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Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Delaware Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

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

This review focused on the activities of the Division of Medicaid and Medical Assistance (DMMA) within DHSS. The DMMA is responsible for Medicaid program integrity activities. This report describes two effective practices, four regulatory compliance issues, and six 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 Delaware improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Delaware's Medicaid Program

The DHSS administers the Delaware Medicaid program. In calendar year 2008, the program provided services to 158,269 recipients. Delaware has enrolled 160,765 recipients in fee-for-service (FFS) Medicaid and 119,044 unduplicated recipients in its managed care programs. Delaware has two managed care organizations (MCO) and one primary care case management program (PCCM).

At the time of the review, DHSS had 8,222 participating Medicaid FFS providers. The managed care program had 6,772 MCO providers and 8,824 PCCM providers. Medicaid expenditures in Delaware for the State fiscal year (SFY) ending June 30, 2009, totaled $407,167,698. The Federal medical assistance percentage (FMAP) for Delaware for Federal fiscal year (FFY) 2009 was 50.00 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 60.19 percent in the first three quarters of FFY 2009 and 61.59 percent in the fourth quarter.

Program Integrity Division

The DMMA, within the DHSS, is the organizational component dedicated to fraud and abuse activities. At the time of the review, the DMMA had 22 of 23 authorized full-time equivalent (FTE) employees focusing on Medicaid program integrity. From SFY 2006 through SFY 2009, DMMA staff conducted an annual average of 23 preliminary investigations and 2 full investigations. The table below presents the total number of investigations and overpayment amounts identified and collected for the last four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2006	24	1	$336,875	$336,875
2007	5	2	$378,552	$378,522
2008	25	1	$126,125	$126,125
2009	39	7	$1,109,882	$1,053,771

*Figures represent cases investigated by DMMA staff. Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Figures represent cases referred to the MFCU. 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.

Methodology of the Review

In advance of the onsite visit, the review team requested that Delaware 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 four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of November 2, 2009, the MIG review team visited the DHSS and MFCU offices. The team conducted interviews with numerous DHSS officials, as well as with staff from the State's provider enrollment contractor and the MFCU. In order to determine whether managed care plans were complying with the contract provisions and Federal regulations relating to program integrity, the MIG team reviewed the State's MCO contracts. The team conducted in-depth interviews with representatives from two MCOs and met separately with DHSS staff to discuss managed care oversight and monitoring efforts. The team also conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the DMMA. Delaware's Children's Health Insurance Program is a stand alone program operating under Title XXI of the Social Security Act and was, therefore, not included in this review.

Unless otherwise noted, DHSS provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that DHSS provided.

RESULTS OF THE REVIEW

Effective Practices

The State of Delaware has highlighted a practice that demonstrates its commitment to program integrity. This involves DMMA's active engagement in building relationships with its MCOs.

Active engagement in building relationships with contracted MCOs

In October 2008, the DMMA's Surveillance and Utilization Review (SUR) Unit actively began to build relationships with the MCOs by convening quarterly meetings with MCO program integrity staff. All attendees presented information regarding their internal program integrity efforts at the initial meeting. In subsequent quarterly meetings, MCO representatives provided updates on fraud and abuse activities and processes, while the State shared lists of providers that are currently under review. This has allowed the MCOs to proactively check their provider networks for similar problems with the provider. The regular meetings have enabled MCO and FFS program integrity staff to work together when problems are detected. One example of this effective relationship was the State's ability to do a more complete investigation on three targeted FFS providers than would have been possible had there been no feedback about these providers' questionable activities in managed care. At the last quarterly meeting on October 13, 2009, the MFCU attended and shared case information as well. The SUR Unit has also developed a form for referrals and shared it with the MCOs. The MCOs have begun using the new form, which enables reporting to be done in a uniform way.

As a means to make the quarterly State-MCO meeting even more effective, Delaware might consider requiring the MCOs to submit formal reports of their investigative activities and referrals. These formal reports would be useful in evaluating levels of activity, trends, or prior communications about problem providers.

