Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Delaware Focused Program Integrity Review

Final Report

February 2016

Submitted By:
Eddie Sottong, Review Team Leader
Richard Colangelo
Julian Isaacs
Annette Ellis
Letitia Leaks, Review Manager

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review to determine the extent of program integrity oversight of the managed care program at the state level and assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the State Medicaid agency. The effectiveness of Delaware's policies, procedures, and oversight of non-emergency medical transportation (NEMT) was also evaluated.

The Delaware Department of Health and Social Services (DHSS) is the agency that has oversight of the Division of Medicaid & Medical Assistance (DMMA) which is responsible for the administration of the Medicaid Program in Delaware. The Delaware Medicaid population operates under an annual budget of approximately $1.8 billion. The review focused on the program integrity activities of DMMA. The review also included a follow up on the state's progress in implementing its corrective actions related to CMS's last program integrity review, conducted in 2010. This report describes effective practices and vulnerabilities in the state's managed care program integrity operations. An assessment of the Medicaid agency's corrective action plan (CAP) status is included in this report.

Background: State Medicaid Program Overview

The Delaware Medicaid population has over 225,000 Medicaid beneficiaries, with approximately 84% of those enrolled in one of two MCOs (UnitedHealthcare and Health Options). Both MCOs serve all three counties in the state, with one plan having 51% of the enrollees and the other having 49% of the enrollment.

DHSS is responsible for the oversight of NEMT. Since the beginning of January 2015, DHSS has contracted exclusively with LogistiCare Solutions for NEMT. Out of approximately 200,000 eligible Medicaid members, there have been approximately 6,865 beneficiaries using NEMT in the first quarter of 2015. LogistiCare services only the Medicaid population in Delaware and has a total of 60 transportation providers. LogistiCare is paid on a per member, per month basis and is anticipating a new contracting process in April 2016.

Methodology of the Review

In advance of the onsite visit, CMS requested that Delaware complete a managed care review guide that provided the review team detailed insight into the operational activities of the areas that were the subjects of the focused review. The MCOs and the NEMT broker also completed questionnaires. A four-person team reviewed the responses and materials that the state and other entities provided in advance of the onsite visit.

During the week of June 8-12, 2015, the CMS review team visited DHSS and other agencies, as well as the program integrity staff of the two MCOs to discuss their program integrity activities, at length. At the time of this review, the MCOs operating in Delaware consisted of UnitedHealthcare Plan and Health Options, a subsidiary of Highmark Blue Cross Blue Shield. In

addition, the team also conducted sampling of Medicaid provider investigations and other primary data to substantiate Delaware's implementation of their managed care program integrity policies and procedures.

Results of the Review

The review team identified two areas of concern with the state's managed care program integrity activities and managed care oversight, thereby creating risk to the Medicaid program. These issues and CMS's recommendations for improvement are described in detail in this report. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible.

Section 1: Managed Care Identified Risks

42 CFR 455.436: Federal database checks
The regulation at 42 CFR 455.436 requires that the State Medicaid Agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on 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 (DMF) , the National Plan and the Provider Enumeration System upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.
The state is at risk of being non-compliant with this regulation.
The state does not contractually require its MCOs to check providers against all federal databases when credentialing and re-credentialing in the same manner as would be required when enrolling providers FFS. Health Options checks its providers and affiliated parties against the LEIE, EPLS, and DMF upon credentialing and re-credentialing, and on a monthly basis thereafter. United checks its providers and affiliated parties against the LEIE and EPLS upon credentialing and re-credentialing, and on a monthly basis thereafter. However, United does not check the DMF and the National Plan and the Provider Enumeration System at the time of credentialing or re-credentialing.
Recommendation: Amend MCO contracts to require MCOs to perform federal database checks as specified in 42 CFR 455.436.
42 CFR 455.23: Suspension of payments in cases of fraud.
The Federal regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment, only in part. Under 42 CFR 455.23(d) the State Medicaid agency must make a fraud referral to either a Medicaid Fraud Control Unit (MFCU) or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.
The state is in compliance with this regulation.

