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Center for Program Integrity

Idaho Focused Program Integrity Review

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Idaho 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. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2010.

Background: State Medicaid Program Overview

Idaho's Medicaid program is administered through the Department of Health and Welfare (IDHW). The Division of Medicaid (DOM) is the division primarily responsible for Medicaid fee-for-service (FFS), primary care case management (PCCM), MCOs, prepaid ambulatory health plans (PAHPs), claims payments, and provider enrollment. The Division of In-direct Services is responsible for all program integrity activities.

Idaho initiated managed care in 2006 with the Healthy Connections PCCM program, which operated statewide. The state contracted directly with primary care physicians to manage care for Medicaid enrollees in the Healthy Connections program. Primary care providers were used to deliver and coordinate primary care and authorize referrals to specialty services. Enrollment with a primary care provider was mandatory for beneficiaries in 42 of 44 counties. Primary care providers were paid a monthly per-member case management fee in addition to the regular Medicaid fee-for-service reimbursement. The state also contracted with prepaid, limited benefit plans to provide dental, transportation, and behavioral health benefits. At the time of the review, Idaho had contracts with four plans to provide managed health care services. Those plans are: Blue Cross of Idaho (BCI), Managed Care of North America (MCNA), Optum of Idaho (Optum), and Molina Healthcare of Idaho (Molina Healthcare was not included in this PI review).

As of June 1, 2018, the program served approximately 278,205 Medicaid beneficiaries. Idaho has a Medicaid managed care program which operates statewide and serves approximately 247,407 beneficiaries, or 89 percent of Idaho's Medicaid population. At the time of the review, the Idaho Medicaid program had 40,218 participating FFS providers. Idaho had four MCOs and a total of 815,045 providers were enrolled in the state's managed care program. Total Medicaid expenditures for federal fiscal year (FFY) 2017 were approximately $2.1 billion. Total capitated payments to MCOs during FFY 2017 were approximately $259.3 million or 12 percent of the total Medicaid expenditures. Idaho elected not to expand Medicaid coverage to low income adults. The Federal Medical Assistance Percentage in Idaho is 71.17 percent.

Methodology of the Review

In advance of the onsite visit, CMS requested that Idaho and the MCOs 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-member review team has reviewed these responses and materials in advance of the onsite visit.

During the week of July 16, 2018, the CMS review team visited the IDHW. It conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with the state's MCOs 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 MCOs' program integrity practices.

Results of the Review

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

Approximately 247,407 beneficiaries, or 89 percent of the state's Medicaid population, were enrolled in three MCOs during FFY 2017. The state spent approximately 259.3 million on managed care contracts in FFY 2017.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review: BCI, Managed Care of North America (MCNA), and Optum Idaho.

The BCI is a not-for-profit insurance company. The BCI's provider network in Idaho include more than 2,400 contracting providers. The BCI's managed care SIU is located within their compliance division and has seven staff members. The SIU at BCI works closely with internal departments and external contacts in all cases of suspected fraud, waste, and abuse and conducts its own exploratory reviews designed to identify referrals. The SIU contracts with multiple post payment audit vendors to conduct an array of concept audits. These vendors do not submit reports, rather they identify issues/overpayments and coordinate corrective action with the SIU. In addition, the SIU conducts an annual fraud, waste, and abuse risk assessment of all known fraud schemes, as well as potential areas of waste and abuse. The BCI conducts on average one announced site visit annually, however, they advised that unannounced site visits are not conducted on an annual basis.

The MCNA is a dental benefits manager providing services to state agencies and MCOs for their Medicaid, Children's Health Insurance Program, and Medicare members serving approximately 4 million children and adults. The MCNA's Program Integrity Unit (PIU) for Idaho is housed in the MCNA office in Lincoln, Nebraska. The PIU team members are responsible for all activities related to the Idaho fraud, waste, and abuse program and works closely with the corporate SIU for activities related to data analysis. Clinical reviewers conduct medical necessity reviews and

deliver provider education in conjunction with the Idaho provider relations team. The PIU/SIU covering the Idaho program consist of six staff members. The MCNA's PIU/SIU coordinates unannounced provider site visits through the provider relations department. The provider relations representatives also conduct weekly unannounced drop-in visits to monitor provider office conditions. Additionally, the PIU/SIU conducts separate unannounced on-site provider audits related to ongoing fraud, waste, and abuse case investigations. The MCNA does not contract with any entity to conduct program integrity activities.

