Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

District of Columbia Focused Program Integrity Review

Final Report

August 2017

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of the District of Columbia to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the District's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar years 2012 and 2014. In addition, the review included a follow up on Trusted Health Plan's (THP) progress in implementing corrective actions to address all issues related to calendar year 2014.

Background: District Medicaid Program Overview

The District of Columbia's Medicaid program is administered through the Department of Health Care Finance (DHCF). The District does participate in Medicaid expansion under provisions of the Affordable Care Act. The District of Columbia operates a Section 1115(a) Medicaid demonstration waiver for childless adults, expanding health care coverage to non-pregnant, non-disabled adults who are 21 through 64 years of age and residents of the District. Additionally, the District of Columbia operates waivers for the Elderly and Individuals with Physical Disabilities (EPD) and Individuals with Intellectual and Developmental Disabilities (ID/DD).

When beneficiaries become eligible for Medicaid services, managed care enrollment is mandatory. The District of Columbia contracts with four plans to provide managed health care services. Those plans are: AmeriHealth Caritas (ACDC), MedStar Family Choice (MFC), Health Services for Children with Special Needs (HSCSN), and Trusted Health Plan (THP).

The District of Columbia's total Medicaid expenditures in federal fiscal year (FFY) 2016 were approximately $3.0 billion. As of December 2016, approximately 190,000 of the Medicaid beneficiaries, or 75 percent, were enrolled in managed care. The total MCO expenditures were approximately $1.0 billion, or approximately 33 percent of the total Medicaid spending. During FFY 2016, the District of Columbia's Federal Medical Assistance Percentage (FMAP) was 70 percent.

Methodology of the Review

In advance of the onsite visit, CMS requested that the District of Columbia and the MCOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A three-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of March 20, 2017, the CMS review team visited DHCF and the District of Columbia's program integrity unit (PIU). They conducted interviews with numerous District staff involved in program integrity and managed care. The CMS review team also conducted interviews with three MCOs and their special investigations units (SIUs). In addition, the CMS

review team conducted sampling of program integrity cases and other primary data to validate the District and the selected MCOs' program integrity practices.

Results of the Review

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

Section 1: Managed Care Program Integrity

Overview of the District's Managed Care Program

As mentioned earlier, approximately 190,000 beneficiaries, or 75 percent of the District's Medicaid population, were enrolled in four MCOs during FFY 2016. The District of Columbia spent approximately $1.0 billion, or approximately 33 percent, on managed care contracts in FFY 2016.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review.

The ACDC is a member of the AmeriHealth Caritas Family of Companies (ACFC). The ACFC is a for-profit health plan and is one of the largest Medicaid MCOs in the United States, serving approximately 5.7 million beneficiaries. The ACDC is also the largest Medicaid MCO in the District of Columbia; has more than 100,000 members; and serves over 51 percent of all Medicaid enrollees in the District. The MCO's SIU is a division of the payment integrity team which is located in the ACFC's corporate headquarters in Pennsylvania. The SIU team, supported by the corporate team of 44 full-time employees (FTEs), has two investigators assigned to ACDC; both investigators are fully-dedicated to conducting fraud and abuse activities for the plan. Additionally, ACDC also provides services to Healthcare Alliance (Alliance), which is a locally-funded program that provides health care to low-income District residents who have no other health insurance and are not eligible for either Medicaid or Medicare.

The MFC is a for-profit, provider-sponsored MCO servicing Medicaid programs in both the District of Columbia and the state of Maryland. The MFC is a subsidiary of MedStar Health, Inc. The MFC provides care for members enrolled in DC Healthy Families (DCHF) and the DC Healthcare Alliance (Alliance) Program as well as MedStar Family Choice Medicare. The MFC's managed care SIU is located within their compliance department and has three staff members. The MFC's subcontractors do not perform any reviews for fraud, waste, or abuse. The compliance director is responsible for coordinating the detection, referral, and investigation of suspected fraud, and typically receives no more than two calls per monthly alleging suspected fraud. During the onsite interviews, MFC stated that two and one-half FTEs were fully-

dedicated to program integrity activities for the District. However, during further discussion, the MCO acknowledged that those same FTEs identified as fully-dedicated to the District's activities were also engaged in fraud, waste, and abuse activities for the other plans serviced which provide health care for non-District Medicaid enrollees.

The THP is a for-profit, Washington DC-based health maintenance organization and MCO. The THP provides services to all eight wards and has a wellness center located in Ward 7. In addition, the THP also provides healthcare services to Alliance members who, as previously mentioned, are low-income District residents who have no other health insurance and are not eligible for either Medicaid or Medicare. The THP's managed care SIU is located within the compliance department and all staff are fully-dedicated to conducting Medicaid fraud and abuse activities in the District. The THP has three subcontractors for its dental, vision, mental health, and pharmacy services; these subcontractors maintain their own SIUs and process their own claims. These subcontractors also provide monthly reports to THP that include investigation and audit activities.

Enrollment information for each MCO as of February 2017 is summarized below:

Table 1.