The Delaware managed care contract does not contain the complete regulatory language specified at 42 CFR 455.23. The lack of a policy that covers the entire regulation leaves the state at risk of not fully addressing all sections of the regulation.
Recommendations: None.

Section 2: Managed Care Program Integrity

Overview of the State's Managed Care Program

For federal fiscal year (FFY) 2014, the state reported total computable Medicaid expenditures of $1,804,561,952. The Federal medical assistance percentage for Delaware for FFY 2014 was 53.63 percent. Payments of over $1.26 billion were made to the two MCOs that were in place during FFY 2014, UnitedHealthcare and Health Options. United has provided managed care in the state for seven years with a network of almost 9,000 providers and 105,000 Medicaid enrollees as of June 2015. Health Options, a subsidiary of Highmark BCBS, is a new plan to the state of Delaware as of January, 2015. Health Options has a network of almost 2,208 providers and 85,068 Medicaid enrollees as of June 2015.

Once beneficiaries become eligible for Medicaid services, they are enrolled fee-for-service (FFS) for the first 30 days and allowed to research and select one of the MCOs. After 30 days, if a plan has not been chosen, the state will assign the beneficiary to a plan. There are a few special populations and services not included in managed care. The special populations include individuals in a Medicare savings program and individuals with intellectual disabilities receiving home and community-based services or living in an intermediate care facility. The state added pharmacy benefits to managed care for the first time in 2015. Behavioral health services are included in managed care, except for those services for individuals with a serious and persistent mental illness, which are carved out and paid FFS. Children's dental services are also carved out of the managed care program and paid FFS. NEMT services are provided by a broker for the state. Although these are capitated payments, they are not a part of the managed care program and will be discussed later in this report.

Summary Information on the Plans Reviewed

During the week of the onsite review, the CMS review team met with the program integrity staff of two MCOs to discuss their program integrity activities at length.

Table 1. Summary data for MCOs.

MCE	Medicaid Enrollees *	Medicaid Contracted Providers*	Size and Composition of SIU	Annual Average Expenditures (SFY**12-14)
United	105,000	9,000	1.75 FTEs (investigator and manager) and 12 part time staff (1 investigator, 5 analysts, 2 reporting/data-mining specialists and 4 managers)	$817 Million
High Mark	85, 068	2,208	7 FTEs (1 senior fraud analyst, 3 fraud analyst, 2 associate fraud analysts, and 2 certified professional coders)	$0 High Mark's contract was not effective until January 2015

MCO Program Integrity Activities

Investigations of Fraud, Waste, and Abuse

During the week of the onsite review, the CMS review team met with staff from the Special Investigation Unit (SIU) of two the MCOs and discussed their activities at length.
United's program integrity activities are supported nationally, by various functions, responsible for the detection, prevention, and investigation of fraud, waste, and abuse perpetrated by their beneficiaries and/or providers. United's program integrity activities are coordinated among various functions, which include its local compliance and program integrity staff, OptumInsight, and its SIU, Government Programs Investigations (GPI). The SIU is located in Minnesota but staff also works in New Jersey, Maryland, New York, and Pennsylvania. OptumInsight will process cases specific to Delaware related to fraud, waste, or abuse that come from various sources like data mining, hotline, etc. The GPI only handles cases referred to the unit for investigation of fraud. Cases that are referred to the state will go through the local compliance officer.

MCO network providers are not enrolled with the state, they are registered. The two plans screen the providers and the provider files are sent to the state so it can enter the provider information into the Medicaid management information system.

Health Option's program integrity activities are supported by Gateway, Inc., an SIU contractor responsible for the detection, prevention, and investigation of fraud, waste, and abuse. Health

*Figures based on data reported by the plans as of June 2015.
**State Fiscal Year (SFY)

Options has an appointed compliance officer. The compliance officer and the Gateway SIU Manager work closely to coordinate compliance activities.