Optum is a health care company that manages the outpatient behavioral health benefits for the IBHP for Idaho Medicaid members and the IDHW. Idaho Medicaid is Optum's only line of business in Idaho. Currently they serve approximately 268,224 members as of June 2018. Optum operates under the umbrella of United Behavioral Health and provides services in each of the seven geographical regions of the state. Optum has provided benefits in the state of Idaho since 2013. Optum's SIU is comprised of one (1) full-time equivalent (FTE) dedicated 100 percent to the Idaho Behavioral Health Plan contract (as of November 2017), who works in collaboration with Optum's national program integrity team located in Eden Prairie, Minnesota. Optum's national team is comprised of 104 FTEs supporting the national program, including Idaho.

Enrollment information for each MCO as of June 2018 is summarized below:

Table 1.

	BCI	**MCNA**	**Optum**
Beneficiary enrollment total	2,996	275,119	268,224
Provider enrollment total	482	553	1,534
Year originally contracted	2007	2017	2013
Size and composition of SIU	7 FTEs	6 FTEs	18 FTEs
National/local plan	Local	National	National

Table 2.

MCOs	**FFY 2015**	**FFY 2016**	**FFY 2017**
BCI	$10.2 million	$17.8 million	$22.3 million
MCNA	-0-	-0-	$34.5 million
Optum	$110.3 million	$105.2 million	$99.6 million

*MCNA did not start providing services until 2017

State Oversight of MCO Program Integrity Activities

The DOM is responsible for programmatic oversight, but delegate's program integrity related functions to the contractor and the Bureau of Audits and Investigations (BAI) for all fraud, waste, and abuse activities.

The Office of Mental Health and Substance Abuse (OMHSA) under the Medical Care Unit in the DOM is responsible for programmatic oversight for the Optum contract. Fraud, waste and abuse

activities have been delegated to the contractor. Collaboration does occur with the PIU and monitoring activities are conducted by the OMHSA staff.

The Contracts Unit within the Medical Care Unit, under the DOM, is responsible for managed care programmatic oversight for the MCNA contract. Oversight of the dental program does not include fraud and abuse-related activities; specific fraud and abuse-related activities have been delegated to the contractor; however, the contracts unit does include program integrity provisions as it relates to the contract requirements such as reviewing reports and participating in quarterly meetings between the contractors PIU and the state's Medicaid PIU. The MCNA PI staff will meet with IDHW PI and MFCU staff on August 7, 2018. Information needed to be included in referrals to IDHW will be discussed and clarification obtained.

The BLTC, under the DOM, is responsible for managed care programmatic oversight for MMCP providers BCI and Molina. Fraud and abuse related activities have been delegated to the contractor, while the BLTC retains contract monitoring oversight of this function.

The BCI and MCNA reports their open and closed cases to the state on a quarterly basis. Optum reports their open and closed cases to the state on a monthly and quarterly basis.

Idaho's MCO contract states, "The Health Plan shall have a mechanism to verify, by sampling or other methods, whether services that have been delivered by network providers were received by enrollees and the application of such verification processes on a routine basis." The BCI, MCNA, and Optum follow the requirement to verify that services billed by providers were received by beneficiaries. However, during the interview with state staff; the review team discovered that the state does not have policies and procedures in place to ensure that the MCOs are verifying beneficiary services.

MCO Investigations of Fraud, Waste, and Abuse

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

Idaho's contract with the MCOs does not require the MCOs to refer directly to the MFCU, instead the state requires all preliminary investigations to be referred to BAI, who is then responsible for case referral to the MFCU after a credible allegation of fraud has been determined.

