OFFICE OF LEGISLATIVE RESEARCH
Objective Research for Connecticut's Legislature

ResearchReport

Medicaid Overpayments

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Issue

You asked about actions the Department of Social Services (DSS) takes to prevent overpayments to Medicaid providers. You also requested information on Medicaid overpayments identified by DSS over the past five years, specifically the: 1) number of overpayment cases; 2) total dollars overpaid; 3) return on investment to recover overpayments; and 4) results of investigations (e.g., financial or criminal penalties).

Summary

The information presented below is derived from joint reports on Medicaid program integrity submitted by DSS in coordination with the Office of the Chief State's Attorney and Office of the Attorney General. These annual reports, since January 2015, are required by PA 13-293, which implemented recommendations of the Legislative Program Review and Investigations Committee's 2012 report, *Medicaid: Improper Payments*. As a result, only three fiscal years of consistent data on Medicaid overpayments are generally available at this time. The FY 17 report is due to the legislature in January 2018.

DSS - Office of Quality Assurance

As part of its duties as the state's Medicaid agency, DSS must administer and supervise Medicaid funds and prevent, detect, and eliminate fraud. The Office of Quality Assurance within DSS is responsible for ensuring the fiscal and programmatic integrity of programs administered by the department. The office has five divisions, as detailed in Table 1.

Table 1: Office of Quality Assurance Organization

Division or Unit	*Duties and Responsibilities*	*New / Ongoing Initiatives (per FY 16 report)*
Audit Division	• Conducts federally mandated audits of medical and health care providers • Performs data analytics to identify aberrant billing activity • Audits claims • Identifies and pursues collection of overpayments • Educates providers on program integrity issues	According to DSS, the division is developing standard audit forms for each provider type and internal audit reports
Investigations and Recovery Division	*Client Investigation Unit* • Conducts investigations using various fraud investigation methods including data integrity matches with other state and federal agencies • Oversees the public fraud hotline	According to DSS, the unit will continue several initiatives, including: • increasing the number of arrest warrant affidavits processed and referred; • individualized staff training on preventing fraud via social media monitoring and data analytics; and • screening a high percentage of fraud hotline complaints on the same day as received
	Resources and Recoveries Unit Ensures DSS is the "payer of last resort" for the cost of a client's medical care by: • detecting and verifying third party resources; • establishing monetary recoveries from liens, mortgages, and property sales; and • establishing recoveries for miscellaneous overpayments	No new initiatives reported
Special Investigations Division	*Provider Investigations Unit* • Investigates provider fraud, abuse, and overpayments using data analytics and referrals • Refers suspected fraud to its law enforcement partners: the Office of the Chief State's Attorney – Medicaid Fraud Control Unit, Connecticut Office of the Attorney General, and the U.S. Department of Health and Human Services – Office of the Inspector General • Suspends payments to any Medicaid provider while investigating credible allegations of fraud	According to DSS, the unit is developing a secure shared website to store DSS referrals
	Provider Enrollment Unit • Conducts screening and background checks of newly enrolled and re-enrolled providers • Requires provider disclosures and verifies information received during the provider enrollment process	According to DSS, the unit continues to: • implement federal ACA provider enrollment requirements that include finger printing of high risk providers and revalidation of all enrolled Medicaid providers; and • integrate the provider enrollment functions with those of the Special Investigations Division

Table 1 (continued)

Division or Unit	Duties and Responsibilities	New / Ongoing Initiatives (per FY 16 report)
Quality Control Division	• Conducts federally mandated quality control reviews to determine DSS' compliance with state and federal program eligibility requirements for Medicaid, the Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families	No new initiatives reported
Third Party Liability Division	• Ensures DSS' compliance with federal Third Party Liability requirements • Recovers taxpayer-funded health care costs from commercial health insurance companies, Medicare, and other legally liable third parties	According to DSS, the division continues to: • expand its matching and verification with Medicare; and • implement new physician, pharmacy, and workers compensation recovery projects

Source: Medicaid Program Integrity reports for FYs 14, 15, and 16.

Overpayments

Third Party Liability

Federal law and regulations require Medicaid to be the "payer of last resort." Although the main goal is to avoid paying Medicaid claims in the first place if the beneficiary has third party insurance coverage, states must seek to recover improperly paid claims when they occur. Investigations, audits and third party liability determinations are the principal means through which DSS will review a claim after it has been paid. Table 2 provides amounts collected from legally liable third parties for the past five fiscal years.

