Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Delaware Focused Program Integrity Review

Medicaid Managed Care Oversight

September 2025

Final Report

Table of Contents

I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review to assess Delaware's program integrity oversight efforts of its Medicaid managed care program for the Fiscal Years (FY) 2020 – 2022. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the State Medicaid Agency (SMA) and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the SMA.

This report includes CMS' observations that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified no findings that create risk to the Delaware Medicaid program related to managed care program integrity oversight.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **four** observations related to Delaware's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of Managed Care Program Integrity Activities

Observation #1: CMS encourages Delaware to ensure MCOs establish a Special Investigation Unit (SIU) with sufficient resources and staffing commensurate with the size of their Medicaid managed care programs. CMS also encourages Delaware to adopt procedures to ensure all the existing staffing elements currently contained in the MCO general contract are addressed.

Observation 2: CMS encourages Delaware to perform unannounced MCO onsite reviews as part of the monitoring process to verify compliance with its fraud, waste, and abuse contractual requirements.

MCO Investigations of Fraud, Waste, and Abuse

Observation #3: CMS encourages Delaware, in conjunction with the Medicaid Fraud Control Unit (MFCU), to provide specific fraud, waste, and abuse, and program integrity training/guidance aimed at enhancing the identification, quality, and quantity of case referrals from the MCOs.

Observation #4: CMS encourages Delaware to urge MCOs to resume conducting announced and unannounced investigative provider site visits now that the public health emergency has ended. CMS further encourages Delaware to consider the inclusion of MCO general contract language to address conducting investigative announced/unannounced provider site visits to oversee network providers more effectively.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services (PCS). These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between SMAs and (MCOs that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the Delaware Managed Care Program and the Focused Program Integrity Review

The Delaware Health and Social Services (DHSS) Division of Medicaid and Medical Assistance (DMMA) is responsible for the administration of the Delaware Medicaid managed care program, Diamond State Health Plan. Within DHSS, the Surveillance and Utilization Review (SUR) Unit is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, Delaware contracted with two MCOs to provide health services to the Medicaid population: Highmark Health Options (Highmark) and AmeriHealth Caritas of Delaware (AmeriHealth). As part of this review, both MCOs were interviewed. Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In July 2023, CMS conducted a virtual focused program integrity review of Delaware's managed care program. This review assessed the state's compliance with CMS regulatory requirements at

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by selected MCOs under contract with the SMA. CMS interviewed key staff, including the MCO's SIUs, as well as reviewed other primary data. CMS also evaluated the status of Delaware's previous corrective action plan that was developed in response to a previous focused program integrity review of Delaware's PCS program conducted by CMS in 2018, the results of which can be found in Appendix A.

During this review, CMS identified a total of **four** observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.
B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.
C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.
D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.
E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.

In Delaware, these oversight and monitoring requirements are met. The DHSS-DMMA SUR Unit will monitor the utilization of Medicaid services to detect, investigate, and take action on findings of fraud, waste, and/or abuse. The DHSS-DMMA performs targeted program integrity reviews under an optional review every few years. In 2021, DHSS-DMMA contracted with an External Quality Review Organization (EQRO), Mercer Government Human Services Consulting (Mercer), to complete a comprehensive compliance review of the two contracted MCOs. The review included a compliance review, validation of performance measures, validation of performance improvement projects, and a comprehensive system capabilities assessment.

CMS determined that MCO contractual program integrity requirements were addressed within the MCO general contract under Section 3.16. According to the contract, the MCOs must have a comprehensive internal fraud, waste, and abuse program to prevent, detect, report, investigate, and correct/resolve potential or confirmed fraud, waste, and abuse in the administration and delivery of services covered under the contract. The MCO must have a surveillance and utilization control program and procedures to safeguard against underutilization, unnecessary or inappropriate use of covered services, and excess payments for covered services. In addition, the MCO must have adequate staffing and resources to identify and investigate potential fraud, waste, and abuse, and develop and implement corrective action plans to assist the MCO in preventing and detecting potential fraud, waste, and abuse. The contract requires the MCO to have the following dedicated staff: a Compliance Officer; an investigator responsible for fraud, waste, and abuse investigations; an auditor responsible for identifying potential fraud, waste, and abuse through analysis of claims and related contractual information; and an analyst responsible for reviewing and researching evidence of potential fraud, waste, and abuse. CMS noted Highmark reported ten SIU staff, four of which reside in Delaware. However, Highmark did not identify a dedicated SIU auditor on staff. AmeriHealth only identified one investigator and one SIU auditor dedicated to Delaware but lacked a dedicated Compliance Officer and analyst, as required in the general contract.