Additionally, Idaho's MCO contract states, "that MCOs must cooperate with all appropriate state and federal agencies in investigating fraud, waste, and abuse; comply with all federal and state requirements regarding fraud waste and abuse, including but not limited to IDAPA 16.05.07 and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act; and furnish the IDHW, the Secretary of the U.S. Department of Health and Human Services Office of Inspector General (DHHS OIG), or Idaho Medicaid Fraud Control Unit (MFCU), with such information regarding payments claimed for services provided under these programs within ten (10) business days of

request, unless an expedited turnaround time is requested at which point the contractor shall comply with the request timeframe.

The contract further states that the MCOs, "should have methods for identification, investigation, and referral of suspected fraud cases. Report all tips and confirmed or suspected fraud and abuse to IDHW and MFCU with IDHW-specified timeframes. Investigate all incidents of suspected and/or confirmed fraud and abuse. Reporting of fraud and abuse activities as required in the Reports Section, including the number of complaints of fraud and abuse that warrant preliminary investigation. For each which warrants investigation, reporting of the Enrollee's name and identification, source of complaint, type of provider, nature of complaint, approximate dollars involved, and legal and administrative disposition of the case. The Contractor shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider is subject to IDAPA 16.05.07 which gives authority for IDHW to establish and enforce rules to protect the integrity of public assistance programs against fraud, abuse and other misconduct and provides the authority for IDHW to investigate and identify instances of fraud, abuse or other misconduct and recover overpayments from the provider and assess civil monetary penalties."

The BCI's SIU coordinates the investigations of potential cases of fraud, waste, and abuse. When a referral is received into the SIU, screening is initiated within five working days to determine the validity. Determining whether a referral has merit and warrants further investigation is facilitated through a process of initial information gathering and/or data analysis. Referrals with enough evidence to pursue an investigation are entered into the SIU case tracking system. All active cases in the SIU case tracking system are reviewed and updated, at minimum, every 30 calendar days. Once the investigation begins, the investigator works with management, and other individuals as needed to determine the scope of the investigation and the resources required. If the investigation uncovers potentially fraudulent or abuse activities, and affirmative action is forthcoming, the investigator notifies the appropriate agency. At the conclusion of each investigation, the investigator documents findings and observations into a case report. The case report includes a summary of findings, observations, and recommendations in a format that can be shared with other BCI departments. During the onsite review, BCI confirmed that the state has not provided guidance to the plan on the elements it would like to see in a referred case. Additionally, the state does not notify BCI of their acceptance of a referral.

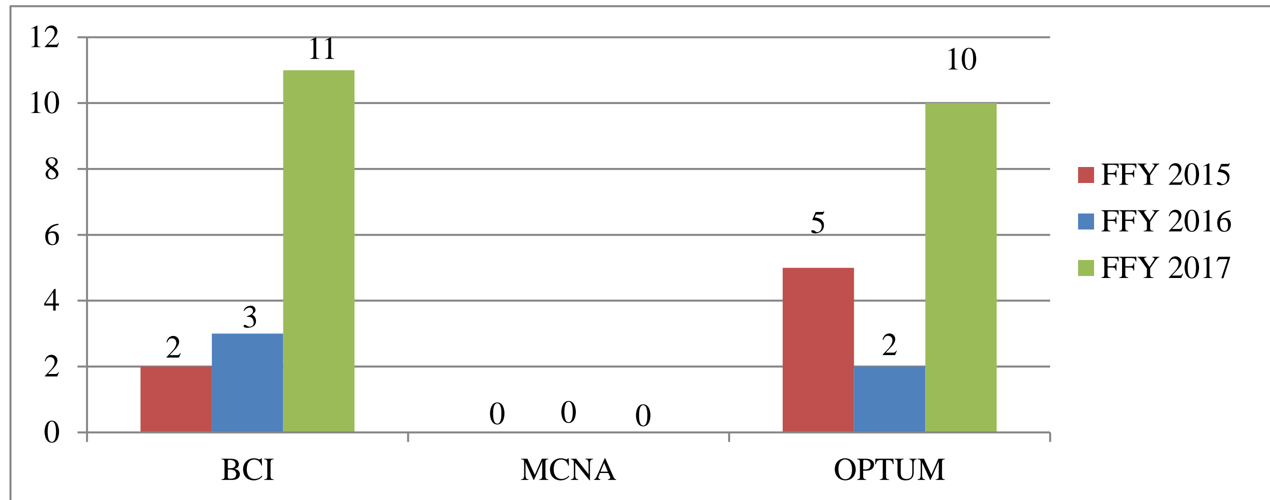
The MCNA's PIU/SIU is responsible for conducting preliminary and full investigations. Once it has been determined that a full investigation is warranted, within 15 business days from the conclusion of the preliminary investigation and referral to the appropriate regulatory agency, the PIU/SIU investigator will select a random sample of member dental records for further review. Once the investigator is completed with their administrative review of the records, they are forwarded to the clinical reviewer to review the records for medical necessity and quality of care. Upon completion of the full investigation, the PIU/SIU investigator will complete the final investigations report and submit it to the PIU/SIU officer and vice president of program integrity to review the case for accuracy and completeness. Upon approval, the PIU/SIU investigator will update the original referral to the appropriate regulatory agency either confirming the suspicion or identifying other outcome. The PIU/SIU investigator notifies the provider of the findings of the investigation, including any identified overpayments and discrepancies. All activities related