Table 2: Collections from Third Parties in Each Fiscal Year

Third Party	FY 12	FY 13	FY 14	FY 15	FY 16
Commercial Insurance	$22,607,847	$22,737,700	$23,810,525	$33,049,317	$31,783,756
Medicare	$3,267,786	$8,331,920	$4,774,145	$4,776,034	$2,693,099
Total	**$25,875,633**	**$31,069,620**	**$28,584,670**	**$37,825,350**	**$34,476,855**

Note: Amounts collected may be for costs incurred prior to given fiscal year.
Source: Medicaid Program Integrity reports for FYs 14, 15, and 16.

Provider Audits

Provider audits refer to the federally mandated audits of medical and health care providers that serve the Medicaid program. An integrity review is a preliminary investigation conducted by DSS upon receipt of a complaint alleging Medicaid fraud or abuse or identification of questionable practices to determine whether there is sufficient basis to warrant a referral for full investigation. Contractor audits refer to audits conducted by Health Management Systems (HMS), the department's Recovery Audit Contractor, a requirement under the Affordable Care Act. Long Term

Care audits were conducted by HMS and Myers and Stauffer. Table 3 shows the number and dollar amount of overpayment cases identified through audit by fiscal year, whereas Table 4 shows the dollar amounts of overpayments recovered and costs avoided.

Table 3: Overpayments Identified by Audit in Each Fiscal Year

Audit Type	FY 14		FY 15		FY 16	
	Number of Audits	Overpayments Identified	Number of Audits	Overpayments Identified	Number of Audits	Overpayments Identified
Provider Audits	135	$16,669,987	119	$20,070,216	110	$14,490,192
Integrity Review	31	$1,198,037	86	$10,375,510	114	$8,880,085
Contractor	20	$960,045	8	$246,268	10	$351,138
Long Term Care	Not reported	Not reported	183	$16,275,559	189	$11,656,179
Total	**186**	**$18,828,069**	**396**	**$46,967,553**	**423**	**$35,377,594**

Note: Amount of overpayments identified is representative of audits closed in given fiscal year.
Source: Medicaid Program Integrity reports for FYs 14, 15, and 16.

Table 4: Overpayments Recovered and Costs Avoided by Audit in Each Fiscal Year

Audit Type	FY 14		FY 15		FY 16	
	Costs Avoided	Overpayments Recovered	Costs Avoided	Overpayments Recovered	Costs Avoided	Overpayments Recovered
Provider Audits	$8,115,481	$16,086,964	$9,559,407	$19,562,625	$6,959,595	$11,468,696
Integrity Review	Not reported	Not reported	$59,661,122	$10,375,510	$57,714,373	$8,815,282
Contractor	$480,023	$736,755	$123,134	$542,287	$175,568	$140,075
Long Term Care	n/a	Not reported	n/a	$16,275,559	n/a	$11,656,179
Total	**$8,595,504**	**$16,823,719**	**$69,343,663**	**$46,755,981**	**$64,849,536**	**$32,080,232**

Note: Amount of overpayments recovered may be for audits conducted and closed prior to given fiscal year.
Source: Medicaid Program Integrity reports for FYs 14, 15, and 16.

Results of Investigations

Most opened investigations are completed within six months, however some investigations can take more than two years to complete. Therefore, outcomes provided in Table 5 may be associated with investigations opened in prior fiscal years.

Table 5: Outcomes of Provider Investigations in Each Fiscal Year

	FY 14	FY 15	FY 16
Opened Investigations	33	32	35
Referred to Law Enforcement	9	22	31
Suspended Payments	6	23	26
Suspended / Terminated Provider Enrollment	3	17	7
Closed Investigations*	31	22	9
Overpayments Identified by Investigations	$1,198,037	$3,076,317	$2,587,486
Overpayments Collected Due to Investigations	$511,928	$2,583,301	Not reported

*Closed investigations, if applicable, may have been forwarded to law enforcement or the Audit Division.
Sources: Medicaid Program Integrity reports for FYs 14, 15, and 16.

Return on Investment

Table 6 identifies the return on investment by Office of Quality Assurance divisions. DSS calculates this measure by dividing the combined amounts of each division's recoveries and avoided costs by the division's cost (Division Recoveries + Cost Avoidance) / (Division Cost).

Table 6: Return on Investment by Division in Each Fiscal Year

	FY 14	*FY 15*	*FY 16*
Audit Division	5.99	17.08	13.92
Investigations and Recoveries Division	8.64	4.97	4.76
Special Investigations Division	0.95	0.41	3.26
Third Party Liability Division	40.92	40.89	52.0

Note: Since submitting its FY 14 report, DSS reorganized the Office of Quality Assurance. Division titles reflect current terminology.
Sources: Medicaid Program Integrity reports for FYs 14, 15, and 16.

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