	ACDC	**MFC**	**THP**
Beneficiary enrollment total	102,906	52,216	33,830
Provider enrollment total	4,379	5,714	10,737
Year originally contracted	2013	2012	2013
Size and composition of SIU	44.0 FTEs	2.5 FTEs	4.0 FTEs
Number SIU FTEs fully-dedicated to District plan	2.0 FTEs	2.5 FTEs	4.0 FTEs
National/local plan	National	Local	Local

Table 2.

MCOs	**FFY 2014**	**FFY 2015**	**FFY 2016**
ACDC	$412.3 million	$449.3 million	$462.2 million
MFC	$152.6 million	$211.3 million	$246.3 million
THP	$111.4 million	$122.6 million	$136.2 million

State Oversight of MCO Program Integrity Activities

The District of Columbia reported that oversight of the managed care system is a collaborative effort between the Health Care Delivery Management Administration (HCDMA) and the District's PIU. The District's PIU consists of 21 FTEs and is responsible for all program integrity, audit, and fraud investigation activities. The District confirmed that it does have operational guidelines, policies and procedures, or interagency agreements that govern the interaction between the District's program integrity efforts and programmatic oversight for each managed care program.

The DHCF's Division of Managed Care (DMC), located within the HCDMA, is responsible for managed care programmatic oversight of the MCOs. Although the DMC's responsibilities do not include fraud and abuse-related activities, DMC works closely with the District's PIU. The

District's Division of Quality and Health Outcomes and the District's external quality review organization, Delmarva, conduct annual onsite audits. While there are special projects that may qualify as program integrity projects, the contract does not specifically include program integrity provisions for fraud and abuse-related activities. The District's PIU does not conduct onsite reviews of the MCOs to verify compliance with its fraud and abuse contract requirements. The District's PIU stated its intentions to begin conducting onsite reviews in 2017; however, a start date to begin these reviews has yet to be determined.

Contract monitoring is conducted by the DMC which interacts with the MCOs on specific areas of the MCOs' contracts. Additional contract monitoring and involvement with writing managed care contract language is conducted by the District's PIU director.

Fraud and abuse cases reported by MCOs to DHCF are reviewed by the District's PIU to determine if they should be referred to the Medicaid Fraud Control Unit (MFCU) as credible allegations of fraud under 42 CFR 455.23.

All of the MCOs reviewed report their open and closed cases to the District on monthly reports. The District confirmed that the number of cases opened, closed, and their disposition, is tracked in a manner that allows for monitoring.

In the District of Columbia, it is the contractual responsibility of the MCO to screen all applications, including initial enrollment, relocation and re-enrollment or revalidation, based on a categorical risk level of limited, moderate, or high for providers and provider categories who pose an increased financial risk of fraud, waste, or abuse to the Medicaid program. It is the responsibility of each MCO to perform all the required federal database checks for the managed care providers as well as collecting and storing all required disclosure information. The District confirmed they do have written policies and procedures for overseeing the screening and enrollment process.

The District of Columbia's MCO contract states, "Contractor shall verify that reimbursed services were actually provided to enrollees by providers and independent contractors." All three MCOs follow the requirement to verify that services billed by providers were received by beneficiaries. The District makes an effort to ensure that client services are verified in the managed care program. Verification is accomplished by mailing explanation of medical benefits on a monthly basis to a sampling size selection of 7.5 percent which is based on paid claims during the previous month. Additionally, the District has increased efforts associated with Public Assistance Report Information System data to verify beneficiaries' eligibility.

Also, the District will impose monetary or restricted enrollment sanctions, corrective actions, fines, penalties, and/or training/education, if a MCO's performance is less than adequate.

MCO Investigations of Fraud, Waste, and Abuse

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

District of Columbia's MCO contract states, "Contractor shall be responsible for promptly reporting suspected fraud, abuse, and waste information, or the terms of the contract to the District of Columbia Office of Inspector General Medicaid Fraud Control Unit, DHCF's Division of Program Integrity, the Division of Managed Care, and the Contracting Officer within five business days of discovery, taking prompt corrective actions and cooperating with DHCF in its investigation of the matter(s). Contractors shall report confirmed violations to DHCF within twenty-four hours of the violation being confirmed."

The District's PIU receives monthly reports of all activities and any findings conducted on their behalf by the MCOs. The MCO is required to use the standard referral form, formats, and methodologies specified in the District's MCO model contract. The DHCF has not historically conducted any investigations of fraud and abuse directly related to allegations against the MCOs.

The MCOs submit monthly reports of fraud, waste, and abuse activity to the District's PIU for review. The contract does include language that requires the MCO to report suspected provider fraud, waste, or abuse to the MFCU.

The ACDC's SIU investigates reported potential fraud and abuse activities and, as appropriate, refers suspected or confirmed fraud or abuse to the appropriate oversight agencies as directed by the District. Upon receipt of a referral, the investigative intake specialist enters the referral into the case tracking system. Upon completion of their assessment, findings and recommendations are also documented in the case tracking system. The SIU manager reviews the intake of the referral for completeness and triages the referral. When a referral warrants investigation, the case is assigned to an investigator. The investigator prepares an initial investigative plan for SIU management review within three business days after assignment. The target case completion is between four to six months from assignment to conclusion. Upon receipt of management approval, the SIU investigator refers the suspected or confirmed fraud, waste, and abuse case to the District's PIU.