Additionally, the MIG review team identified one practice that is particularly noteworthy. The CMS recognizes Delaware's enhanced program integrity efforts following an internal reorganization in 2007.

Enhanced program integrity activities following the program integrity component's reorganization.

The State Medicaid agency in Delaware initiated a reorganization of its program integrity component in May 2007. The reorganization did much to strengthen the State's program integrity operations. The change has led to significant increases in a number of indicators of program integrity effectiveness, such as audits, recoveries, and referrals to the MFCU.

As part of the reorganization, Delaware's program integrity operations grew from a single SUR Unit with four staff FTEs to a larger component that consists of the SUR Unit, a Claims Resolution Unit, a Third Party Liability Unit, and an Edits and Audit and Code Maintenance Unit. This enlargement included an increase in FTEs from 4 to 23 (current SFY 2010 authorization). Key additions to the expanded component include

nurses, social service administrators, auditors, and a data analyst. The additional staff allows the State to effectively conduct more prepayment and post-payment claims reviews and identify, investigate, and refer more cases to the MFCU.

The result has been an increase in the number of closed desk and field audits from 5 in SFY 2007 to 39 in SFY 2009. Total program integrity-related recoveries increased from an average of $281,000 per year in SFYs 2006-08 to approximately $1,100,000 in SFY 2009 (not including global settlements). Likewise, the number of fraud and abuse referrals to the MFCU, which averaged one per year in SFY 2006-08, increased to seven in SFY 2009. These 7 referrals were in addition to the 14 fully-researched pre-referral cases which the DMMA sent to the MFCU that year for evaluation and recommendation per a post-reorganization process that has developed between the two organizations.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding ownership and control and health care-related criminal conviction disclosures, the prohibition of payments to excluded providers, and the notifications that the State must make when providers are excluded from the Medicaid program.

The State does not capture all required ownership, control, and relationship information in its FFS operations from providers and from the fiscal agent. (Repeat Finding)

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person 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. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person 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. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

This is a repeat finding from the previous MIG program integrity review in July 2007. The DMMA uses a form called the DMMA Disclosure of Ownership and Control Interest Statement to collect ownership, control and disclosure information from FFS providers during enrollment. The form and the enrollment application do not request the information required by 42 CFR § 455.104 on persons having an ownership or control interest of 5 percent or more in any subcontractor. The form also does not ask if any of the persons identified as having ownership and control interests are related to one another as parent, child, sibling or spouse. Following the

2007 MIG review, Delaware created a new disclosure form in an effort to comply with the regulation, but the State was not able to implement the form for budgetary reasons.

In addition, based on interviews with DMMA staff and the fiscal agent, as well as State responses to the review guide, the team determined that disclosures required under 42 CFR § 455.104 are not collected for DMMA's fiscal agent.

Recommendations: Modify all provider enrollment forms, applications and contracts to capture the required ownership, control, and relationship information. Obtain necessary disclosures from all providers and from the fiscal agent.

The State does not require criminal conviction disclosures from managing employees of MCOs and the transportation broker.

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 the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) whenever such disclosures are made.

The MCO and transportation broker contracts do not contain language requiring the MCOs and the transportation broker to collect health care-related criminal conviction disclosures from their own managing employees or contractors. This prevents DMMA from complying with the regulation at 42 CFR § 455.106(b)(1) requiring that the State agency notify HHS-OIG of such disclosures in the required 20 day timeframe.

Recommendations: Modify the MCO and transportation broker contracts to meet the full criminal conviction disclosure requirements of the regulation. Develop and implement a procedure to report criminal conviction information to HHS-OIG within 20 working days.

The State enrolled and paid an excluded provider.

The regulation at 42 CFR § 1001.1901(b) states that when a provider has been excluded by HHS-OIG, Federal health care programs are prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities unless and until the provider has been reinstated by HHS-OIG.