to the investigation are documented in the PIU/SIU's case management system within DentalTrac. The MCNA must provide the IDHW with information related to all payment recoupments, to include recoupments made on the basis of audit findings, in the quarterly program activities report. Recoupments from fraud, abuse, and misuse of Medicaid funds and resources shall be in accordance with Code of Federal Regulations and the IDHW rules for recoupment. They notify the IDHW, and the Medicaid PIU via the Medicaid PIU SharePoint site, within five business days, when concerns and/or allegations of any fraud, waste, and abuse are authenticated. This information shall also be reported to the IDHW in the quarterly program integrity activities report. During the onsite review, MCNA confirmed that the state has not provided guidance to the plan on the elements it would like to see in a referred case.

Optum's new case notifications and confirmed fraud, waste, or abuse notifications are sent to a secure database which is maintained in SharePoint and operated by the state's Medicaid PIU. Optum does not have a formal audit work plan, which is in violation of their MCO contract. Optum meets monthly with the states PIU and on an as needed basis with the MFCU to discuss concerns applicable to potential fraud, waste, and abuse and actively investigates concerns identified both internally and at the direction of the state. Optum adjusts fraud, waste, and abuse mitigation strategies based on identified concerns and trends. Optum's Program Network Integrity (PNI) team has a SIU that is located throughout the United States which supports all lines of business for Optum nationally. The SIU has investigators and senior investigators that are focused regionally. In addition, in some markets a dedicated investigator located in that market is assigned to focus on that market's fraud, waste, and abuse cases. For Optum, there is one such dedicated investigator, and the backing of the national team as needed. The majority of SIU activities are performed at the national/corporate level. Optum PNI SIU assesses national caseloads and contractual requirements to ensure adequate SIU staffing is in place to support total SIU caseloads. Contractual, regional, and market-specific caseloads are reviewed to ensure adequate caseload balancing. The PNI team works with providers to identify billing as well as payment patterns and trends which may require education or modification of practices or processes on the part of the provider or Optum. Overpayments are identified by Optum's PNI retrospective investigations team and are collected by Optum's payment integrity recovery team. The state has provided a template on the elements needed to report a case, which is utilized by Optum PNI.

Table 3 lists the number of referrals that BCI, MCNA, and Optum SIU's made to Idaho in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by the MCOs is low, compared to the size of the plan. The level of investigative activity has changed over time.

Table 3.



*MCNA did not start providing services until 2017

MCO Compliance Plans

The state does require its MCOs 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 MCO's compliance plan and communicates approval/disapproval with the MCOs.