CMS further observed that the MCO general contract does not address onsite unannounced reviews of the MCOs by DMMA. While not a federal requirement, unannounced onsite visits are a useful tool in the monitoring process to verify compliance with its fraud, waste, and abuse contractual requirements.

Observation #1: CMS encourages Delaware to ensure MCOs establish a SIU with sufficient resources and staffing commensurate with the size of their Medicaid managed care programs. CMS also encourages Delaware to adopt procedures to ensure all the existing staffing elements currently contained in the MCO general contract are addressed.

Observation #2: CMS encourages Delaware to perform unannounced MCO onsite reviews as part of the monitoring process to verify compliance with its fraud, waste, and abuse contractual requirements.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The MCO general contract for Delaware is developed by DHSS through coordination with the Request for Proposal (RFP) developer who meets with and consults with each area of DMMA for input into each section of the RFP.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and state requirements.
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract.
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract.
5. Effective lines of communication between the Compliance Officer and employees.
6. Enforcement of standards through well-publicized disciplinary guidelines.
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems

promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

Section 3.16.5.2 of Delaware's MCO general contract explicitly addresses the requirement that all seven compliance plan elements listed above be addressed. A review of the MCOs' compliance plans and programs found that each MCOs compliance plan contained the required elements in accordance with §§ 438.608(a)(1)(i)-(vii). The DMMA SUR Unit performs an annual review of the MCO compliance plans.

CMS did not identify any findings or observations related to these requirements.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

In Delaware, this requirement is met through the MCO general contract Section 3.16.3, which requires the MCOs to implement a process for verifying with beneficiaries whether services billed by providers were received. The MCO must employ a methodology and sampling process previously approved by the DHSS-DMMA to verify with its beneficiaries monthly whether services billed to the MCO by providers were actually received. The methodology and sampling process must include criteria for identifying high-risk services and provider types. The MCOs must submit a quarterly report of all verifications to DHSS-DMMA.

CMS did not identify any findings or observations related to these requirements.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

The state is compliant with this requirement. The MCOs are required by Section 3.16.5.2.15 of the MCO general contract to have written policies for all employees, contractors, or agents that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

CMS did not identify any findings or observations related to these requirements.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

Delaware Medicaid MCOs are contractually required to suspend payments to providers, but only at the state's request. The MCO general contract requires MCOs to suspend providers once the state has determined a payment suspension should be imposed. General contract Section 3.16.1.10 requires the MCOs to establish processes for the suspension of payments to a participating provider for which the state determines there is a credible allegation of fraud. Furthermore, Section 3.21.9.6 requires the MCO to submit a quarterly *Provider Suspensions and Terminations Report* that lists by name all participating provider suspensions or terminations. This report shall include information on all participating providers, and if the MCO has taken no action against a provider during the quarter, the MCO must document this in the report.

CMS did not identify any findings or observations related to these requirements.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

The state adequately addressed the requirements at §§ 438.608(a)(2) and (d). According to the MCO general contract Section 3.16.1.7, the MCOs are entitled to retain overpayment recoveries, including overpayments due to fraud, waste, or abuse that were first identified by the MCO. The MCO is not entitled to recover overpayments identified by DHSS-DMMA. The MCO must notify DHSS-DMMA of any proposed recoveries within 5business days after identification. Section 3.10.2.1.34 of the MCO general contract requires the return of provider overpayments to the MCO within 60 calendar days from the date the overpayment is identified. Overpayments that are not reported and returned within 60 calendar days from the date the overpayment was identified may result in a penalty. The MCO must report collected overpayments to DHSS-DMMA at least annually, or as otherwise directed by DHSS-DMMA.

CMS did not identify any findings or observations related to these requirements.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. Delaware has a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria. Specifically, there is a MOU that contains procedures by which the MFCU will receive referrals of potential fraud from MCOs as required by 455.21(c)(3)(iv). Additionally, the state and the MFCU participate in monthly calls with the individual MCOs to discuss potential and active referrals and to discuss fraud, waste, and abuse trends. In addition, the state and the MFCU meet quarterly with the MCOs to discuss case referrals, the status of referrals, policy changes, fraud scheme trends, pro-active measures to combat fraud using data bases available at the state and federal level, and cross-training initiatives.