MCO Oversight of Network Providers

The state Medicaid agency does not conduct any onsite reviews of the MCOs. Instead, the state relies on the onsite reviews conducted by the contracted external quality review organization (EQRO). Initially, the contract language provided by the state did not indicate that that EQRO was looking at any program integrity functions. However, the team requested copies of the previous two EQRO reports for each of the MCOs that had been in place, and these reports did indicate that the EQRO reviewed the MCOs for compliance with the Medicaid managed care program integrity regulations at 42 CFR 438.608 and 438.610.

The state also monitors each MCO's program integrity activities through a monthly tracking tool that MCOs submit electronically. Some of the information captured in this report includes, but is not limited to: the number of provider applications submitted/declined/accepted, provider investigations that have been opened, the type of improper billing behavior, the identified dollars associated with an investigation, any actions taken, and recoveries identified and collected from investigations.

The state does not initiate audits of network providers, but upon receiving a referral from an MCO regarding a network provider, the state will confirm whether the provider is also enrolled in Medicaid FFS to determine if it could be an additional risk to the state. If so, the state will open a case on the provider in FFS. There are limitations with the encounter data, as discussed later, that hinder the state from being able to provide this type of ongoing monitoring.

Meetings and Training

The PIU meets quarterly with the MCOs and the MFCU to review any open cases on network providers and their status. The Chief of Managed Care Operations also attends this meeting. This time may be used to conduct training for the MCOs on program integrity issues in managed care. In addition, Managed Care Operations will meet with the MCOs monthly to review any contractual issues. The Chief of Managed Care Operations has conducted training for the MFCU on the basic elements of Medicaid managed care. There is no formal training among departments within the state. As the state Medicaid agency is small, communication is regular and there is ongoing cross-training among the units.

The state Medicaid agency has conducted formal training with the MCOs as recently as April 2015, regarding how to complete the monthly MCO report. At the quarterly meetings attended by the state's DMMA, MCOs, and the MFCU, the MCOs are informed of program integrity issues and provided guidance on how to improve their program integrity practices. United and Health Options are required to complete at least 9 hours of anti-fraud training annually. The MCOs meet the requirement by attending web-based training sessions hosted by the National Health Care Anti-fraud Association, through industry related meetings and through internal computer based training. In addition, all MCO staff must complete corporate compliance training, annually. However, the training listed for staff, and that which is available to providers on United's website was focused on Medicare, not Medicaid.

Health Options Corporate Compliance conducts training for new hires on their first day of employment. Employees learn about definitions of fraud and abuse, the key responsibilities of the SIU, and the fraud and compliance hotline number are included in the new hire corporate orientation. Training on fraud, waste, and abuse is conducted annually and includes: laws and regulations, process and methods for reporting, protections for employees who report, and types of member, provider, and employee fraud, waste and abuse that can occur.

Encounter Data

The state Medicaid agency does receive encounter data from the MCOs, but reported that it does not conduct analysis of the data due to limitations with their legacy system and the Medicaid Management Information System (MMIS). The state is in the process of developing a new MMIS, which is scheduled to go live in 2016. This new system is being designed to address many of the areas related to fraud, waste, and abuse. The state's limited ability to analyze encounter data hinders them in identifying aberrant provider billing patterns in the managed care sector. As the state is predominantly managed care, this further hinders the state in being able to monitor the MCOs' program integrity activities and whether plans are adequately identifying fraud, waste, and abuse in the program.

CMS recommends that Delaware continue its efforts to improve its ability to analyze encounter data reported by MCO contractors and perform state-initiated data mining activities to assist MCOs in identifying fraud, waste, and abuse issues with MCO network providers.

Reporting of Investigations and Overpayments

The state reported that none of the plans had identified or returned payments to the state in the past four FFYs. Although the state added revised language in 2015 to the MCO contract regarding returning overpayments, the state indicated that it had not had the opportunity yet to collect any funds.

A follow-up discussion was conducted with United staff after the review of fraud, waste, and abuse tracking cases. Of the ten cases sampled, there was one case which appeared to be closed prematurely. After further discussion with United staff, regarding this case, they indicated that cases could be closed if no action is taken in a specific time period so that cases do not remain open with no action.