The MFC's compliance director is responsible for coordinating the detection, referral and investigation of suspected fraudulent activity. Once an allegation of potential fraudulent activity is reported to the compliance director, or discovered during routine or random reports and audits, an investigation into the allegation is initiated promptly by the compliance department. The allegation is documented in the appropriate compliance software system. Once the compliance director determines that a fraudulent activity may have occurred, the matter will be shared with the compliance committee, the executive operations team, and the board as appropriate. The corporate compliance officer and the compliance director will conduct a more detailed investigation.

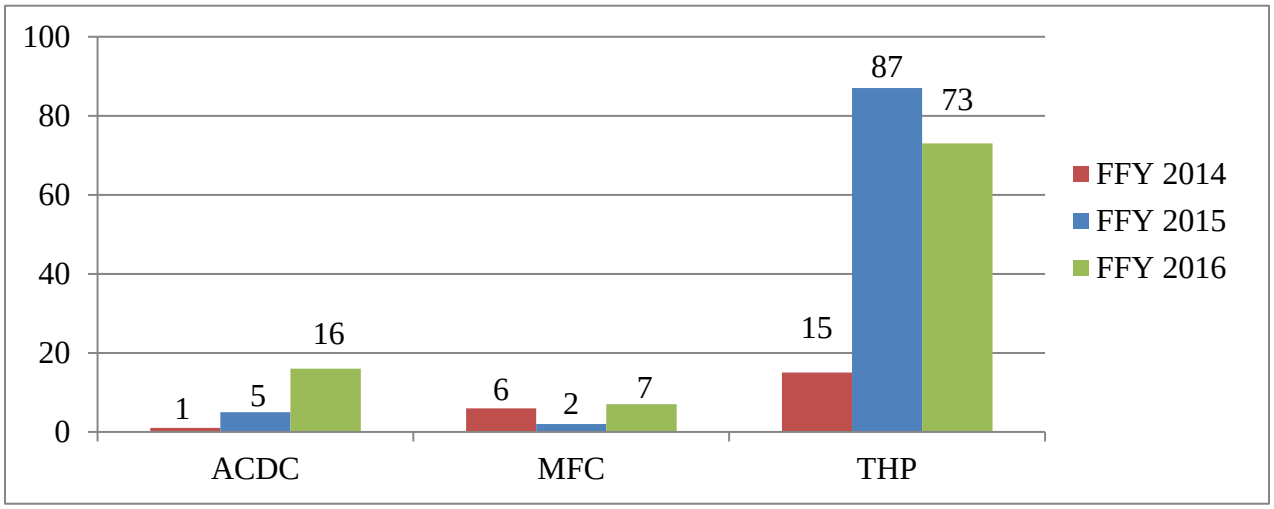
The THP's compliance department receives a referral, based on the type of case. From there, it is triaged to the appropriate staff member to conduct a preliminary review. The THP receives

referrals from a variety of sources. The MCO told the CMS review team that they then "bucket" the referrals into cases either regarding claims coding issues or all other issues; the MCO stated that is how they determine who is assigned a case. The MCO also said that each staff member is working between two to five cases on average. If the preliminary review determines that there is a validated suspicion, the case will be converted into a full investigation. All suspected fraud, waste, and abuse is referred to the District's PIU within five business days, and confirmed fraud, waste, abuse is referred within 24 hours.

Overall, the District's PIU considers the quality and quantity of the MCOs' referrals to be improving. The MCOs had limited program integrity oversight for an extended period of time, due to the DHCF's program integrity director position being vacant. Increased oversight and training has been a major focus during the past year; improvements made include: expanded reporting; increased liaison coordination; meetings held with the MCOs, MFCU, and law enforcement on both a monthly and an as needed basis; and the development of new reporting forms.

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

Table 3.



The CMS review team selected samples of five MCO network provider investigations conducted by the District during the past four FFYs. Upon review of the case files, three providers resulted in credible allegations of fraud which are ongoing investigations being conducted by the FBI, OIG, and MFCU; one provider is currently being investigated by the District's PIU to determine if a credible allegation of fraud exists; and one provider is currently being monitored by the District's PIU, although the District's PIU concluded there was no evidence of a credible allegation of fraud existing in the District of Columbia and this same provider was indicted for fraud in Maryland.

Meetings and Trainings

District of Columbia program integrity staff meets monthly with the District managed care staff to discuss program integrity activities. The last meeting was held on January 3, 2017.

The District's PIU meets monthly with the MFCU and the MCOs. During these regularly scheduled meetings, additional program integrity training is conducted on an as needed basis, or when there is a specific question or topic. Program integrity staff provide training covering topics that include recent trends in fraud, waste, and abuse; this training assists in developing and enhancing case referrals; identifying and investigating potential fraudulent billing practices by providers; managed care oversight; effective communications and information sharing; provider payment suspensions; self-audit procedures; online education; and other general program issues. These meetings also provide an opportunity for MCOs to communicate with law enforcement agencies and the District's PIU concurrently regarding potential cases of fraud, waste, and abuse. In addition, the District's PIU and MFCU jointly provide program integrity training to the MCOs during these monthly meetings. However, the MCOs are also responsible for providing program integrity training to their SIU personnel.

