Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Delaware Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

CMS' Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Delaware Medicaid Program. The onsite portion of the review was conducted at the Delaware Division of Medicaid and Medical Assistance (DMMA) offices, but the team also visited the State's Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Program Integrity Section, which is primarily responsible for Medicaid program integrity. The report addresses regulatory compliance issues and vulnerabilities. The review team identified three areas of non-compliance with Federal regulations during its review.

- 42 CFR § 455.104 provides that State Medicaid agencies must require providers to disclose specific ownership and control information relating directly to the provider and concerning any subcontractors in which the provider has direct or indirect ownership of 5 percent or more.
- 42 CFR § 455.105(b)(2) requires States to include in the provider agreement that the provider agrees to furnish to the State Agency or the Secretary information related to certain business transactions with wholly owned suppliers or any subcontractors.
- 42 CFR § 455.106 provides that State Medicaid agencies must require providers to disclose the identity of any owner, agent, or managing employee convicted of a health-care related criminal offense. When apprised of such information, the Medicaid agency must report it to the Department of Health and Human Services-Office of the Inspector General (HHS-OIG) within 20 working days.

The State indicated that it has corrected or was taking actions to correct all areas of non-compliance and vulnerability. Because the State provided its responses to each area of non-compliance or vulnerability in the body of the draft report, we have excerpted the responses and added them to the body of this final report, but have not appended the draft report with the State's responses to this final report as is our practice.

The MFCU Director reviewed the draft report. He commented there had been a shortage of useful referrals to the MFCU in the years leading up to the review. When the review team asked the State's Medicaid Surveillance Administrator about the number of MFCU referrals, she agreed there should be more referrals to the MFCU. However, she disputed that there had been no useful referrals to the MFCU and showed the review team files that had been referred. Therefore, the review team did not include the MFCU's observation in the draft report. Since the time of the onsite review, the Medicaid agency has made organizational and personnel changes, which the MFCU Director commented has improved the situation.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and noteworthy 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 DMMA administers the Delaware Medicaid program. As of July 2007, the average number of recipients in the program was 127,721. Total State and Federal Medicaid expenditures in Delaware as of June 8, 2007 for the State fiscal year (SFY) ending June 30, 2007 were $746,022,757. The Federal medical assistance percentage for Delaware is 50 percent. The DMMA processed an average of 490,758 FFS claims annually for the past three SFYs.

Approximately 76 percent of Delaware Medicaid recipients were enrolled in two Medicaid managed care plans, Delaware Physicians Care, Inc. (DPCI) and Unison Health Plan (Unison), and a fee-for-service (FFS) alternative health plan, Diamond State Partners. The two managed care organizations (MCO) contracted with 3,453 providers. At the time of the review, DMMA had enrolled 20,556 FFS providers.

Program Integrity Section

The Program Integrity Section is the organizational component within DMMA dedicated to fraud and abuse activities. It was created in May 2007 and includes the Surveillance and Utilization Review (SUR), Audits and Edits, Claims Resolution, and Third Party Payments Units. The State had not yet filled the position of chief of the Program Integrity Section at the time of the onsite review. DMMA has 24 full-time equivalent staff assigned to program integrity. The State legislature approved the SFY 2008 budget with four additional staff for the Program Integrity Section.

Methodology of the Review

In advance of an onsite visit, the review team requested that Delaware complete a comprehensive review guide and supply documentation to support its answers to the review guide. The review guide included such areas as provider enrollment, claims payment and post-payment review, managed care, Surveillance and Utilization Review Subsystem, and the MFCU. A three-person team reviewed the answers and materials that the State provided in advance of the onsite visit.

During the week of July 10, 2007, the MIG review team visited the DMMA offices and the MFCU. The team conducted interviews with numerous DMMA officials as well as with staff from Electronic Data Systems (EDS), the State's health benefits manager, provider enrollment, and claims processing contractor; and with the MFCU director. To

determine whether managed care plans were complying with the contract provisions and other Federal regulations relating to program integrity, the CMS team reviewed the contract provisions and gathered information from the MCOs through in-depth interviews with representatives of each of the MCOs. The team met separately with staff from the Medical Management and Delegated Services Unit, the unit within DMMA responsible for the managed care program, to discuss the Department's managed care oversight and monitoring efforts.

Scope and Limitations of the Review

This review focused on the activities of the Program Integrity Section. That portion of the Delaware Healthy Children Program, Delaware's State Children's Health Insurance Program, operating as a Medicaid expansion program was included in this review. Unless otherwise noted, DMMA 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, financial, or collections information that DMMA provided.