Health Options case tracking is done by Gateway's SIU. Gateway has established monitors to prevent and track fraud and abuse cases in addition to quality issues. All referrals and cases are documented in a referral tracking system within 7 business days of the referral receipt. If the referral is deemed egregious, the referral will be entered into the tracking system immediately. Gateway tracks and investigates any action by providers, vendors, members, or employees that affects program integrity.

Payment Suspensions

Delaware Medicaid MCOs are not contractually required to suspend payments to providers at the state's request. United indicated that it does not have a payment suspension policy; however, they include information regarding payment suspensions in the regulatory appendix to every provider agreement. United would suspend payments at the direction of the state. It would also suspend payments, if necessary, depending on the individual circumstances in a provider investigation. When provider payment suspension requests from the state are received, they are referred to OptumInsight, a wholly-owned data mining subsidiary of United, to immediately place a flag on the provider's claims in order to stop any payment to the provider. Apart from providers sent to United by the state within the last four FFYs, United has not initiated the suspension of provider payments apart from holding payment until medical records are received or as part of settlement negotiations.

Health Options indicated that it has not yet suspended any payments to providers since the start of its operation in the state of Delaware. Health Options, however, would suspend payments at the direction of the state. It would also suspend payments, if necessary, depending on the individual circumstances identified in a provider investigation.

The state's contract requires MCOs to initially report to the state and the MFCU any suspected fraud, waste, or abuse by its providers, members, employees, or subcontractors within two business days of discovery, by utilizing the state's approved notification form. The MCO is then given ten days to complete a preliminary investigation and report its findings to the state and the MFCU within two business days. If directed by the state, the contractor may be asked to complete a full investigation, and if so, must again report its findings to both agencies within two business days of completing the full investigation. Although a review of the state's contract indicated a concurrent referral to the Program Integrity Unit (PIU) and the MFCU, it was learned during the onsite portion of the review that the actual process for any referral to the MFCU is that the MCO will refer the case to the state, which will, in turn, refer it to the MFCU. The discrepancy here may be due to new contract provisions in 2015 and the PIU staff not being fully aware of the requirements being placed on MCOs. This could cause some confusion for plans and for the various state staff who may be processing referrals and overseeing contract compliance.

Terminated Providers

The state's model contract requires MCOs to suspend or terminate providers who had been suspended or terminated by the state Medicaid agency, and to terminate any providers who have been terminated from Medicare, another federal health care program, or another state's Medicaid or Children's Health Insurance Program. The contract also requires the plans to notify the state within two business days of taking any action against a provider for program integrity reasons. In addition, the state reported that it does communicate terminations to the Department of Health and Human Services' Office of Inspector General, other states, and the plans. Terminations are discussed with the MCOs during the quarterly meetings.

United provided reports showing that they reported providers to the state who were terminated from their network or denied credentialing for program integrity reasons. United has also indicated that a majority of the terminations they undertook for-cause were in response to

licensure actions or notifications about state exclusionary actions. However, a sampling of ten for-cause termination cases by United showed that four of the ten cases had no provider names listed in the CMS terminations database. Health Options indicated that it had not yet terminated or disenrolled any providers for-cause.

As the chart below notes, United averaged 4 provider terminations over the 3 year period. Additionally, Health Options reported no termination or disenrollments.

Table 2: Provider Terminations in Managed Care

MCO	Number of providers in FFY 2014	Providers enrolled in last 3 completed FFYs	Providers disenrolled or terminated in last 3 completed FFYs	Providers terminated for-cause in last 3 completed FFYs
United	**FY14:** 9,000	**FY14:** 7,133 **FY13:** 6,305 **FY12:** 5,860	**FY14:** *No Data **FY13:** *No Data **FY12:** *No Data	**FY14:** 3 **FY13:** 5 **FY12:** 4
Health Options	2,208 from 01/01/2015 through 06/25/2015	**FY15:** 147 Initial files were processed from 01/2015 through 05/2015	**FY15:** 0	**FY15:** 0