MCO Compliance Plans

The District does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608. The District does have a process to review the compliance plans and programs.

As required by 42 CFR 438.608, the District does review the MCO's compliance plan and communicates approval/disapproval with the MCOs.

Each plan is reviewed by the District's PIU director on an annual basis. The review process ensures the plans comply with 42 CFR 438.608, and all relevant District and federal laws, regulations, policies, procedures, and the District's MCO model contract requirements. Additionally, the effectiveness of the compliance program is monitored annually. The most recent review of the compliance plans was in March 2016. The next review of the compliance plans is scheduled for April 2017. The review of the compliance plan revealed minimal issues, such as grammatical errors.

All of the MCOs provided the review team with a copy of their compliance plans that have been submitted to the District. A review of these plans revealed they were in compliance with 42 CFR 438.608.

Encounter Data

The MCO model contract with the District requires the submission of complete, timely, and accurate encounter information, claims data, and other data documenting service utilization (both current and historical) to DHCF at least once per week. The District does receive weekly encounter data from the MCOs and reported that it does receive all the certified data the District requires to perform data mining activities. The District uses varying data mining techniques dependent upon the department performing the query and the purpose, such as financial, utilization, or quality. Additionally, the District contracts with an actuary, Mercer, to review, compile, and attest to the actuarial soundness of the capitation rates. Mercer also uses medical loss ratio (MLR) financial data and compares this to the submitted encounter data to determine completeness and solvency.

In addition, the three MCOs interviewed stated their SIUs have access to all levels of data within the MCO to conduct data mining and to analyze claims data. The ACDC performs both prospective (pre-check run) and retrospective (post-check run) data mining. The ACDC utilizes several vendors to analyze claims data. Each vendor utilizes various algorithms for data mining. Standard and ad hoc reports are provided by the vendors and internal team. The MFC performs data mining by running routine reports which include correct coding initiative unbundling, duplicate denials, line item denials, identification (ID) card requests, and evaluation/management trend reports. Ad hoc reports include queries by specialty, provider National Provider Identifier (NPI), Current Procedural Terminology (CPT), tax ID, diagnoses, combination CPT, and delegated vendor queries. The THP recently contracted with a vendor that performs fraud, waste, and abuse recovery services which include unusual billings for providers and any activities indicating non-compliance.

Overpayment Recoveries, Audit Activity, and Return on Investment

The District's MCO model contract does not require MCOs to return overpayments recovered from the providers as a result of fraud and abuse investigations or audits to the District. Also, the District's MCO model contract does not require the MCOs to report on overpayments recovered from providers as a result of MCO program integrity activities. Although, the MCOs do report overpayments recovered from providers as a result of fraud and abuse investigations or audits in the monthly report to the Program Integrity Division.

The District does not have any regulations or policies for identifying, collecting, or reporting and returning to the District overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits. However, the District is in the process of revising their new MCO contract which addresses these issues in the future for the new procurement. In general, the District allows the MCOs to collect and retain overpayments that are or are not potentially fraud-related. The District directs the MCOs to report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits. With the exception of the monthly report provided to the District's Program Integrity Division, overpayment recovery information is neither verified nor monitored by the District of Columbia. The District has stated that it will address this issue in its upcoming model contract revision which will become effective in FY 2018.

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

Table 4-A.

FFY	Preliminary Investigations*	Full Investigations*	Total Overpayments Identified	Total Overpayments Recovered
2014	51	51	$9.2 million	$4.4 million
2015	40	40	$13.2 million	$11.8 million
2016	80	80	$9.8 million	$17.8 million

*The MCO draws no distinction between preliminary and full investigations.

The ACDC's preliminary and full investigations significantly increased in FFY 2016 due to additions in the following areas: staffing, data mining efforts, outreach to staff, and the number of external tips received. The ACDC also stated that the variances in identified and recovered overpayments for FFY 2016 may be attributed to investigations spanning multiple years and the fact that recovered amounts do not always correlate to the years in which they were identified. The ACDC's recovered overpayments from providers as a result of its fraud and abuse investigations are tracked by their Program Integrity Division and reported to the District on a monthly basis.

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

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2014	6	6	$4,828	$4,828
2015	5	2	$2,019	$2,019
2016	12	7	$85,342	$32,965

The MFC's identified overpayments increased in FFY 2016, as a result of an audit of a provider who billed excessively using modifiers and for medical services that did not meet the appropriate reimbursement criteria. The MFC's identified and recovered overpayments are tracked by their compliance department and reports are sent to the District on a monthly basis.

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

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2014	172	18	$3,126	$3,126
2015	447	94	$4,919	$4,919
2016	335	76	$88,072	$56,294

The THP's identified and recovered overpayments are tracked by their compliance department and reported to the District on a monthly basis. Both preliminary and full investigations significantly increased in FFY 2015, as a result of the formation of the compliance department during June 2014. Also, THP added an investigator/auditor with coding experience in 2016; this additional staff member improved the outcome of the investigations.

