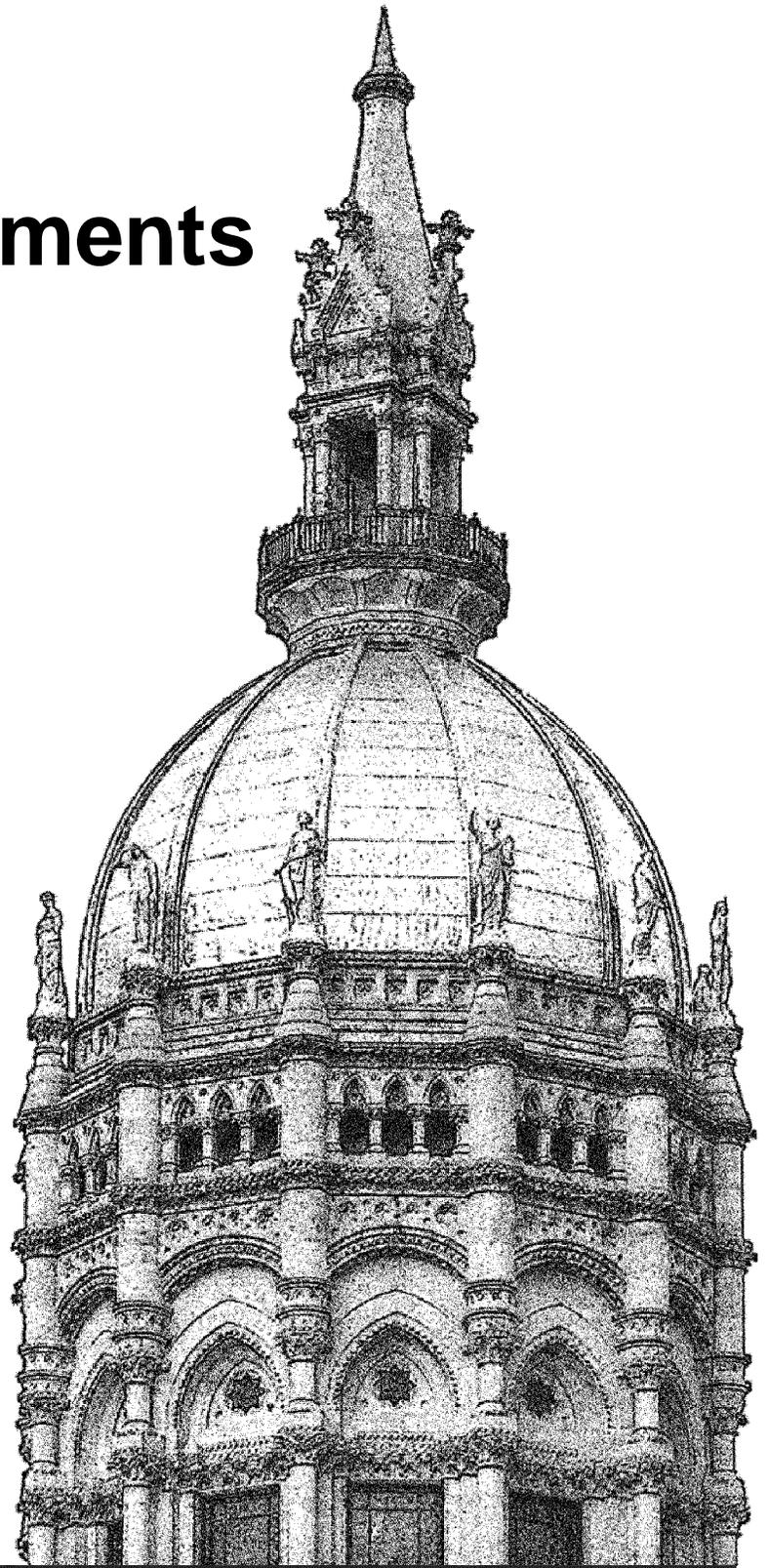


Medicaid: Improper Payments

December 2012



PRI

**Legislative Program Review and
Investigations Committee**

Connecticut General Assembly

**CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

The Legislative Program Review and Investigations Committee is a bipartisan statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

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Medicaid: Improper Payments

Background

In May 2012, the PRI committee authorized a study to evaluate the processes the state uses to prevent, detect and recover any improper payments in the Medicaid program due to fraud, abuse, and errors.

Jointly funded by federal and state government, Medicaid is a means-tested medical assistance program for the poor, elderly, and disabled.