**There is no data to show terminations or disenrollments that were for non-cause reasons.*

Section 3: NEMT

DHSS is responsible for the oversight of NEMT. Since the beginning of January 2015, DHSS has contracted exclusively with LogistiCare Solutions for NEMT. Out of approximately 200,000 eligible Medicaid members, there have been approximately 6,865 beneficiaries using NEMT in the first quarter of 2015. LogistiCare services only the Medicaid population in Delaware and has a total of 60 transportation providers. LogistiCare is paid on a per member per, month basis and is anticipating a new contracting process in April 2016.

On enrollment, transportation providers are required to present a certificate of transportation and have no more than three moving violations. They are also required to have a criminal background check, drug screening, and a driver history abstract. During the enrollment process**,** the state contract requires LogistiCare to conduct complete searches for individuals and entities excluded from participating in Medicaid.

- LogistiCare checks LEIE and EPLS (SAM) on the owner company name and driver upon enrollment and monthly thereafter. In addition, persons with ownership and control interests and the drivers providing the service are checked against the LEIE. There are no ongoing monthly searches of federal databases for providers or any person with an

ownership or control interest or who is an agent or managing employee of the provider. Managing employees are not being checked against databases at all.

- Transportation providers are required to submit self-evidence of criminal background checks for their employees, which are reviewed by Delaware Operations and Corporate Credentialing Department. Exclusion checks are performed by Corporate Credentialing every 30 days.

- All out of state provider vehicles are inspected by LogistiCare. No radius limitations are in place for out of state enrollment inspection of vehicles.

- LogistiCare's staff includes a Quality Assurance Representative, Utilization Review Representative, and a Field Monitor, any of whom can be involved in investigations of transportation providers.

- LogistiCare has the ability to track complaints as they come in via email, fax, or phone through a complaint tracker. LogistiCare has a dedicated hotline number to report fraud and abuse complaints, and complaints are responded to within 5 business days.

Section 4: Effective Practices

The state has revised its contract with the MCOs to include enhanced language related to program integrity. Some of the elements found in the contract which appeared to enhance the state's ability to provide guidance and oversight of the MCOs included the following:

- Contract requirement for MCOs to suspend or terminate providers who had been suspended or terminated by the state Medicaid agency, and to terminate any providers who have been terminated from Medicare or any state Medicaid or CHIP program.

- Contract requirement for MCOs to notify the state within two business days of taking any action against a provider for program integrity reasons.

- Clear directions on recoupment of overpayments, reporting of collection of overpayments, and which party is eligible to retain the recoupment.

- Requirements for disclosure of criminal action for dishonesty or breach of trust by contractor's staff.

- Clear directions on reporting of investigations and timeframes.

- Provisions on payment suspensions.

- Enhanced provisions for a Fraud, Waste, and Abuse Compliance Plan.

Opportunities for Improvement

- Amend MCO contracts to require MCOs to perform federal database checks as specified in 42 CFR 455.436.

- Confirm expectations for the MCOs in making referrals, i.e., to the state and the MFCU as indicated in the contract, or just to the state. Amend contract language if needed. Educate all state staff in managed care and program integrity on any new processes.

- Develop written policies and procedures which outline which state unit will be responsible for the various program integrity oversight functions.

- Continue efforts to improve ability to analyze encounter data reported by MCOs and perform state-initiated data mining activities to assist MCOs in identifying fraud, waste and abuse issues with network providers.

- Provide formal trainings on Medicaid program integrity issues to the MCOs. These could be conducted at the quarterly meetings with the state's MCO unit.

- State should report terminations by MCOs to CMS database.

- CMS recommends that the state clarify its expectations for the MCOs in making referrals and that this information be communicated clearly in the contract. All state staff involved in these processes should be educated on the contractual requirements.

