise the contracts to require disclosure upon request of the information identified in 42 CFR § 455.105(b). The MIG made this same recommendation regarding NEMT in its 2008 review report.

The State does not capture criminal conviction disclosures from providers or contractors.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The DCH FFS individual provider applications ask if the applicant has ever had any adverse legal actions imposed by Medicare, Medicaid, or any other Federal or State agency, but the question is not asked for persons with ownership or control interests. The application also asks

if any family or household member of the applicant has ever been convicted of any health care-related crime. However, the form does not ask for this same information from agents or managing employees as required in the regulation.

The managed care contracts do not contain language to collect the required health care-related criminal conviction disclosures related to Medicare, Medicaid, and Title XX programs. As a matter of policy, DCH does not report any criminal conviction disclosures to the HHS-OIG because letters sent have been returned as non-deliverable for the last two years. Subsequent to the review, the MIG review team identified the contact at the HHS-OIG and conveyed that information to DCH.

Recommendation: Develop policies and procedures for the appropriate collection of disclosures from providers and MCEs regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers and MCEs, who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs. Modify disclosure forms as necessary to capture all disclosures required under the regulation.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal 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 HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS) no less frequently than monthly.

Prior to implementation of this new regulation, CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the Medicare Exclusion Database (MED) upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties.

The State does search the LEIE for exclusions at enrollment and monthly thereafter. However, prior to November 1, 2010 only business managers were captured and routinely checked. As of November 1, 2010 those with ownership or control interests began being added to the database for new enrollments and checked for exclusions. Therefore, monthly checks do not include all individuals with ownership or control interests in providers enrolled prior to November 1, 2010. In addition, agents are not captured or searched for exclusions at all.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or

the MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded person or entities.

The State does not report all adverse actions taken on provider participation to the HHS-OIG.

The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The State does not notify the HHS-OIG of adverse actions taken on provider applications for participation in the Medicaid program. The DCH stated it does not notify HHS-OIG because letters sent have been returned as non-deliverable for the last two years. Therefore, no official notifications of denials, terminations, or limits placed on a provider have been made. Subsequent to the review, the MIG review team identified the contact at the HHS-OIG and conveyed that information to the State.

Recommendation: Develop and implement procedures for reporting to HHS-OIG program integrity-related adverse actions taken on a provider's participation in the Medicaid program.

The State does not have administrative procedures to initiate exclusions for any reason for which the HHS-OIG could exclude a provider.

The regulation at 42 CFR § 1002.210 requires that the State institute administrative procedures to exclude a provider for any reason for which the HHS-OIG could exclude a provider under 42 CFR Parts 1001 and 1003.

The State does have termination policies and procedures that follow HHS-OIG exclusions. However, the State does not have administrative policies and procedures to initiate exclusions of providers of its own volition. The absence of written policies and procedures leaves the State vulnerable to paying providers who could otherwise be excluded from the Medicaid program.

Recommendation: Develop and implement policies and procedures to unilaterally initiate provider exclusions from the Medicaid program rather than only excluding providers that have already been excluded by HHS-OIG.

The State does not comply with its State Plan regarding False Claim education monitoring.

Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least $5 million annually under a State's Medicaid program have: (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and

abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

The State requires providers to send in attestations of compliance regarding the False Claims Act by the end of every calendar year. No one is reviewing the attestations to see if all of the entities required to send in the attestation are actually doing so. The State Plan Amendment states that compliance and oversight will be accomplished by incorporating reviews for the specific requirements of 1902(a)(68) as standard operating procedures for utilization reviews. The review team was told by DCH-OIG management that the function to monitor compliance recently shifted to the DCH-OIG and is accomplished through provider utilization reviews. However, this monitoring step is not included in onsite review standard operating procedures.

Recommendation: Develop and implement policies and procedures to monitor compliance of all providers and contractors in accordance with the State Plan.

