



*Testimony before the Legislative Program Review
and Investigations Committee*

Medicaid: Improper Payments Study

John F. McCormick, Director Office of Quality Assurance

June 29, 2012

Good morning, Senator Fonfara, Representative Rowe and members of the Legislative Program Review and Investigations Committee, my name is John McCormick and I am the Director of the Office of Quality Assurance of the Department of Social Services (DSS). Over the last several weeks, we have had the pleasure of meeting with your staff to explore the work of the department in the area of quality assurance and specifically how the department identifies improper payments made under the Medicaid program. We welcome this opportunity to speak before you today and to participate in this study, as it is our belief that the breadth and depth of the quality assurance efforts engaged in at DSS are not widely known.

My testimony today will provide you with an overview of the scope of work of the DSS Office of Quality Assurance (QA).

QA is responsible for ensuring the fiscal and programmatic integrity of all programs administered by DSS as well as all administrative functions of the department. The division is committed to the belief that program integrity can be best achieved through the fair application of proactive, creative, and coordinated initiatives designed to both prevent and recover improper payments.

Organizationally, QA is located in the Department's Central Office at 25 Sigourney Street in Hartford. In addition, we have QA staff in our regional offices throughout the state who currently report to regional office management. However, we are in the process of centralizing the oversight of the fraud investigators located in the regions. This long standing reporting structure has resulted in an inconsistent approach to fraud investigations and we believe that centralizing the reporting structure will result in improved outcomes.

QA has four separate divisions, each with unique program integrity functions. The four divisions are: Audit, Fraud & Recoveries, Quality Control, and Special Investigations. QA is currently staffed by 92 employees and we are in the process of filling additional positions.

Overall in SFY 2011, QA identified over \$372 million in overpayments, third party recoveries, and cost avoidance.

The Audit Division

The Audit Division performs several audit related functions. The Provider Audit Unit is responsible for conducting federally mandated audits of medical and health care providers that are paid through the various medical assistance programs funded by the department. The vast majority of audits target Medicaid providers. In some cases, our audit may reveal suspected Medicaid fraud. In such cases, the Audit Division will make a referral to the Special Investigations Unit for a more focused review, which could result in legal action brought by the Attorney General and/or Chief State's Attorney.

The Grants & Contracts Unit is responsible for reviewing federal and state single audit reports. The unit is also responsible for reviewing the financial reporting of various grants and contracts that the Department has with non-profit agencies and municipalities.

The Audit Division also performs internal audits of the department. These audits involve the review of administrative and programmatic functions within the department as well as the electronic data processing systems used in their support. In addition, the Audit Division is responsible for coordinating the department's response to all outside audit organizations, including but not limited to, the State Auditors of Public Accounts and federal audit organizations.

As required by the federal Deficit Reduction Act, the Centers for Medicare and Medicaid Services (CMS) has contracted with a Medicaid Integrity Contractor (MIC) to audit Medicaid claims paid by DSS. The Audit Division is responsible for coordinating and approving the audits performed by this contractor.

More recently, DSS has contracted with Health Management Systems, Inc. (HMS) to serve as the state's Recovery Audit Contractor (RAC), which is a requirement of the federal Patient Protection and Affordable Care Act. In the very near term, HMS will begin initiating audits and various paid claim reviews. They will be paid a percentage of the funds actually recovered; 9.3% for automated reviews and 10.5% for complex reviews.

Every three years, DSS is subject to a Payment Error Rate Measurement (PERM) review by CMS. The Audit Division coordinates the record submission process and leads the corrective action plan development.

Through a total of 104 audits issued during Fiscal Year 2011, the Audit Division identified \$14.7 million in overpayments and cost avoidance. Historically, the Audit Division has a return on investment of \$700,000 per auditor.

Despite the success of the Audit Division, the audit process is challenged annually through proposed legislation seeking to weaken the state's ability to identify and recover improper payments made to providers.

The Fraud & Recoveries Division

The Fraud & Recoveries Division insures that DSS is the payer of last resort for the cost of a client's medical care. This is accomplished through a variety of strategies including, 1) detecting, verifying, and utilizing client third party payer resources; 2) establishing monetary recoveries realized from releasing liens, mortgages, and selling property that the department holds; 3) prevention of fraudulent payments to clients; 4) pursuing client fraud through detection, prosecution, and the recovery of fraudulent overpayments; 5) and establishing recoveries for miscellaneous Medicaid overpayments.