In accordance with the MOU, DHSS-DMMA and the MCOs will notify the MFCU within 2 business days of discovery of a credible allegation of suspected fraud, or abuse. The MCOs are required to submit referrals simultaneously to DHSS-DMMA and the MFCU. The DHSS-DMMA and the MCOs must suspend payment to a provider when it is determined that a credible allegation of fraud exists. Within 30 days of a fraud or abuse case referral, the MFCU screens the case to determine whether the matter will be opened for investigation. If an investigation is opened, the MFCU will notify the Medicaid Surveillance Administrator in writing prior to the expiration of the 30-day period. The MFCU provides DHSS-DMMA, no less frequently than quarterly, written updates of open investigations, and whether a payment suspension or good cause exception continues to be warranted. At the conclusion or termination of any investigation, the MFCU will provide DHSS-DMMA with a closing letter describing the resolution with a brief explanation of the MFCU's findings.

While there is no requirement for SMAs to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The SMA holds monthly and quarterly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions.

CMS did not identify any findings or observations related to these requirements.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Delaware has such a process in accordance with §§ 455.13-17 and 438.608(a)(7). Sections 3.16.4.2-5 of the MCO general contract outlines the process MCOs are to use to refer suspected fraud, waste, and abuse to the state. According to the contract, the MCO shall have methods for identifying, investigating, and referring suspected fraud, waste, and abuse. Within 2 business days, the MCO must concurrently notify DHSS-DMMA and the MFCU of all cases of suspected fraud, waste, or abuse by its providers, beneficiaries, employees, or subcontractors using the state-approved notification form. After notifying DHSS-DMMA and the MFCU, the MCO must promptly perform a preliminary investigation of the reported suspected fraud, waste, or abuse to determine whether there is sufficient basis to warrant a full investigation. Unless prior written approval is obtained from DHSS-DMMA, after notifying DHSS-DMMA and the MFCU of suspected fraud, waste, or abuse, the MCO must not contact the subject of the investigation about any matter related to the investigation, enter into or attempt to negotiate any settlement or agreement regarding the incident, or accept any monetary or other type of consideration offered by the subject of the investigation in connection with the incident.

CMS determined there was no fraud, waste, or abuse, or program integrity training provided to the MCOs during the review period. The DHSS-DMMA and the MFCU hosted training for the MCOs on April 13, 2023, which was outside of the review period.

> **Observation #3:** CMS encourages Delaware, in conjunction with the MFCU, to provide specific fraud, waste, and abuse, and program integrity training/guidance aimed at enhancing the identification, quality, and quantity of case referrals from the MCOs.

MCO Oversight of Network Providers

CMS verified whether each Delaware MCO had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

Both MCOs reported use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. Indicators of potential issues were identified through different sources, including but not limited to claims data, hotline calls, referrals from subcontractors, referrals from DHSS-DMMA, algorithms, and data mining. A preliminary investigation is conducted to see if the case should be opened by the SIU. When the opening of a case is warranted as a result of the preliminary investigation the

case is assigned to a SIU investigator and a full investigation is conducted. When warranted case referrals are sent concurrently to both the state and the MFCU.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to meet CMS requirements and state contract requirements. However, it was noted that the MCOs were not conducting announced or unannounced provider site visits during the public health emergency, which fell within the review period. Highmark conducted one site visit during 2020, whereas AmeriHealth did not conduct any during the review period.

Figure 1 below describes the number of investigations referred to DHSS-DMMA and the MFCU by each MCO. As illustrated, the number of Medicaid MCO provider referrals is low.