Vulnerabilities

The review team identified eight areas of vulnerability in Georgia's program integrity practices. These involved ensuring CMOs do not have a relationship with debarred individuals or entities, incomplete exclusion searches, and the collection of disclosures from managed care and NEMT providers. They also include the failure to ensure the exclusion of CMOs subject to HHS-OIG exclusions, the reporting of adverse actions taken against managed care and NEMT network providers, and the failure to remove excluded individuals from the MMIS provider data.

Not verifying whether CMOs have relationships with debarred, suspended, or excluded persons or entities.

Under the regulation at 42 CFR § 438.610, a managed care organization (MCO), primary care case manager (PCCM), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) may not have a relationship with a director, officer, partner, an employee, consultant, a person with a 5 percent or more ownership interest, or a contractor for items or services that are material to the MCE's obligations to the State who has been debarred, suspended, or excluded, or who is an affiliate of a person who is debarred, suspended, or excluded. If the State Medicaid agency learns that the MCO, PCCM, PIHP, or PAHP has a relationship with such a debarred, suspended, or excluded person, or a person who is an affiliate of a person who is debarred, suspended, or excluded, the State Medicaid agency must notify the Secretary. The State may continue the contract with the MCO, PCCM, PIHP, or PAHP, unless the Secretary instructs the State Medicaid agency to terminate the contract; and the State may not renew or extend the contract with the MCO, PCCM, PIHP, or PAHP, unless the Secretary provides the State and Congress with compelling reasons for continuing the contract.

The CMO contract indicates that the contractor shall not knowingly have a relationship with debarred, suspended, or excluded individuals. The State agency policy lists these same requirements for the contractor to comply with, and includes a corrective action plan that addresses non-contract compliance. The State agency's policy does not include any direction about how the State will assure the contractor is not doing business with debarred, suspended,

or excluded providers. The State merely takes the word of the CMO. Since the State does not have any procedures to verify whether a CMO is doing business with such individuals, it will not be able to report any non-compliant relationships to the Secretary.

Recommendation: Develop and implement policies and procedures to ensure CMOs do not have a relationship with an excluded, debarred or suspended individual or entity.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

The regulations at 42 CFR §§ 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the MMIS, then the State cannot conduct adequate searches of the LEIE or the MED.

The CMS issued SMDL #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the EPLS on a monthly basis.

Upon enrollment, CMOs check network providers against the LEIE and EPLS. However, after initial enrollment only the provider applicant is checked. The CMOs do not maintain the complete information required on owners, agents, and managing employees in a searchable database. As a result, CMOs are not able to conduct comprehensive monthly exclusion and debarment searches on all applicable parties.

Recommendations: Amend the contract to the appropriate collection and maintenance of disclosure information about disclosing entities, and about 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. Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Not capturing ownership and control disclosures from network providers.
The CMOs' network provider applications for facilities do not require the name, address, DOB, SSN, or employer identification number of persons with an ownership or control interest in the provider or subcontractors that Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers. The CMO network provider is also not required to disclose the relationship of disclosed owners or interests in another disclosing entity. In addition, the CMO network provider applications do not require managing employees to provide SSN, DOB, and address.

Recommendations: Modify the managed care contract to require, or ensure that managed care provider enrollment forms require, the disclosure of complete ownership, control, and relationship information from all MCE network providers. Include contract language requiring MCEs to notify the State of such disclosures on a timely basis.

Not adequately addressing business transaction disclosures in network provider contracts.
The CMOs' network provider agreements contain no provision requiring the provider to supply the same type of business transaction information that FFS providers would be required to furnish at the request of State agencies or the HHS Secretary under 42 CFR § 455.105.

Recommendation: Modify the managed care contract to require disclosure upon request of the information identified in 42 CFR § 455.105(b).

Not capturing criminal conviction disclosures from network providers.
The CMOs do not request disclosure of criminal convictions in health care-related crimes from their network providers that Federal regulations at 42 CFR § 455.106 would otherwise require from FFS providers. The Council for Affordable Quality Healthcare credentialing form that two of the CMOs use in their internal credentialing process only asks if the provider has been denied, revoked, or suspended from Medicare, Medicaid, or other government program participation within the past three years. The applications do not request health care-related criminal conviction disclosures since the inception of the Federal programs. In addition, they do not request similar disclosures from persons with ownership or control interests, agents, or managing employees.