RESULTS OF THE REVIEW

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to required disclosures in FFS and managed care provider enrollment and credentialing.

DMMA does not meet Federal disclosure requirements concerning the ownership and control of providers and subcontractors.

Under 42 CFR § 455.104(a)(1), a provider, or "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. Neither of Delaware's MCOs' credentialing application forms captures the names of individuals who own or have controlling interests in disclosing entities or providers or related subcontractors, their relationships, or the identity of other disclosing entities in which these individuals have an ownership or controlling interest.

Recommendation: Require MCOs to modify credentialing applications to request the information required to be disclosed under § 455.104.

State Response: DMMA will work with its contracted MCOs to add this element as a requirement for their provider credentialing applications as required under 42 CFR § 455.104(a)(1).
Anticipated Completion date: 12/31/08

DMMA's managed care provider credentialing forms lack required disclosures of business transactions.
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. Neither DPCI nor Unison requires disclosure of the specified business transaction in their credentialing forms.

Recommendations: Require MCOs to modify credentialing forms to require disclosure upon request of the information identified in § 455.105.

State Response: DMMA will work with its contracted MCOs to add this element as a requirement for their provider credentialing forms under 42 CFR § 455.105(b)(2).
Anticipated Completion date: 12/31/08

DMMA does not meet Federal regulations requiring the disclosure of criminal conviction information in its provider enrollment packages.
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. While the MCOs' credentialing applications request information on the provider applicant's criminal convictions, neither of the MCOs' credentialing applications captures managing employee criminal conviction information. The omission prevents Delaware from forwarding information on providers, owners, and managing employees to HHS-OIG within 20 working days, as is required by the regulation.

Recommendations: Modify enrollment packages to request managing employee criminal conviction information. Refer that information to the HHS-OIG as required.

State Response: DMMA will work with its contracted MCOs to add this information to the provider enrollment packages. DMMA will refer any reported information to the HHS-OIG as required.
Anticipated Completion date: 12/31/08

Areas of Vulnerability

The review team identified four areas of vulnerability in Delaware's practices. They specifically include concerns about provider enrollment and MCO reporting of suspected fraud and abuse.

Not verifying disclosures made by provider entities.

Regulations at 42 CFR § 455.104 and 42 CFR § 455.106 require disclosing entities to provide information about persons with ownership or controlling interest in the disclosing entity and whether the disclosing entity has any criminal convictions related to Medicare, Medicaid, or Title XX programs.

Although the Delaware FFS Disclosure of Ownership and Control Statement requires disclosure of some information required by these regulations, the State requires submission of the Disclosure of Ownership and Control Statement only at initial application. Because provider applications are not renewed, but are effective unless terminated, the State never requires resubmission or updating of disclosures. The State does not verify any information provider applicants submit, confirming only that the provider applicant has submitted a completed application. If the State requires neither periodic resubmission of disclosures nor verification of the disclosures made at initial application, the State cannot know that the disclosures are accurate or whether the State should reject the provider application and refer the action to HHS-OIG.

Recommendations: Verify provider disclosures. Require periodic updating of disclosures.

State Response: In order to verify the provider disclosures the HHS Office of Inspector General Website http://exclusions.oig.hhs.gov/search.aspx is reviewed for each new provider application by the Provider Relations team at EDS. We have an additional resource; Excluded Parties List System, (EPLS) http://www.epls.gov/ that can be used to check information. Both websites display provider sanction information. The provider's name is entered into the site and if the name comes up as a possible match, the provider's Social Security Number is entered to narrow down the search. If the provider comes up as a match, a print of the Web page is put in the provider's file and the information is forwarded to DMMA from EDS for review and to determine if the enrollment can continue. If no match is found for the provider, a print of the Web page is added to the provider's file and the enrollment is continued. DMMA will also be working with EDS to develop an automated process to periodically update provider disclosure information.
Anticipated Completion date: 12/31/08

Not verifying out-of-state provider licenses during the application process.

To be a complete application, a provider must submit a copy of its current license for the applicable profession issued by the State in which the provider is located. Providers in border States – Pennsylvania, New Jersey, Maryland, and the District of Columbia – are

considered in-state providers. Out-of-state providers may not be enrolled unless they have provided services to a Delaware Medicaid recipient and submitted a claim for services. While the State has an interface with the Delaware licensing agency, it does not have such an interface or relationship with the licensing agencies of border States or other States. Thus, Delaware does not verify border State or out-of-state provider licenses; the State confirms only that the licenses have not expired. Furthermore, while the State responds to requests from border States, the State does not initiate requests to border States' licensing agencies to verify provider licenses issued by those border States. Without routine independent verification of licensure, the State cannot know with certainty that providers submitting applications have licenses in good standing in Delaware or any other State.