According to IDHW contract requirements with the MCOs, "they should have a written fraud and abuse compliance plan. A paper and electronic copy of the fraud and abuse compliance plan shall be provided to IDHW PIU within 90 calendar days of the contract effective date and annually thereafter. The IDHW will provide notice of approval, denial, or modification of the fraud and abuse compliance plan to the health plan within 30 calendar days of receipt. The health plan shall make any requested updates or modifications available for review to IDHW as requested by IDHW and/or the IDHW PIU within 30 calendar days of a request." The BCI provided the review team with a copy of their compliance plan from 2016.

Optum did not submit their compliance plan to the state in 2017, which was in violation of their MCO contract. The BCI and MCNA provided the review team with a copy of their compliance plan that has been submitted to the state. A review of the submitted compliance plans revealed they were in compliance with 42 CFR 438.608.

Encounter Data

The BCI contract with the state requires the MCO to implement and maintain policies and procedures to support encounter data reporting and submission and provide an encounter data work plan prior to implementation and update the work plan at least annually. The BCI should submit timely encounter data submissions and should include; original claim submissions paid or

denied, reversed claims, adjusted claims and voided claims. Pended claims are not required; weekly submissions of financial data paid on behalf of Idaho Medicaid participants; and weekly submissions of provider related data, including existing data, new additions and changes as specified in the encounter on-boarding manual. The BCI ensures submissions are accurate including all required data elements, validating that actual services were provided and accurately adjudicated; meet any encounter reporting requirements that are in place for Medicaid MCOs as may be updated from time to time to meet state and federal reporting requirements; ensure the health plan's systems generate and transmit encounter data files according to IDHW-approved specifications; maintain processes to ensure the validity, accuracy, and completeness of the encounter data, including any sub-capitation encounter data, in accordance with the standards specified in this section. IDHW provides technical assistance to the health plan for developing the capacity to meet encounter reporting requirements, collecting and maintaining encounter data for all covered services provided to enrollees. The BCI has access to all levels of data within the MCO to conduct data mining and to analyze claims data. The BCI utilizes proprietary algorithms in order to conduct the analysis done by the SIU investigators. The investigators have the ability to create standard and ad hoc reports on an as needed basis. This is in addition to customized reports created at the request of the SIU.

The MCNA contract with the state requires the MCO to implement and maintain policies and procedures to support encounter data reporting and submission and to provide an encounter data work plan prior to implementation and update the work plan at least annually. The MCNA is required to produce encounter data in an electronic format that adheres to the IDHW's approved data specifications for content, content definitions, format, file structure, and data quality. The submitted encounter data is required to meet federal and state reporting requirements, and be submitted weekly to the Medicaid Management Information System (MMIS) in a mutually agreed file format and timeline as defined by the IDHW, MMIS vendor, and MCO. The MCNA should reconcile all encounter data being sent against the data being loaded monthly and provide the reconciliation to the IDHW on the tenth business day of the month. The MCNA's PIU/SIU has access to all levels of claims data to conduct data mining. The MCNA utilizes various algorithms for the detection of fraud. The MCNA's profiling reports are generated weekly, monthly, and on an ad hoc basis.

The Optum contract with the state requires the submission of encounter data to the IDHW and or its designee on all IBHP services; the contractor shall submit data certifications for all data utilized for the purposes of rate setting; ensure data certification includes certification that data submitted is accurate, complete, and truthful and that all encounters are for services provided to or for enrolled members per state and federal requirements; ensure data submission complies with the federal confidentiality requirements of 42 CFR Part 2, and may require the development of Qualified Service Organization Agreements; and submit encounter claims data to the IDHW for submittal to the MMIS on a monthly basis, no later than 30 calendar days following the data collection month. The IDHW reserves the right to change format requirements at any time following consultation with the contractor and retains the right to make the final decision regarding format submission requirements. Optum will submit an electronic file of all finalized encounter data, including those of its subcontractors to the IDHW and or its designee. Encounter data shall be in the format mutually agreed on by the IDHW and the contractor.

The review team determined from the interview with BCI that they have not submitted encounter data to the state, however, BCI is currently in the testing phase and once completed they advised they will submit encounter data to the state on a weekly basis. Currently, BCI is awaiting feedback from IDHW on the test files loaded to the database, in order to move forward with encounter data submission. The MCNA and Optum submits encounter data to the state as required.