The division is sub-divided into four primary areas of focus: Central Processing, Client Fraud, Real Property and Third Party Liability.

Central Processing Unit

The Central Processing Unit (CPU) is responsible for ensuring client benefits from several major programs are processed in the most accurate and efficient manner. The CPU's functions include: Electronic Benefit Transfer (EBT) processing, Notification of Newborn Applications, essential services payments, replacement medical card requests and vendor information, discontinuation of benefits where appropriate, IRS 1099 mailings for Department vendors, Statements of Assistance, Emergency child support pass through payments.

Client Fraud Unit

The Client Fraud Unit investigates alleged recipient fraud in various programs administered by the Department including Care4Kids, Supplemental Nutritional Assistance (SNAP), Connecticut Energy Assistance (CEAP) and Medicaid. The Unit also performs data integrity matches with other state and federal agencies (i.e. CT Department of Corrections, CT Judicial Department, U.S. Health and Human Services, U.S. Social Security Administration) to identify inappropriate payments made to recipients.

The unit oversees and maintains the department's toll-free Fraud Hotline. The Hotline is available to the public to report situations of suspected fraud in public assistance programs.

During Fiscal Year 2011, the central office investigations staff identified over \$6.5 million in overpayments, recoveries, and cost avoidance. The unit also received and processed over 2,100 Fraud Hotline calls during the same period.

In addition, the investigations staff located in the department's 12 regional offices identified \$5.1 million in overpayments, recoveries and cost avoidance.

All Client Fraud unit staff (in both central office and the regions combined) identified \$2.4 million in cost avoidance from actions taken as a result of various federally mandated computer matches.

Real Property Unit

The Real Property Unit is responsible for the placement of liens and security mortgages on the real properties of recipients who receive benefits under the department's various benefit programs. Upon the sale or a mortgage refinance of a property, the unit must be contacted by the recipient or their closing attorney for the payoff amount due on the state's lien or security mortgage, and to request a release of the department's encumbrance.

The unit works closely with the Office of the Attorney General and the Department of Administrative Services in support of these recovery efforts.

During Fiscal Year 2011, the Real Property Unit created 742 encumbrances against real properties of recipients receiving public assistance benefits and recovered \$5.5 million of the public assistance granted.

Third Party Liability Unit

Section 1902(a)(25)(9A) of the Social Security Act requires states to take all reasonable measures to ascertain the legal liability of third parties to pay for services available under Medicaid. The Third Party Liability (TPL) Unit insures these requirements are met. The TPL Unit plans, develops, and oversees the department's TPL cost containment and recovery programs that currently include two major contracts.

HMS (previously mentioned as the state's RAC contractor) is under contract with the department to perform third party liability and program integrity work. HMS performs comprehensive client health insurance identification matches which are utilized to prevent the payment of claims and to recovery claims paid by Medicaid. In addition, HMS supports the joint DSS/DPH Connecticut AIDS Drug Assistance Program (CADAP) premium purchase program which, through federal funding, pays the health insurance premiums for CADAP clients. Finally, HMS performs acute care hospital and skilled nursing facility credit balance audits.

In SFY 2011, the Department realized approximately \$292 million in Medicaid cost avoidance. In addition, HMS recovered \$23 million in Medicaid payments from third party payers and \$17 million through nursing facility and hospital credit balance audits.

The Center for Medicare Advocacy, a not-for-profit corporation located in Mansfield, Connecticut, is under contract with DSS to perform Home Health Care and Skilled Nursing Facility Medicare advocacy work. The Center utilizes the Medicare Administrative Appeals Process (i.e. the due process rights afforded to all Medicare beneficiaries in the country) to obtain Medicare coverage for home health and skilled nursing facility/chronic disease hospital care for Connecticut's Medicare/Medicaid eligible population. The Center files Medicare appeals to insure the Federal Medicare Program pays its fair share of client services.

In SFY 2011, \$4.3 million in Medicaid payments were recovered through the Medicare appeal process.

The Quality Control Division

As part of a national performance reporting system, DSS is required to conduct Quality Control reviews. The Quality Control Division (QC) is responsible for federally mandated reviews of Care4Kids, Medicaid, and SNAP. A newly established set of federally required Medicaid reviews has been implemented under the PERM program. Reviews of Temporary Assistance for Needy Families (TANF) cases and special projects may also be performed by this unit. QC reviews are conducted to determine the Department's compliance with federal and state program eligibility requirements.