Connecticut's Department of Social Services (DSS) is responsible for administering Medicaid. It is one of the state's largest expenditures, representing over one-fifth of the state budget and receives 50 percent federal reimbursement for most services.

The federal Centers for Medicare and Medicaid Services (CMS) require DSS to establish program integrity measures to reduce the amount of improper payments that result from fraud, abuse, and errors. These measures are implemented by DSS' Office of Quality Assurance (OQA).

Among these efforts are provider enrollment checks, claims processing edits, DSS and contractor audits, third party liability checks, data mining, and investigations.

OQA is required to refer cases of suspected fraud to the state's Medicaid Fraud Control Unit (MFCU), located in the Office of the Chief State's Attorney for possible criminal prosecution.

Referrals are also made to the Office of the Attorney General (OAG) for civil litigation as well as the federal Office of Inspector General (OIG).

PRI conducted numerous interviews with different state and federal agencies in addition to state contractors and provider groups. The committee worked with several entities to collect, reconcile, and aggregate data among the various sources.

Main Committee Findings

Overall, the state's system to address improper payments within the Medicaid program is functional but improvements are needed.

DSS, as the single state entity for Medicaid, is primarily responsible for program integrity efforts. However, activities to prevent and deter error, abuse or fraud are split among many entities including several contractors.

Additional cost-avoiding of improper payments is possible through prevention. Basic tools for management oversight are limited, outdated, or lacking.

Specifically: DSS claims payment system is insufficient for preventing improper payments; there are few OQA policies and procedures in place to guide operations; case management and information systems are deficient; there is no formal audit plan, audit guides, or protocols; data mining technology to identify improper payments is obsolete. Third party liability recoveries could be increased.

Information from the different entities is not always reconciled or evaluated for potential improvements to the system. Better interagency collaboration would strengthen communication and coordination among the entities.

PRI Committee Recommendations

The goals of the committee recommendations are fivefold and are intended to:

- **Better support providers' ability to avoid improper payments** - Obtain provider input on enrollment, increase provider education, and prepare audit guide/protocols.
- **Improve DSS tools to avoid and detect improper payments** - Plan for new screening and enrollment requirements, assess claims system, explore use of pre-payment analytics, and upgrade data mining technology.
- **Strengthen DSS management and oversight** - Adopt policies and procedures, improve case tracking, establish performance measures, and review audit sampling and extrapolation methodologies.
- **Explore opportunities to increase recovery of improper payments** - Consider audit expansion and review third party liability denials and assess strategies for potential expansion.
- **Improve interagency collaboration and communication** - Increase cross-training, provide reasons for prosecution denials, update licensing boards, prepare joint annual report, and establish periodic monitoring and self-evaluation.

List of Acronyms

ACA	Affordable Care Act
ASO	Administrative Services Organization
CHN	Community Health Network
CMA	Center for Medicare Advocacy
CMS	Centers for Medicare and Medicaid
CPI	Center for Program Integrity
CUTPA	Connecticut Unfair Trade Practices Act
DOJ	Department of Justice
DPH	Department of Public Health
DSS	Department of Social Services
EPLS	Excluded Parties List System
FBI	Federal Bureau of Investigations
FFP	Federal Financial Participation
FAO	Fraud, Abuse and Overpayment System
FRED	Fraud Early Detection Program
HHS	Department of Health and Human Services
HMS	Health Management Systems
HP	Hewlett-Packard
LEIE	List of Excluded Individuals/Entities
LTC	Long-term care
MFCU	Medicaid Fraud Control Unit
MIC	Medicaid Integrity Contractor
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
NAMFCU	National Association of Medicaid Fraud Control Units
NCCI	National Correct Coding Initiative
NPI	National Provider Identifier
OAG	Office of the Attorney General
OCSA	Office of the Chief State's Attorney
OHA	Office of Healthcare Advocate
OIG	Office of the Inspector General
OQA	Office of Quality Assurance
PCA	Personal Care Assistant
PERM	Payment Error Rate Measurement
RAC	Recovery Audit Contractor
ROI	Return on investment
SIU	Special Investigations Unit
SURS/Profiler	Surveillance and Utilization System
TPL	Third-party Liability Contractors

Medicaid: Improper Payments

Connecticut's Medicaid program is one of the state's largest single expenditures. For FY12, the state is projected to expend approximately \$5 billion in federal and state funds on Medicaid, representing over one-fifth of the state budget. Given the size of this expenditure, even a small percentage of improper Medicaid payments to providers can have a significant effect.