Figure 1. Number of Investigations Referred to Delaware by each MCO

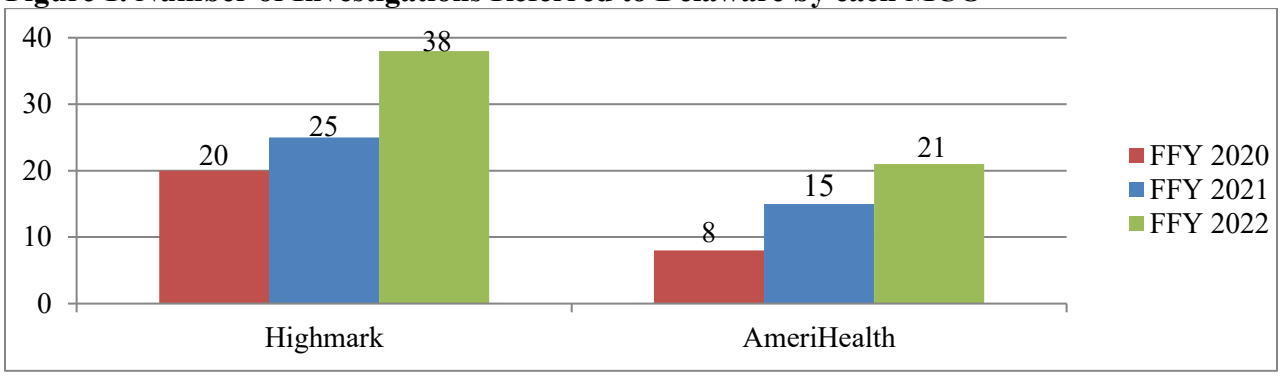

Table 1, below, describes each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month.

Table 1: MCO Recoveries from Program Integrity Activities

Highmark's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	0	0	$0	$0
2021	0	2	$5,218.71	$0
2022	0	7	$337,770.10	$337,770.10

AmeriHealth's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	0	0	$0	$0
2021	0	1	$788.81	$788.81
2022	0	3	$177,806.72	$177,806.72

Observation #4: CMS encourages DHSS-DMMA to urge MCOs to resume conducting announced and unannounced investigative provider site visits now that the public health emergency has ended. CMS further encourages DHSS-DMMA to consider the inclusion of MCO general contract language to address conducting investigative announced/unannounced provider site visits to oversee network providers more effectively.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of the Delaware MCO general contract and interviews with each of the MCOs, CMS determined that Delaware was in compliance with § 438.242. Specifically, the contract language in Section 3.18.4 includes all the necessary provisions in accordance with § 438.242. The MCOs are contractually required to submit encounter data to DHSS's fiscal agent, Gainwell Technologies, no less frequently than weekly in the required claim format. CMS determined during the review that both MCOs were in compliance with this requirement. The MCOs reported that the state provides response files to weekly submissions that provides an accepted or rejected status, and the details of any rejected encounters. These encounters are passed to the DMMA rate setting contractor for evaluation of the appropriateness for capitation rate setting.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. Delaware was in compliance with § 438.602(e) for the review period. Specifically, Mercer, DHSS's contracted EQRO, performs a full audit every 3 years of the MCOs, with the results of each being published to DHSS's website.

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. Delaware has

a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, the state conducts data mining of encounter data via queries of the Medicaid Management Information System (MMIS). Such data mining is often conducted in conjunction with Gainwell Technologies. The MMIS uses standard edits/audits to validate the submitted encounter data for appropriateness and accuracy. The encounter data is also analyzed based on parameters specified by the end-user.

CMS did not identify any findings or observations related to these requirements.

IV. Conclusion

CMS supports Delaware's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified four observations that require the state's attention

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

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

V. Appendices

Appendix A: Status of Prior Review

Delaware's last CMS program integrity review focused on Personal Care Services was in July 2018, and the report for that review was issued in January 2019. The report contained 17 recommendations. During the virtual review in July 2023, the CMS review team conducted a thorough review of the corrective actions taken by Delaware to address all recommendations reported in calendar year 2018. The findings from the 2019 Delaware focused PI review report have not all been satisfied by the state. The state provided responses to #3,#6 and #17.

Findings

1. ***Consider creating annual audit work plans that serve as guidance to MCOs on state oversight objectives and oversight priorities.***
   Status at time of the review: Corrected

   Delaware Program Integrity/SUR has created an annual audit workplan.

2. ***Revise policies and procedures to ensure MCOs submit accurate encounter data that can be data mined and analyzed by DMMA for aberrant trends.***
   Status at time of the review: Corrected

   Delaware developed policies and procedures to ensure MCOs submit accurate encounter data that can be data mined and analyzed by DMMA for aberrant trends.

3. ***Consider allocating appropriate FTEs to oversee managed care expenditures and conduct regular data mining and audit activities on MCO encounter data.***
   Status at time of the review: Not Corrected.

4. ***Consider revising policies and procedures to ensure compliance with payment suspensions under 42 CFR 455.23.***
   Status at time of the review: Corrected

   Delaware Program Integrity/SUR has policies and procedures in place.

5. ***The DMMA should review internal processes and procedures to ensure overpayments and terminated providers are accurately recorded and tracked.***
   Status at time of the review: Corrected

   Delaware SUR currently has policies and procedures in place to ensure overpayments are accurately recorded and tracked.