Recommendations: Verify out-of-state and border State provider licenses for providers submitting applications in Delaware.

State Response: DMMA will be working with our fiscal agent EDS to develop a change control to establish an interface with the licensing boards of each border state to allow for verification of provider licenses at the time of renewal. This process would follow the current process in place for the Delaware board of licensing.

In the meantime, as part of each new enrollment application screening, the licensing board Web sites (addresses below) for Delaware and/or the Border States will be reviewed for professional providers by the Provider Relations staff. EDS will also review the information on the various states licensing board websites. This action will verify that the provider has a valid, active license. A copy of the verification from the licensing Web site will be placed in the provider's file.

Links to the Delaware and border state licensing boards:
DE: http://dpr.delaware.gov/boards/medicalpractice/index.shtml
PA: http://www.licensepa.state.pa.us/
MD: https://www.mbp.state.md.us/bpqapp/
http://dhmh.state.md.us/pharmacyboard/verifications/index.htm
NJ: http://www.state.nj.us/cgi-bin/consumeraffairs/search/searchentry.pl
DC: http://app.hpla.doh.dc.gov/weblookup/Search.aspx
Anticipated Completion date: Completed

Not having written policies and procedures for reporting adverse actions to HHS-OIG. The regulation at 42 CFR § 1002.3 requires reporting to HHS-OIG any actions a State takes on provider applications for participation in the program. Under that regulation, actions to deny or terminate participation include when an owner or managing employee has been convicted of a criminal offense related to the Medicare, Medicaid, or Title XX programs or when the provider did not fully or accurately make certain disclosures. The State indicated that there had been no adverse actions against a provider requiring reporting to HHS-OIG. However, there was a recent instance of a convicted provider

who sought re-enrollment in the Medicaid program. That provider was convicted of fraud and the State notified HHS-OIG of the conviction. The provider later contacted the State regarding re-enrollment, but did not formally submit an application. No reporting would have been necessary to comply with the regulation at that time. Nevertheless, such an instance illustrates that the State will have occasion to report adverse actions to HHS-OIG and should have procedures in place to address the reporting requirement.

Recommendation: Institute policies and procedures for reporting adverse actions to HHS-OIG.

State Response: The Program Integrity Section will develop policies and procedures for reporting adverse actions to HHS-OIG.
Anticipated Completion date: 06/01/08

Inconsistent reporting of suspected provider fraud and abuse to the State by MCOs.
Delaware's managed care contract with DPCI and Unison clearly requires that MCOs report all suspected cases of provider fraud and abuse directly to the Program Integrity Section. DPCI indicated to the review team that the MCO refers matters to the MFCU rather than to the Program Integrity Section. Unison had not yet begun to perform its contract, so it did not yet have referrals to report to the State.

The DMMA Deputy Director admitted that its monitoring mechanisms were inadequate and, specifically, that no one was monitoring DPCI's program integrity, but noted that its structure for program divisions and program integrity were undergoing reorganization which would help to remedy shortcomings in fraud and abuse monitoring outside of FFS provider enrollment. For example, each MCO and the FFS alternative, DSP, would have a liaison in the SUR Unit who will monitor reports and contract performance. Given the high level of managed care penetration in Delaware, it is imperative that the State enforces contract provisions designed to identify fraud and abuse issues.

Recommendation: DMMA should closely monitor the MCOs to ensure that suspected cases of provider fraud and abuse are reported directly to the Program Integrity Section for further evaluation.

State Response: DMMA will institute monitoring mechanisms for the managed care organizations where cases of suspected provider fraud and abuse are reported directly to the Program Integrity Unit for further evaluation.
Anticipated Completion date: 07/01/08

CONCLUSION

The State of Delaware has been reorganizing its program integrity operations. DMMA was optimistic that with reorganization and the inclusion of additional staff, the State's program integrity operations would improve. CMS encourages DMMA to look for additional opportunities to improve overall program integrity.

However, the identification of three areas of non-compliance with Federal regulations is of concern. In addition, four areas of vulnerability were identified in this review. CMS encourages DMMA to closely examine the four areas of vulnerability. It is important that these issues be rectified as soon as possible. In its response to our draft report, DMMA provided its corrective plans and schedule for completion.

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 program improvements.