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

Additionally, the review team discussed cost avoidance measures with the MCOs reviewed. The ACDC utilizes prepayment review to ensure that the provider's documentation supports the claim's billed services. The ACDC placed one provider on prepayment review for a six month period in FFY 2016. The MFC currently does not perform prepayment review, but they advised the CMS review team that they are in contract negotiations with General Dynamics Information Technology to conduct prepayment review during the current calendar year. The THP uses prepayment review for high dollar claims only. The THP stated that it is their belief that any provider who belongs on prepayment review should not be participating in their network. During the interview with THP, it was also stated that Syrtis, one of their two third party liability contractors, uses prepayment review as a way to measure cost avoidance for pharmacy claims.

Waste Recoveries Retained by the MCOs

As previously mentioned, the District of Columbia does not require MCOs to return overpayments recovered from providers as a result of fraud and abuse investigations or audits to the District. Also, the District of Columbia's MCO model contract does not require the MCOs to report on overpayments recovered from providers as a result of MCO program integrity activities. The District generally allows the MCOs to collect and retain overpayments that are not potentially fraud-related.

Although not required, the District of Columbia directs the MCOs to report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits. However,

overpayment recovery information is neither verified nor monitored by the District. Since this information is not monitored, the CMS review team further evaluated the amount of recoveries attributed to either fraud and abuse, or waste.

Both MFC and THP reported overall low recovery amounts resulting from fraud, waste, and abuse cumulatively; the majority of the recoveries for those plans was categorized as fraud and abuse-related. However, ACDC's recoveries from program integrity activities demonstrated that almost 100 percent of the total overpayments recovered were attributed solely to waste. (Fraud and abuse activities comprised only a fractional margin, or less than 0.02 percent, of all program integrity-related recoveries.) During the three FFYs reviewed, ACDC reported cumulative program integrity-related recoveries of $34,017,619; however, only $5,360 of its total recoveries were attributed to fraud and abuse. This amount is extremely low, in comparison to the plan's total waste recoveries of $34,012,259.

The table below shows the specific recovery amounts attributed to wastes and reported by ACDC for the past three FFYs.

Table 5.

FFY	Overpayments Recovered (Fraud and Abuse)	Overpayments Recovered (Waste)	Total Overpayments Recovered (Fraud/Waste/Abuse)
2014	$0	$4,409,255	$4,409,255
2015	$0	$11,777,875	$11,777,875
2016	$5,360	$17,825,129	$17,830,489

Overall, the amount of ACDC's recoveries categorized as waste is significant and the implications of identifying a case as waste potentially exempts suspect providers from being reported to the District or MFCU, payment suspensions, termination actions, and the other processes that are part of the fraud and abuse-related program integrity activities.

Payment Suspensions

In District of Columbia, Medicaid MCOs are contractually required to suspend payments to providers at the District's request. The District confirmed that there is contract language mirroring the payment suspension regulation at 42 CFR 455.23.

The District instructs the MCOs to suspend payments to MCO network providers based upon a pending investigation of a credible allegation of fraud. As previously mentioned, the MCO contract with DHCF requires contractors to report confirmed violations to DHCF within 24 hours. All three MCOs follow this requirement and only suspend payments to network providers upon credible allegation of fraud determinations by the District, and at the direction of either DHCF or the MFCU.

The ACDC, MFC, and THP suspend provider payments upon receipt of payment suspension notification via secure email from the District's PIU. The District informed the CMS review team that it has requested that the MCOs suspend payments to two providers due to credible

allegations of fraud in the past FFY. The District's PIU had recently established a procedure for notifying all of the MCOs regarding all DHCF Medicaid provider payment suspensions and terminations, independent of known MCO network inclusion, to ensure proper notification.

Terminated Providers and Adverse Action Reporting

The District MCO contract states, "Contractor shall notify DHCF within two (2) business days of any termination of a contract with a network provider. Contractor shall send written notice of termination of a network provider to each enrollee who received his or her primary care or was seen on a regular basis by the terminated provider, within fifteen (15) days after contractor's receipt or issuance of the termination notice."

During the onsite interview, the District's PIU confirmed there is a monthly process in place to ensure that the MCOs are terminating providers for cause. Additionally, the District's managed care division does notify MCOs of any terminated providers from other plans, so that the MCOs may ensure that terminated providers are not operating in another plan. The three MCOs interviewed confirmed that they report all terminated providers to the District's PIU within two business days of any provider termination via secure email and on a monthly basis. The ACDC submits a monthly termination report, which includes the reason for termination, to the District's PIU. The MCO's market president, compliance officer, and/or SIU team receive notifications from the District's PIU regarding providers who have been terminated for cause. The compliance officer forwards the notice to the ACDC provider network management director, credentialing director, and SIU manager for next steps relative to claims/impact analysis and termination of provider contract, updates to the credentialing, and claims adjudication systems. Members are notified in accordance with MCO contract requirements, when applicable.

The MFC submits a monthly termination report, which includes the reason for termination, to the District's PIU. The MCO's compliance officer receives notifications from the District's PIU regarding providers who have been terminated for cause. The credentialing department updates the credentialing database, generates a practitioner change report, and sends a copy of the practitioner changed report to the practitioner contracting/database management department. Termination letters are kept in the practitioner's file.