6. ***Consider identifying state approved training for home health aides and developing a registry for home health aides.***
   Status at time of the review: Corrected

7. ***The DMMA should review internal procedures to ensure skilled home agencies are enrolled in accordance with 42 CFR 455.436, and subsequently screened against the appropriate databases on a monthly basis.***
   Status at time of the review: Corrected

   Delaware Program Integrity/SUR is currently executing this process.

8. ***Ensure MOCs screen managing partners and individuals with a controlling interest, as required by 42 CFR 455.436, against appropriate databases.***
   Status at time of the review: Corrected

   Delaware is currently performing this process.

9. ***Consider amending the MCO contract to include specific guidance with regards to federal database checks, 42 CFR 455.436; namely for appropriate databases and which parties require screening. DMMA should communicate expectations and provide guidance to ensure MCOs, downstream risk entities, and provider agencies utilize the appropriate database screening procedures in accordance with 42 CFR 455.436.***
   Status at time of the review: Corrected

   Delaware is currently performing this process.

10. ***The DMMA should revise oversight efforts to communicate expectations about suspected fraud reporting. The DMMA should ensure home care agencies report aide terminations to DMMA, and/or the MFCU, that were a result of suspected fraud.***
    Status at time of the review: Corrected

    Delaware is currently performing this process.

11. ***The DMMA should develop communication strategies to confirm providers are aware of how to report suspected fraud to DMMA.***
    Status at time of the review: Corrected

    Delaware is currently performing this process.

12. ***The DMMA should review and revise internal procedures to ensure state termination and Medicare revocation lists are reviewed no less than monthly, and ensure providers terminated for adverse actions are reported to CMS.***
    Status at time of the review: Corrected

Delaware is currently performing this process.

13. ***The DMMA should develop adverse termination criteria consistent with Section 6501 of the Affordable Care Act and amend the MCO contract to mandate prompt reporting of adverse action terminations. The DMMA should ensure MCOs develop similar criteria for adverse terminations and develop clear reporting requirements for providers that have been terminated for adverse actions.***
    Status at time of the review: Corrected

    Delaware is currently performing this process.

14. ***Consider revising oversight self-directed PCS oversight efforts by initiating regular programmatic audits, and investigations of self-directed PCS.***
    Status at time of the review: Corrected

    Delaware is currently performing regular programmatic audits, and investigations of self-directed PCS.

15. ***Ensure attendants are screened against the appropriate databases in order to verify attendants have not been excluded from receiving Medicaid reimbursements.***
    Status at time of the review: Corrected

    Delaware's providing agencies are currently screening attendants that have not been excluded against the appropriate databases.

16. ***Consider conducting regular assessment audits and POC audits to determine if there could be overutilization of PCS or improper billing. Or consider implementing a conflict-free assessment procedure to determine appropriate services necessary for PCS delivery.***
    Status at time of the review: Corrected

    Delaware is currently performing this process.

17. ***Consider creating a reconciliation report run to match the number of hours billed against the hours authorized.***
    Status at time of the review: Corrected:

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- 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. https://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Enrollment and Expenditure Data

Table C-1 and Table C-2 below provide enrollment and expenditure data for each of the selected MCOs.

Table C-1. Summary Data for Delaware MCOs

Delaware MCO Data	Highmark	AmeriHealth
Beneficiary enrollment total	150,327	98,780
Provider enrollment total	215,423	59,566
Year originally contracted	1/1/2015	1/1/2018
Size and composition of SIU	10 FTE – 1 Director (CFE) 1 Lead Investigator 2 Senior Business Process Analysts 3 Senior Investigators 3 Investigators	22 FTE – 1 Manager 1 Investigator 1 Auditor 6 Coding and Clinical 6 Data and Analytics 7 Intake
National/local plan	Local	National/Local

Table C-2. Medicaid Expenditure Data for Delaware MCOs

MCOs	FY 2020	FY 2021	FY 2022
Highmark	$1,361,562,409	$1,367,120,232	$1,509,313,804
AmeriHealth	$735,158,633	$925,057,989	$1,038,327,448
Total MCO Expenditures	$2,096,721,042	$2,292,178,221	$2,547,641,252

Appendix D: State Response

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
N/A	No recommendations are included in this report.	**X**	

Acknowledged by:

Joel Riley, Social Service Chief of PI

_____
[Name], [Title]

__September 10, 2025_____
Date (MM/DD/YYYY)