Section 5: Status of Corrective Action Plan

As part of the focused review, the CMS review team evaluated the status of the state's CAP submitted in response to CMS's last review conducted in 2010. During the 2010 program integrity review the team identified four regulatory compliance issues and six vulnerabilities. On February 28, 2010, Delaware submitted a CAP to address the findings and vulnerabilities. At the time of the 2015 Focused Review, the CMS review team found that Delaware has corrected all of the areas of concern from the 2010 program integrity review.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Delaware 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 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 can help address the risk areas identified in this report. Courses that may be

helpful to Delaware 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, the Regional Program Integrity Directors calls, and Small States Calls to hear other states' ideas for successfully managing program integrity activities.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Delaware review the effective and noteworthy practices in program integrity and consider emulating these practices as appropriate.
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html

Conclusion

CMS supports Delaware's efforts and encourages it to look for additional opportunities to improve overall program integrity. The CMS focused review identified areas of concern and an instance 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 plan should identify those corrections as well.

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

Official Response from Delaware
March 2016

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE
OFFICE OF THE DIRECTOR

March 4, 2016

Laurie Battaglia, Acting Director
Division of State Program Integrity
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard Mail Stop AR-21-55
Baltimore, Maryland 21244-1850

Dear Ms. Battaglia:

Thank you for the Delaware Focused Review Final Report. The recommendations have been reviewed and you will find the State responses below:

1. **Recommendation:** Amend MCO contracts to require MCOs to perform federal database checks as specified in 42 CFR 455.436

   State response: DMMA amended the MCO contracts for the 2016 contract year. Section 26.3.21.14.6 states that the MCO's must perform federal data base checks as specified in 42 CFR 455.436. Section 15.3.9.7.14 which states that providers must be checked in the data bases as part of their initial screening monthly screening. Please see Attachment #1.

2. **Recommendation:** Confirm expectations for the MCOs in making referrals, i.e., to the state and the MFCU as indicated in the contract, or just to the state. Amend contract language if needed. Educate all staff in managed care and program integrity oversight functions.

   State response: On June 5, 2015, DMMA sent memo #101-2015 (Attachment #2) to both Managed Care Organizations outlining the Program Integrity and Medicaid Fraud Control Unit (MFCU) reporting process. During regularly scheduled monthly meetings DMMA continued to remind the MCO's and MFCU about the process for making referrals.

3. **Recommendation:** Develop written policies and procedures which outline which State unit will be responsible for the various program integrity oversight functions.

   State response: The policies and procedures can be found in the Surveillance and Utilization (SUR) Policy Manual (Attachment #3). The manual defines responsibility for the oversight functions of the Program Integrity Unit.

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4. **Recommendation:** Continue efforts to improve ability to analyze encounter data reported by MCOs and perform state-initiated data mining activities to assist MCOs in identifying fraud, waste and abuse issues with network providers.

   State response: The State is currently with two contractors Truven and Health Integrity to conduct data mining, predictive modeling, and claims analysis. This will assist DMMA in identifying fraud waste and abuse issues with both fee for service and the MCO network providers. DMMA will continue to work with the MCO's to improve our ability to analyze encounter data.

5. **Recommendation:** Provide formal training on Medicaid Program Integrity issues to the MCOs. These could be conducted at the quarterly meetings with the State's MCO units.

   State response: DMMA has both formal and informal meetings with the MCO's. During the quarterly meetings staff have conducted trainings and presentations about new fraud schemes, Medicaid Integrity Audits, Drug Diversion, OIG Audits, MFCU, and appropriate referrals.

6. **Recommendation:** The State should report terminations by MCOs to CMS database

   State response: The State continues to report terminations to the CMS database.

7. **Recommendation:** CMS recommends that the state clarify its expectations for the MCOs in making referrals and that this information be communicated clearly in the contract. All state staff involved in these processes should be educated on the contractual requirements.

   State response: In the DMMA Operational Memo#101-2015 the expectations for referrals were clearly outlined.

Sincerely,

Stephen Groff
Medicaid Director

cc: Linda Murphy, DMMA Chief Program Integrity
Kathleen Dougherty, Chief Managed Care Operations
Pednika White, SUR Administrator