The State provided the team with a list of providers against whose participation in the Medicaid program the State agency had taken adverse action in the past four SFYs for case sampling. The list contained three entries (two pharmacies and one provider) whose records were sampled onsite. The review of the case files revealed that the provider was a psychiatrist in Delaware who had been excluded by the HHS-OIG on 10/13/98. During a demonstration of the provider enrollment process, the fiscal agent reported that this provider subsequently furnished an incorrect Social Security Number and was mistakenly reenrolled. At the time of reenrollment, the fiscal agent was not accepting an actual copy of the Social Security card, nor in this case did

the fiscal agent check the provider's name in HHS-OIG's List of Excluded Individuals/Entities (LEIE). According to Delaware's case summary, from 07/15/06 to 07/15/09 Medicaid paid the provider $172,211.39. At the time of the review, DMMA indicated that the payments to the excluded provider have not been reported to the CMS Philadelphia Regional Office, but DMMA reported that it has discussed the case with HHS-OIG. According to the case summary, the provider was also referred to the State MFCU.

Recommendations: Recover improper payments from the excluded provider and return the Federal portion of the payments. Modify or implement internal controls to prevent excluded providers from participating in the Medicaid program. Please refer to the June 12, 2008 State Medicaid Director Letter (SMDL) #08-003 on exclusions which can be found on the CMS website at http://www.cms.hhs.gov/smdl/downloads/SMD061208.pdf.

The State does not perform all required notifications about excluded providers.
The regulation at 42 CFR § 1002.212 requires a State agency that has initiated an exclusion to notify the individual or entity subject to an exclusion, as well as other State agencies, the State medical licensing board, the public, recipients, and other interested parties.

During interviews, program integrity staff noted that DMMA does not undertake a sufficiently broad range of notifications when it excludes individuals or entities from the Delaware Medicaid program. Besides notifying the excluded individual or entity of the action, the agency or its fiscal agent only notifies the MCO with which the excluded party was affiliated, if applicable. There is no clear indication that the State medical licensing board is notified (although this may occur in OIG-initiated exclusions), nor are there mechanisms for informing other State agencies that have an oversight role or Medicaid recipients and the public at large.

Recommendation: Develop and implement policies and procedures to ensure that all parties identified by the regulation are notified of a State-initiated exclusion.

Vulnerabilities

The review team identified six areas of vulnerability in Delaware's program integrity practices. These related to the collection of ownership and control, business transaction, and health care-related disclosure information from MCO and transportation network providers as well as the failure to verify receipt of provider services with recipients, to conduct complete exclusion searches, and to collect information on managing employees.

Not collecting ownership and control disclosures from MCO network providers and transportation providers.
Delaware's umbrella managed care contract does not require MCOs to collect the full range of ownership and control disclosures that Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers. In practice, only one of two MCOs collects such disclosures. This MCO captures ownership and control disclosures every three years at the time of credentialing and recredentialing. The MCO indicated that it began to collect them in response to a State

communiqué following the June 2008 publication of SMDL #08-003, which provided guidance to States on disclosure and exclusion checking requirements. The other contracted MCO in Delaware does not capture this information.

Based on the interview with the transportation broker and a review of the transportation provider enrollment packets, the broker does not collect ownership disclosure information from its providers.

Recommendation: Modify the managed care and transportation contracts to require the full range of disclosures at 42 CFR § 455.104 in accordance with SMDL #08-003.

Not requiring MCO and transportation providers to disclose specific business transactions.
Neither the DMMA contract with MCOs nor the MCO provider agreements require network providers to disclose the required business transaction information on request that is stipulated at 42 CFR § 455.105. The transportation broker also does not require disclosure of business transactions on its credentialing forms for network providers.

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

Not capturing the full range of criminal conviction information from managed care providers and transportation providers.
The MCO and transportation broker enrollment applications and forms do not capture health care-related criminal conviction information for the full range of parties that would otherwise be required of FFS providers under 42 CFR § 455.106. These include persons with ownership and control interests in the provider as well as agents and managing employees. This prevents DMMA from complying with the regulation at 42 CFR § 455.106(b)(1) requiring that the State agency notify HHS-OIG of such disclosures within a 20 day timeframe.

Recommendation: Develop and implement procedures to collect health care-related criminal conviction information from MCO and transportation broker network providers and to report relevant disclosures submitted by all providers to HHS-OIG as required.