Overpayment Recoveries, Audit Activity, and Return on Investment

Idaho's MCO model contract states, "the health plan is entitled to retain recoveries of overpayments to network providers related to FWA". In addition, Idaho's MCO model contract does require the MCOs to report on overpayments recovered from providers as a result of MCO program integrity activities.

The MCO contract with the state also requires all MCOs to maintain policies and procedures for treatment of recoveries made by the MCO of overpayments to providers in accordance with 42 CFR 438.606(d). The state requires the MCOs to include in any of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider is subject to IDAPA 16.05.07 which gives authority for IDHW to establish and enforce rules to protect the integrity of public assistance programs against fraud, abuse, and other misconduct and provides the authority for IDHW to investigate and identify instances of fraud, abuse, or other misconduct and recover overpayments from the provider and assess civil monetary penalties. The contract stipulates that the MCO has twelve months from the date a service is billed to audit the service. After twelve months, the IDHW has the right to audit and recover identified overpayments, and once the provider agrees to the findings or exhausts all appeal rights, overpayments will be recovered from the MCO.

All three MCOs submitted overpayment information on a monthly and quarterly basis as required per contract language.

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

Table 4-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2015	13	10	$42,376.00	$42,376.00
2016	36	14	$77,961.82	$77,961.82
2017	88	17	$72,387.72	$72,387.72

The BCI's preliminary investigations significantly increased in FFY 2016 and FFY 2017 due to all cases are now triaged by the SIU manager; increase in staff; and more efficient processes have been implemented. The BCI's recovered overpayments from providers as a result of its fraud and abuse investigations are tracked by their Claims Quality Control and Audit unit.

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

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2015	-0-	-0-	$0.00	$0.00
2016	-0-	-0-	$0.00	$0.00
2017	8	-0-	$0.00	$0.00

The MCNA became contracted with the state in 2017. The MCNA's identified and recovered overpayments are tracked by their finance department which is located in Florida and reports are sent to the state on a quarterly basis.

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2015	59	56	$10,450	$10,450
2016	31	31	$76,768	$47,895
2017	20	18	$31,271	$40,514

During the interview process, Optum attributed the decrease in cases to the fact the state has been very clear on the types of case referrals they would like to see. Once reported, Optum investigates all cases from inception through reconciliation. Although fewer cases were identified, overpayments identified and recovered showed an increasing trend since FFY 2016. The increase in overpayments recovered over overpayments identified for FFY 2017 was attributed to one case having a payback period of eighteen months. The Optum's fraud, waste, and abuse tips are handled by a national intake and validation team within Optum's PNI. Upon completing the intake and validation procedures, cases requiring further investigation are assigned based upon contractual requirements, regional assignments, caseloads, and/or SIU manager direction. As of May 2018, the average national caseload per Optum PNI SIU investigator was 60.4 open cases.

Overall, the amount of overpayments identified and recovered by the MCOs appears to be low for a managed care program of Idaho's size. Although MCOs are not required to return overpayments from their network providers to IDHW, it is important that the IDHW obtain a clear accounting of any recoupments, since these dollars are factored into establishing annual rates. Without these adjustments, the rates paid to these MCOs may be inflated per member per month.

Additionally, the review team discussed cost avoidance measures with the MCOs reviewed. The BCI, MCNA, and Optum do utilize prepayment review to ensure that the provider's

documentation supports the claims billed services. However, only Optum placed a provider on prepay review in the last complete FFY.

Payment Suspensions

In Idaho, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language mirroring the payment suspension regulation at 42 CFR 455.23, however, when reviewing the MCO contracts for suspension language, MCNA's contract did not contain the appropriate language. The MCNA and Optum did provide a suspension policy to the CMS review team, however, BCI does not have a payment suspension policy.

Additionally, BCI and MCNA informed the CMS review team that the state has not provided guidance on handling payment suspensions based upon a pending investigation of a credible allegation of fraud.