The THP submits a monthly termination report, which includes the reason for termination, to the District's PIU. The MCO's compliance officer receives notifications from the District's PIU regarding providers whom have been terminated for cause. The compliance department then reviews claims to verify claim payments to the provider. Upon confirmation, the compliance department submits a request to suspend all claim payments. The compliance department forwards a notice to the provider relations department. Upon receipt, the provider relations department then forwards a notice of suspension of payment to the provider.

Table 6.

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated for Cause in Last 3 Completed FFYs	
ACDC	2014 2015 2016	6 4 14	2014 2015 2016	4 4 5
MFC	2014 2015 2016	236 267 210	2014 2015 2016	6 57 12
THP	2014 2015 2016	253 281 123	2014 2015 2016	11 21 8

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

The District reported to the CMS review team that it was having issues with the TIBCO MFT portal for approximately four months. However, the District's PIU is now successfully downloading and checking the monthly Medicare revocation list, and stated that it will be providing the downloaded TIBCO list of terminated providers to their MCOs to assist in identifying providers who should be terminated from the plans' networks. In addition, the District's PIU said that it will begin reporting managed care providers terminated for cause to CMS.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

As previously mentioned, the MCO is contractually responsible for provider screening and enrollment in the District. The onsite review team confirmed that ACDC is performing all required federal database checks for the managed care providers as well as collecting and storing all required disclosure information. The MFC and THP are collecting and storing all required disclosure information, however, they were not in full compliance with checking all required

federal database checks. The MFC and THP do not check the SSA-DMF. Additionally, MFC does not check the NPPES.

Recommendations for Improvement

- Given the limited number of provider investigations and referrals by the MCOs along with the low number of overpayments and terminations that the MCOs reported, the District of Columbia should ensure that both the DHCF and its MCOs are allocating sufficient resources to the prevention, detection, investigation and referral of suspected provider fraud. In addition, the District should confirm that MCO program integrity resources reported as fully-dedicated to their program are not engaged in conducting fraud, waste, and abuse activities for other plans which cover residents not eligible for the Medicaid program.
- The District's PIU should implement its plan to conduct annual onsite visits at the MCOs to verify compliance with its fraud and abuse contract requirements. Regular onsite visits would provide increased oversight by the state Medicaid agency, in addition to the reporting methods currently in place.
- The District should proceed with its revision of the MCO model contract to include language regarding identifying, collecting, and reporting overpayments by the MCOs, and returning to the District overpayments recovered from providers resulting from MCO fraud and abuse investigations and/or audits. In addition, the District should develop written policies and procedures for the overpayments recoveries oversight process; verify that identified and collected overpayments are fully reported by the MCOs; and confirm that these amounts are incorporated into the rate-setting process along with the overpayments determined by District-initiated reviews.
- The District should have policies and procedures which establish guidelines for the identification of waste cases. Parameters would prevent cases not meeting the criteria for waste from being improperly classified and, therefore, exempted from fraud and abuse program integrity activities, such as suspect providers being reported to the District or MFCU, payment suspensions, and termination actions. Also, the District should include language in its MCO model contract addressing the handling of recoveries attributed to waste and specify requirements regarding the retention, reporting, and monitoring of program integrity-related recoveries attributed to waste.
- The District and the MCOs should work together to strengthen parameters regarding prepayment rules, policies, and requirements. The MCOs utilizing post-payment recovery measures, should be encouraged by the District to consider instituting cost avoidance measures which lessen the need for recovery of monies overpaid.
- The District's PIU should verify that it's PIU is providing the downloaded TIBCO list of terminated providers to the MCOs to assist in identifying providers who should be terminated from the plans' networks. In addition, the District should confirm that it's PIU is reporting managed care providers terminated for cause to CMS.
- The District should ensure that the MCOs, or its delegates responsible for enrollment and credentialing functions, are performing all required federal database checks for the organization (42 CFR 455.436) and for all others required (42 CFR 438.610) at the appropriate time intervals specified in the regulations.

Section 2: Status of 2014 Corrective Action Plan

District of Columbia's last CMS program integrity review was in June 2014, and the report for this review was issued in December 2015. The report contained one finding and six vulnerabilities. During the onsite review in March 2017, the CMS review team conducted a thorough review of the corrective actions taken by District of Columbia to address all issues reported in calendar year 2014. The findings of this review are described below.

Findings -

1. ***Develop and implement the full range of policies and procedures needed to comply with the provider screening and enrollment requirements of 42 CFR 455, Subparts B and E: pre-enrollment site visits; fingerprinting and criminal background checks; collection of disclosure and ownership information; and performance of all required federal database checks.***

   Status at time of the review: Not Corrected

   - The District reported that they implemented the pre-enrollment site visit requirement in August 2014, and began collecting application fees on May 1, 2015. The District provided the CMS review team with a copy of the provider enrollment site visits policy scope.
   - The District is still waiting for FBI approval to channel the background checks and fingerprints. (Under the *Departmental Order for FBI Channeling*, the results of fingerprint checks may be expedited directly to the FBI.) A response regarding the FBI's delivery date has not yet been provided.
   - The District requires all providers to complete a uniform disclosure of ownership form, as part of their initial and re-enrollment applications. The CMS review team was provided with a copy of the disclosure of ownership and control interest statement, the criminal information form, and provider instructions.
   - The District confirms the identity and determines the exclusion status of providers and any person with an ownership or controlling interest or who is an agent or managing employee of the provider through the LEIE, SAM, and NPPES. The SSA-DMF is being checked as a part of the provider enrollment process with the Provider Data Management System (PDMS) vendor.