Recommendations: Modify the managed care contract to require, or ensure that managed care provider enrollment forms require, the disclosure of health care-related criminal convictions on the part of persons with an ownership or control interest, or persons who are agents or managing employees of network providers. Include in the contract language requiring MCEs to notify the State of such disclosures on a timely basis.

Not ensuring exclusion of certain MCEs from participation if these entities could be subject to HHS-OIG exclusion.
The regulation at 42 CFR § 1002.203 stipulates that the State must provide that it will exclude from participation any health maintenance organization (HMO), or entity furnishing services under a 1915(b)(1) waiver, if such organization or entity could be excluded under 42 CFR § 1001.1001 or § 1001.1051, or has a direct or indirect contractual relationship with an individual or entity that could be excluded under § 1001.1001 or § 1001.1051.

The State does not have a policy or any language in its contracts with the CMOs stipulating that the entity will be excluded if it has a direct or indirect contractual relationship with an individual or entity that could be excluded under 42 CFR § 1001.1001 or § 1001.1051.

Recommendation: Develop and implement policies and procedures for Georgia to exclude entities that have a direct or indirect contractual relationship with an individual or entity that could be excluded under the regulations.

Not reporting all adverse actions taken on provider participation to the HHS-OIG.
The regulation at 42 CFR §1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The State Medicaid agency does not have clear policies and procedures or contract requirements directing the CMOs to report to it any program integrity-related adverse actions the CMO takes on a provider's participation in the network, e.g., denials of credentials, enrollment, or contracts, or terminations of credentials, enrollment, or contracts. Program integrity reasons include fraud, integrity, or quality.

Recommendations: Require contracted CMOs to notify the State when they take adverse action against a network provider for program integrity-related reasons. Develop and implement procedures for reporting these actions to HHS-OIG.

Not updating MMIS data for excluded individuals.
The State provided reports with seven positive MMIS matches for individuals excluded dating back to 1998. The matches were the result of the State searching the excluded individual's SSN against the MMIS provider data fields that include provider tax identification (ID) numbers. In three instances, the excluded individual still shows as an owner or managing employee for a provider in the MMIS. However, the excluded individual had been terminated from the provider before their exclusion dates. The other four matches resulted from the excluded individual's SSN matching an unrelated provider's tax ID number.

Recommendation: Develop and implement policies and procedures to deactivate excluded individuals from MMIS provider data and conduct accurate searches to prevent inaccurate exclusion matches.

Conclusion

The State of Georgia practices several effective practices that demonstrate program strengths and the State's commitment to program integrity. These practices include:

- effective projects to identify overpayments such as the three-day readmit project,
- realignment of provider enrollment under DCH-OIG,
- use of a contractor to review dual eligible claims and identify overpayments, and
- a close relationship between CMOs and program integrity staff.

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

However, the identification of eight areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, eight areas of vulnerability were identified. The CMS encourages DCH-OIG to closely examine the vulnerabilities that were identified in this review.

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

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

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

David A. Cook, Commissioner **Nathan Deal, Governor**

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February 27, 2012

CMS Medicaid Integrity Group
Robb Miller
Director, Division of Field Operations
233 North Michigan Avenue
Suite 600
Chicago, IL 60601

Dear Mr. Miller,

Thank you for the opportunity to respond to the letter from Angela Brice-Smith, Medicaid Integrity Group Director, dated January 27, 2012 and the accompanying report.

Enclosed with this letter you will find the Departments Corrective Action Plan (CAP) addressing the various deficiencies and vulnerabilities. The CAP is formatted as requested. The Department will continue to improve on processes for the identifying and recovery of overpayments as evidenced within this CAP.

Should you have any questions or concerns please contact me at 404-651-8681.

Sincerely,

Jerry Dubberly, Pharm. D.
Director, Medicaid Division

Enclosures