Terminated Providers and Adverse Action Reporting

The state MCO contract states, "the Contractor shall submit monthly lists of all involuntary provider terminations (including providers termed due to sanctions, invalid licenses, or program integrity concerns). Include in the report the effective date of the termination, provider ownership, basis for termination and length of termination."

The BCI notifies the state when a MMCP provider is terminated for any reason and for cause to the states PIU. The BCI's healthcare operations team receives notifications from the states PIU regarding providers whom have been terminated for cause. The email is then forwarded to provider network management for processing the termination and creating the termination letter which is sent to the provider and the provider information management team so the provider can be terminated in the BCI system. In addition, the BCI will notify the enrollees of terminated providers within 15 calendar days in accordance with the MCO contract requirements.

The MCNA does submit a termination report to the state. The MCNA has not received any provider termination notices from the state in the past three FFYs. Should MCNA receive a notice of termination, the provider would be removed from the network and a notice would be sent to the provider stating the reason for termination. In addition, the MCNA will notify the members of terminated providers within 15 business days in accordance with the MCO contract requirements.

Optum notifies the state when a provider is terminated for any reason and for cause to the states PIU. The MCO will notify the network provider in writing when a determination is made to terminate a provider from the network and ensure prior written notice includes details pertaining to the decision to terminate. Optum also ensures IDHW is notified within two business days if a provider fails to meet licensing criteria, or if the MCO decides to terminate, suspend, limit, or materially change qualified service providers or subcontractors. Notifications to the state are sent via the monthly report OR-54. Notifications are not sent to other MCOs. Additionally,

Optum will notify the enrollees of terminated providers within 15 calendar days in accordance with the MCO contract requirements.

Table 5:

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated for Cause in Last 3 Completed FFYs	
BCI	2015	3	2015	2
	2016	7	2016	3
	2017	3	2017	-0-
MCNA	2015	-0-	2015	-0-
	2016	-0-	2016	-0-
	2017	13	2017	-0-
Optum	2015	36	2015	3
	2016	34	2016	1
	2017	30	2017	1

*MCNA did not start providing services until 2017

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

Idaho reported to the CMS review team that they are downloading and checking the monthly Medicare revocation list and providing the downloaded TIBCO list of terminated providers to their MCOs to assist in identifying providers who should be terminated from the plans' networks.

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.

The onsite review team confirmed that BCI, MCNA, and Optum were all collecting and storing required disclosure information and conducting required federal database checks, however, MCNA was not in full compliance with checking all required federal database checks. The MCNA does not check the SSA-DMF.

Recommendations for Improvement

- The state should consider conducting onsite announced and unannounced visits at the MCOs to verify compliance with its fraud and abuse contract requirements.

- The state should ensure that policies and procedures are in place to ensure that the MCOs are verifying beneficiary services.

- The state should work with the MCOs to develop specific program integrity training to develop and enhance the quality of case referrals from the MCOs; provide more frequent feedback to the plans on the cases they refer to the state; and ensure that all SIU staff receive appropriate training in identifying and investigating potential fraudulent billing practices by providers.

- The state should ensure MCOs are in compliance with contractual requirements for submitting their audit work plan.

- The state should ensure all MCOs submit a compliance plan and be reviewed by the state on an annual basis in accordance with federal regular 42 CFR 438.608.

- The state should continue efforts to improve their ability to analyze encounter data and perform data mining activities to identify fraud, waste, and abuse issues with MCO network providers.

- The state should verify that identified and collected overpayments are fully reported by the MCOs and that these amounts are incorporated into the rate-setting process.

- The state should work with MCOs to develop policies consistent with the payment suspension requirements in the federal regulation at 42 CFR 455.23. The state should provide training to its contracted MCOs 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.
- The state should ensure all MCO contracts contain payment suspension language.

- The state should monitor the MCOs' compliance with contractual requirements for conducting monthly checks on the SSA-DMF, upon enrollment and reenrollment.