Vulnerabilities -

1. ***Strengthen internal policies and procedures for monitoring the provision of Personal Care Services (PCS) by the MCOs serving clients in the District's Child and Adolescent Supplemental Security Income Program (CASSIP).***

   Status at time of the review: Corrected

   - The District reported they have made several changes to its internal policies to strengthen its monitoring of services personal care assistants (PCAs) rendered to CASSIP recipients by HSCSN which is a nonprofit MCO that coordinates care for children and young adults with disabilities and complex medical needs.
   - The District provided the review team with a copy of the updated policies and procedures for monitoring of PCS by the MCOs for CASSIP.
   - The District provided the CMS review team with a copy of the final approval of the amendment of solicitation/modification of contract.

2. ***Develop and implement a policy and procedure for tracking problem PCAs on a regular basis, either by maintaining an internal database which generates a listing of certified PCAs who have received disciplinary sanctions or by systematically checking existing resources, such as the Board of Nursing's PCA listings.***

   Status at time of the review: Corrected

   The District reported that, on a monthly basis, the Board of Nursing provides DHCF with a list of all PCAs against whom disciplinary action has been taken. In addition, annual audits are being conducted by the District's PIU. The District reported it has increased monitoring and oversight through data analysis and investigation.

3. ***Ensure that billings submitted by the Home Health Agencies (HHAs) contain a record of all PCAs who served Medicaid beneficiaries consistent with District requirements.***

   Status at time of the review: Corrected

   - The District reported that it has successfully modified its Medicaid Management Information System (MMIS) in October 2015 to allow inclusion of multiple PCA NPI numbers, so that claims will not be rejected.
   - To ensure HHAs are billing based on services authorized, authorizations for PCA services are based on the amount and frequency determined by the assessment.
   - The DHCF also implemented system functionality to deny all claims for a PCA who has billed for more than 16 hours of PCA services on single date of service.

4. ***Enhance the protocols for auditing HHAs serving Medicaid beneficiaries in the District to ensure that HHA audits by district personnel and/or qualified contractors are regularly conducted in a comprehensive manner.***

   Status at time of the review: Corrected

   The District reported that they have updated the HHA audit protocol to include rigorous financial accountability requirements, in addition to the programmatic requirements set forth by regulation. The District provided the CMS review team with a copy of their audit protocol.

5. ***Ensure that elements of the new District regulations designed to protect against possible fraud and abuse in the District's PCS program, such as the surety bond requirements, are implemented and enforced.***

   Status at time of the review: Corrected

   - The District reported all current and prospective providers of PCA services are required to submit proof of a $50,000 surety bond with their application.
   - Screening for proof of the surety bond for PCA providers is completed as a routine part of DHCF's screening process. This was implemented in 2015.

6. ***Develop a plan for future monitoring of PCS services.***

   Status at time of the review: Corrected

   The District reported that they have strengthened provider screening and enrollment requirements and processes; strengthened program requirements; increased training and technical assistance to providers; increased monitoring and oversight through data analysis and investigation; added edits to the MMIS to deny claims which appear to be fraudulent; hired new leadership and reorganized the Program Integrity Division; and significantly strengthened partnerships with their sister agencies and law enforcement entities.

Section 3: Status of 2012 Corrective Action Plan

The District of Columbia's comprehensive program integrity review was conducted in August 2012, and the report for this review was issued in February 2014. During the onsite review in March 2017, the CMS review team conducted a thorough review of the corrective actions taken by District of Columbia to address all issues reported in calendar 2012. The findings of this review are described below.

1. ***The District is not complying with the statutory requirements on False Claims Act Education.***

   Status at time of the review: Corrected

   The District provided the CMS review team with copies of regulations/transmittals that address 42 CFR 455, Subpart E - False Claims Act Education updates as well as the Affordable Care Act provider screening and enrollment requirements.

2. ***The District does not adequately have program integrity activities.***

   Status at time of the review: Corrected

   The District reported that the webpage is operational. The District provided the CMS review team with the link to the webpage including a demonstration of the website's functionality.

3. ***The District does not have internal policies and procedures on payment suspensions.***

   Status at time of the review: Corrected

   The District reported that it has developed policies and procedures for the payment suspension process which has been shared with the District's staff. The District provided the CMS review team with a copy of the payment suspension policy.

4. ***The District is not adequately incorporating program integrity principles and policies in its managed care program.***

   Status at time of the review: Corrected

   The District reported that it has developed policies and procedures that adequately address program integrity oversight. The District provided the CMS review team with copies of policies and procedures detailing its program integrity oversight activities and processes.

5. The District is not checking the TIBCO managed file transfer (MFT) server, when screening newly enrolling providers.

Status at time of the review: Corrected

The District reported to the CMS review team that it is checking the TIBCO MFT server, when screening newly enrolling providers.

6. The District's forms and web-based enrollment process did not reflect the ownership and control disclosure requirements that became effective on March 25, 2011.