Not verifying with managed care recipients whether services billed by providers were received.
While the State meets the requirements of 42 CFR § 455.20 by sending explanations of medical benefits to FFS recipients, information obtained by the MIG review team during interviews with the two MCOs revealed that the MCOs are not performing any verification of recipient services. A review of the contract between the State agency and MCOs revealed that Delaware does not require the direct verification of services with recipients.

Although both MCOs report that they perform routine and ongoing data mining and claims audits that identify outliers or ensure that payment is consistent with the scope of service in

provider contracts, the MCOs do not use direct recipient verification to ensure that services for which the State paid were actually provided.

Recommendation: Develop and implement a procedure for verifying with recipients whether billed services were actually received.

Not conducting complete exclusion searches.
On June 12, 2008, CMS issued SMDL #08-003 providing guidance to States on checking providers and contractors for excluded individuals. 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 staff and subcontractors for excluded parties, including owners, agents, and managing employees. The FFS program, MCOs, and the transportation broker in Delaware do not conduct exclusion searches that are fully consistent with this guidance.

For example, in the FFS program, the fiscal agent only runs provider names against the LEIE, not all names collected during the enrollment process. The fiscal agent cannot run all the names that should be checked against the LEIE because even where information on owners, officers, agents, and managing employees is collected, the names are not entered into the Medicaid Management Information System (MMIS) or another searchable data repository. This precludes automated exclusion checks on such individuals from being undertaken on an ongoing basis.

The DMMA noted that it shared SMDL #08-003 with the MCOs, and both MCOs indicated in interviews that they check the LEIE for providers. However, one of the MCOs does not collect the full range of required disclosures, such as owners, agents, and managing employees. While the other plan collects this information, it does not check the names of everyone against the LEIE. In addition, neither the transportation broker nor the MCOs require or check disclosures on the owners and managing employees of their own subcontractors or vendors against the LEIE.

Recommendation: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information to ensure that the FFS program, contracted MCOs, the transportation broker, and network providers conduct exclusion searches using the LEIE or the Medicare Exclusion Database at the time of provider enrollment, re-enrollment, and at least monthly thereafter in accordance with SMDLs #08-003 and #09-001.

Not capturing managing employee information on FFS provider enrollment forms.
Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." The State does not solicit managing employee information on FFS provider enrollment forms. Thus, the State would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

One instance in which serious issues with an employee in an important position came to light occurred when a pharmacy contacted DMMA about problem claims related to one of its pharmacists. The matter was referred to the MFCU which found dispensing issues with the pharmacist and the moving of inventory from employer to employer. Because the State does not enroll pharmacists directly, it initially could take no direct action against the pharmacist. The State could only impose an overpayment on the two pharmacies where inventory was shifting. However, the pharmacist in question resurfaced with a new pharmacy in March 2008, and the MFCU alerted the State that he was actually the owner of the new entity. The State then suspended all claims payments to the new entity in May 2008. The pharmacist in turn reached a plea bargaining agreement in August 2008 on matters relating to his earlier conduct as a managing employee. The MFCU reported the pharmacist afterwards to HHS-OIG, which successfully excluded him in June 2009.

Although the pharmacist in question was eventually excluded, the State's failure to collect information on managing employees raises the possibility that the excluded party could reemerge again in a position of authority at yet another pharmacy. In addition, this case raises concerns about DMMA's inability to implement intermediate sanctions against the problem pharmacist, which might have limited financial harm to the program well before the suspension of claims payments and the final exclusion.

Recommendations: Develop and implement procedures to capture information on managing employees in the MMIS or in an alternate repository that would permit ongoing exclusion checks to be performed. Consider requesting rulemaking authority to impose intermediate sanctions, such as payment suspensions or deferrals, against Medicaid participating facilities with non-Medicaid certified employees suspected of Medicaid fraud or abuse.

CONCLUSION

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

- active engagement in building relationships with MCOs, and
- enhanced program integrity efforts following an internal reorganization.

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

However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, six areas of vulnerability were identified. The CMS encourages DHSS to closely examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require DHSS 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 Delaware 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 Delaware 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 Delaware on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.