Section 2: Status of 2010 Corrective Action Plan

Idaho's last CMS program integrity review was in November 2010, and the report for this review was issued in June 2011. The report contained 3 regulatory compliance issues and 6 vulnerabilities. During the onsite review in July 2018, the CMS review team conducted a thorough review of the corrective actions taken by Idaho to address all issues reported in calendar year 2010. The findings of this review are described below.

Regulatory Compliance Issues -

1. ***The state does not capture all required ownership, control, and relationship information from FFS providers, the NEMT broker, the dental managed care entity (MCE) and the dental services subcontractor.***

   Status at time of the review: Corrected

   Idaho provided the CMS review team with a copy of the revised enrollment application and revised contract for the FFS providers, NEMT broker, the dental MCE, and the dental services subcontractors.

2. ***Idaho's provider enrollment agreement does not require disclosure of business transactions, upon request, from FFS providers, the NEMT broker, the MMCP PAHP entities and the dental MCEs. (Uncorrected Repeat Finding 2008)***

   Status at time of the review: Corrected

   Idaho provided the CMS review team with a copy of the revised provider enrollment agreement and revised state contract for the FFS providers, NEMT broker, MMCP PAHPs, and the dental MCEs.

3. ***Idaho does not capture criminal conviction information from all required parties in its FFS program and from its dental MCE. (Uncorrected Partial Repeat Finding 2008)***

   Status at time of the review: Corrected

   Idaho provided the CMS review team with a copy of the revised enrollment application and revised contract for the FFS providers and the dental MCE.

4. ***Not capturing managing employee information on FFS provider enrollment forms.***

   Status at time of the review: Corrected

   Idaho provided the CMS review team with a copy of the revised enrollment application for the FFS providers.

5. ***Not collecting ownership and control disclosures from NEMT subcontractors and the PAHP and dental network providers. (Uncorrected Partial Repeat Vulnerability 2008)***

   Status at time of the review: Corrected

   Idaho provided the CMS review team with a copy of the revised enrollment application and revised contract for the NEMT subcontractors, PAHP, and the dental network providers.

6. ***Not requiring business transaction disclosures from the MMCP PAHP and dental network providers. (Uncorrected Repeat Vulnerability 2008)***

   Status at time of the review: Corrected

   Idaho provided the CMS review team with a copy of the revised provider enrollment agreement for the MMCP PAHP and dental network providers.

7. ***Not requiring disclosure of health care criminal convictions from the MMCP PAHP network providers. (Uncorrected Partial Repeat Vulnerability 2008)***

   Status at time of the review*:* Corrected

   Idaho provided the CMS review team with a copy of the revised provider enrollment agreement for the MMCP PAHP network providers.

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

   Status at time of the review: Corrected

   Idaho provided the CMS review team with policies and procedures to perform monthly provider database checks.

9. ***Lack of effective coordination and communication within the state agency and between the state and the MFCU. (Uncorrected Partial Repeat Vulnerability 2008)***

   Status at time of the review: Corrected

   Idaho reported that they are utilizing the MIG's Best Practices for Medicaid PI units' interactions with MFCU. Idaho also reported ongoing effective internal coordination and communication within the state agency.

Technical Assistance Resources

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

- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which may help address the risk areas identified in this report. Courses that may be helpful to Washington 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.
- 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.
- CMS provides a fraud prevention toolkit located on CMS.gov that includes:
    - The 4Rs (Record, Review, Report, and Remember) brochure
    - Fact sheets on preventing and detecting fraud
    - Frequently Asked Questions
    - The CMS.gov website also contains information regarding the Center for Program Integrity and fraud prevention efforts in Original Medicare (FFS), Parts C and Part D, and Medicaid. For more information on the fraud prevention toolkit, visit CMS.gov/outreach-and-education/outreach/partnerships/fraudpreventiontoolkit.
    - For the latest news and information from the Center for Program Integrity, visit CMS.gov/about-cms/components/cpi/center-for-program-integrity.html.

Conclusion

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

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

Additionally, if the CMS focused review identified noteworthy and best practices in your state, they will be published and shared with others states so that they may consider those enhancements to their own state Medicaid programs.

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