Status at time of the review: Corrected

The District reported that the revised provider enrollment forms went into effect in September 2014, and were last updated on March 31, 2016. The District provided the CMS review team with a copy of the revised enrollment forms.

7. The District does not have policies and procedures that provide for regular meetings between the MFCU and the program integrity section of the Medicaid agency.

Status at time of the review: Corrected

The District reported that it has developed policies and procedures, including a revised memorandum of understanding (MOU), which require regularly scheduled meetings between the MFCU and the program integrity section of the state Medicaid agency.

8. The District does not have an updated MOU between the state Medicaid agency and the MFCU to improve the referral process, and facilitate the sharing and discussion of case information at regular meetings.

Status at time of the review: Corrected

The District reported that it has revised the MOU to improve the referral process; facilitate the sharing and discussion of case information at regular meetings; and address both the payment suspension procedure and quarterly certification process at a high level. The District provided the CMS review team with a copy of the revised MOU.

Section 4: Status of the 2014 Corrective Action Plan - THP

The CMS review team conducted an in-depth review of the corrective actions taken by THP to address all issues reported in calendar year 2014. The findings of this review are described below.

*1. Monthly reconciliations were not performed or were inaccurate.**

Status at time of the review: Corrected

- The THP provided the CMS review team with copies of the member eligibility file update and reconciliation process, and the member reconciliation process.
- The THP also provided the following reports to the CMS review team: the roster discrepancy, enrollment/disenrolled, invalid recipient number, and members enrolled.
- Corrections were processed as follows:
  - In June 2013, a week prior to the scheduled roster delivery date to all contracted District MCOs, a preliminary enrollment file was provided by the District to all MCOs of enrollees from the outgoing MCO. The THP improperly loaded this file into the MCO's management system as their first effective date (July 1, 2013) enrollment file. The file was not intended to be the official listing of THP's upcoming July enrollment of Medicaid beneficiaries. The DHCF provided ample notice and clarification to the MCOs prior to this action. The official July enrollment file was delivered a week later to all District contracted MCOs.
  - In October 2013, THP's claims vendor (DST) was alerted that they had incorrectly loaded an enrollment file into the MCO's management system.
  - The DST began analysis and "clean up" of the incorrect enrollment data. By October 31, 2013, a total of 1,919 incorrect beneficiaries were terminated from the MCO.
  - On November 13, 2013, a total of 1,576 claims associated with the incorrect enrollment file were adjusted by DST.
  - In May 2014, THP conducted an audit of its enrollment at DST. The District had 30,096 beneficiaries assigned to THP and DST had 30,100. The four additional beneficiaries were identified as having recently switched MCOs; these 4 beneficiaries were corrected.
  - By June 2014, all claims and encounters related to the beneficiaries incorrectly loaded into THP's management system were voided. All clean up and reconciliation activities were successfully completed by June 30, 2014.

2. The THP's MLR was below 85 percent.

Status at time of the review: Corrected

The THP provided the CMS review team with a copy the first quarter of 2014 MLR letter that was sent to the District indicating an updated MLR of 89.7 percent.

3. Medical expenses were overstated.

Status at time of the review: Corrected

The THP provided the CMS review team with copies of audit engagement letters and checklists for the past six months, and copies of overpayments identified and recovered for the past six months.

4. The CVS pharmacy had the following issues relating to the safeguarding of protected health information and unclean conditions: the back storeroom had mud on the floor and standing water; files were in disarray with many prescriptions missing and no evidence of sequential order; and requested records were not able to be located through electronic image.

Status at time of the review: Corrected

The THP provided the CMS review team with copies of the most recent tracking spreadsheet including seven separate summaries of surprise visits conducted by THP of their various provider's facilities to ensure facilities meet the regulatory standards. The tracking spreadsheets contained all compiled data gathered during these unannounced visits which included: possible hazards; cleanliness of facility; and the security of medications and member information.

5. Lack of documentation regarding member care and authorizations.

Status at time of the review: Corrected

The THP provided the CMS review team with copies of the *Care Connect Associate Activity & Call Report;* meeting minutes for the weekly rounds with Beacon Behavioral Health; the most current policy for prior authorizations and care coordination; the most recent tracking spreadsheet for the letters of agreement; the authorization policy and provider manual; and the provider agreement for physical and behavioral health care. The records provided by the MCO demonstrated adequate documentation regarding member care and authorizations.

6. Lack of primary care physician oversight and coordination.

Status at time of the review: Corrected

The THP provided the CMS review team with copies of the monthly audits of the case management files for the past six months of 2016. The provided documentation demonstrated appropriate primary care physician oversight by the MCO and coordination.

7. Failure to meet prompt payment requirements.

Status at time of the review: Corrected

The THP provided the CMS review team with copies of the updated policies and procedures regarding the reporting and monitoring of prompt payment requirements. Prompt Payment Act requirements addressed under DC Code §31-3132 directs MCOs to pay clean claims within 30 days of submission. The documentation provided by the MCO during the CMS onsite review indicated that THP now meets the prompt payment requirements.

Technical Assistance Resources

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

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the District's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems 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 District of Columbia are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- 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. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

Conclusion

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

We require the District 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 District will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the District 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 District 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 District has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with District of Columbia to build an effective and strengthened program integrity function.