The QC staff review approximately 3,100 cases per year, plus an additional 1,837 cases during the federally required PERM and Childcare review cycles. In SFY 2011, the QC staff reviewed 1,127 Medicaid cases.

The Special Investigations Unit

Created in Fiscal Year 2010, the Special Investigations Unit (SIU) is charged with the responsibility of coordinating and conducting activities to prevent, detect and investigate fraud, waste, abuse and overpayments in the Connecticut Medicaid Program.

Provider Enrollment

Fraud prevention is also achieved by instituting provider disclosure requirements and verifying the screening of information received during the enrollment process. SIU is responsible for conducting screenings and background checks of newly and re-enrolled providers to determine their suitability for enrollment in Medicaid.

The Office of Inspector General of the U.S. Department of Health and Human Services has the authority to exclude any individual or entity from the Medicaid program that meets the basis for liability under federal rules. The unit is responsible for reporting to the federal government any adverse action taken against providers as required under 42 CFR 455.17. SIU also maintains, updates, and utilizes the "List of

Excluded Individuals” to ensure excluded providers do not participate in Medicaid. In addition, the Department initiates its own suspension of providers from the Medicaid program when indicated.

Data Analysis and Research

The SIU utilizes available technology to identify potentially fraudulent payments. This “Fraud and Abuse Detection System” incorporates the processes and procedures involved in the detection of aberrant Medicaid providers whose service/claim profile necessitate further review to determine if fraud, abuse, or overpayments have occurred. This includes the operation and maintenance of the Surveillance and Utilization System (SURS/Profiler) and the Fraud, Abuse, and Overpayment System (FAO).

- The SURS/Profiler system provides statistical profiles of health care delivery and utilization patterns of both providers and recipients based on federal and state guidelines and user-defined parameters.
- The FAO comprises of thirty-one targeted queries that isolate specific areas of focus.
- The current SURS/Profiler and FAO are based on technology that is close to two decades old. A state-of-the-art fraud detection system that includes the ability to perform predictive analytics will greatly improve the SIU’s ability to identify aberrant payments through data analysis.

In addition, data mining allows the staff to develop custom queries with user-defined criteria to perform detection, investigation and research functions.

As previously mentioned, the audits performed by the MIC are monitored by the Audit Division. A second “review” MIC performs data analysis that must be vetted by the department. The SIU is responsible for testing and validating all algorithms proposed by the “review” MIC.

Finally, the SIU is responsible for providing the Medicaid claim data to the PERM contractor.

Investigations

The Investigation Unit has several functions including:

- Preliminary and Full Scale Provider Reviews - Providers or schemes targeted as a result of complaints received by the department and/or from the Fraud and Abuse Detection System, are subject to a preliminary review as defined by federal regulations. Based on the outcome of the preliminary review, the provider or scheme may be subject to a more intensive Full Scale review or the case may be developed into a fraud referral.

- Fraud Referrals - The department is required under federal regulations to refer matters of suspected Medicaid fraud and abuse to the Medicaid Fraud Control Unit of the Office of the Chief State's Attorney ("MFCU"). Cases are only referred to the MFCU if the suspected fraud can be corroborated by our own review and investigation. In addition to the MFCU, all fraud referrals are simultaneously sent the OIG Office of Investigations and to the Office of the Attorney General. This procedure is in compliance with a Memorandum of Understanding between the Department and the three parties.
- Law Enforcement Support - The SIU supports law enforcement efforts by developing reports and/or obtaining documentation, as requested and by providing support for fraud cases referred by the department.
- Payment Suspension – The Affordable Care Act requires the suspension of payments to any Medicaid provider when there is pending an investigation of a "credible allegation of fraud".

SFY 2011 Activity

Activity Type	Total
Fraud Referrals	8
Payment Suspensions	6
Completed Integrity Reviews	296
Integrity Reviews - Amounts Recovered	\$1,784,570
Complaints Received	154
Complaints Investigated and Closed	118
Provider Enrollment Applications Processed	6,359

Thank you for the opportunity to present before you today on the department's quality assurance efforts and welcome any questions you may have.