Scope of Study

In May 2012, the PRI committee authorized a study to evaluate the processes the state uses to prevent, detect, and recover any improper payments in the Medicaid program due to fraud, abuse, and errors. Included are payments:

- on behalf of individuals ineligible for Medicaid;
- for services not covered;
- requiring, but not receiving, prior authorization;
- for services billed but not received;
- that are duplicate; and
- that do not include credits for applicable discounts.

Not all improper payments are a result of intentional misconduct (i.e., fraud and/or abuse). Payment errors may occur as a result of clerical error or misunderstanding of the complicated Medicaid billing and claims submission process. Recoupment of Medicaid dollars by the Department of Social Services (DSS) is the focus of state program integrity activities. Occasionally, however, provider billing practices warrant investigation and referral to civil and criminal law enforcement. For this reason, state procedures used to investigate and prosecute providers suspected of fraud and abuse, as well as any resulting sanctions were also examined.

Study Parameters

The study was aimed at examining the pre- and post-payment processes used to prevent or capture improper payments to Medicaid providers. It did not examine improper payments that were the result of client enrollment error or fraud nor contain an in-depth examination of specific providers (e.g., pharmacies, hospitals, long-term care). In addition, this study did not examine the use and efficacy of prior authorization for certain medical procedures or tests.

Methodology

The program review committee staff employed several methods to conduct this study:

- *Data analysis* - analyzed data from various sources including DSS databases on complaints, audits, fraud investigations and referrals to law enforcement; conducted a case review of 32 DSS referrals; a review of financial documentation of Medicaid

recoveries reported to the federal government; and referral data received by the Medicaid Fraud Control Unit (MFCU) as well as the Office of the Attorney General (OAG) including the number and types of cases, outcomes, and amount of any recoveries.

- *Document review* - examined various documentation including: federal and state statutes and regulations; policy directives; bulletins; annual reports; mandated reports; guidance and best practices documents; federal evaluations of Connecticut's Medicaid program.
- *Literature research* - gathered a significant number of federal and national reports on Medicaid as well as state-specific reviews and evaluations of Medicaid program integrity operations in other states.
- *Interviews* - conducted numerous interviews with management and professional staff of DSS, OAG, and MFCU. Interviews were also held with all the contractors, a representative of the federal Office of Inspector General (OIG), and with Centers for Medicare and Medicaid Services (CMS) staff. Two provider groups were also interviewed to obtain their perception and concerns about DSS program integrity activities.
- *Public hearing* - Testimony was received at a public hearing held June 29, 2012.

Study Challenges and Limitations

There were several challenges and limitations to this study. First, while the broad nature of the study offered a valuable chance to look at the entire state Medicaid program improper payment system, it was not geared for in-depth review of any single component of the sub-systems in place to both prevent and recover Medicaid improper payments. The state's Medicaid program is a large and complex enterprise. Similar reviews in other states have been conducted as multi-year projects or targeted a specific segment, such as improper payments related to the home health care industry, or the adequacy of the state's Medicaid Management Information System (MMIS), which is responsible for preventing improper claims submissions.

Second, part of Medicaid's complexity is the fact that there are multiple entities - both federal and state - involved in preventing improper Medicaid payments. This leads, at times, to a disjointed system with no one entity having a comprehensive view of all of the program integrity activities occurring in the state. In addition, there were numerous data challenges including: access to and availability of data across all three state entities that were part of this study as well as issues of accuracy and completeness of data once it was provided. DSS also has numerous contractors involved in program integrity activities, with various responsibilities, making it difficult to get a complete picture of all the separate program integrity efforts.

Finally, the data presented in this report often could not be reconciled between various systems or across the various agencies. The different reporting timeframes as well as the state's lack of investment in case management systems lead PRI staff to caution about the information

presented and its completeness. Further, the PRI staff could not identify a single source that provides a complete and accurate accounting of the amount of money we spend on the state's program integrity activities, what is identified as improper payments, the amount recouped, and the amount returned to the federal government for its share of the improper payments.

Report Organization

This report is organized into five chapters and also contains a number of appendices that include supporting documentation and additional descriptive information for the prior chapters.

Background - provides an overview of the Medicaid program, basic definitions of what constitutes an improper Medicaid payment, and the major entities involved in program integrity functions.

Prepayment - discusses how an improper Medicaid payment can be cost avoided (i.e., prevented) by DSS so improper claims are not submitted for payment or if submitted, are rejected. Ways to prevent improper payments include: provider enrollment/re-enrollment activities to ensure only qualified providers receive Medicaid reimbursement; provider education to minimize billing mistakes or claim error; and ensuring a state-of-the art Medicaid Management Information System (MMIS), the foundation of Medicaid claims processing, which rejects claims containing incomplete, inaccurate, or conflicting information.

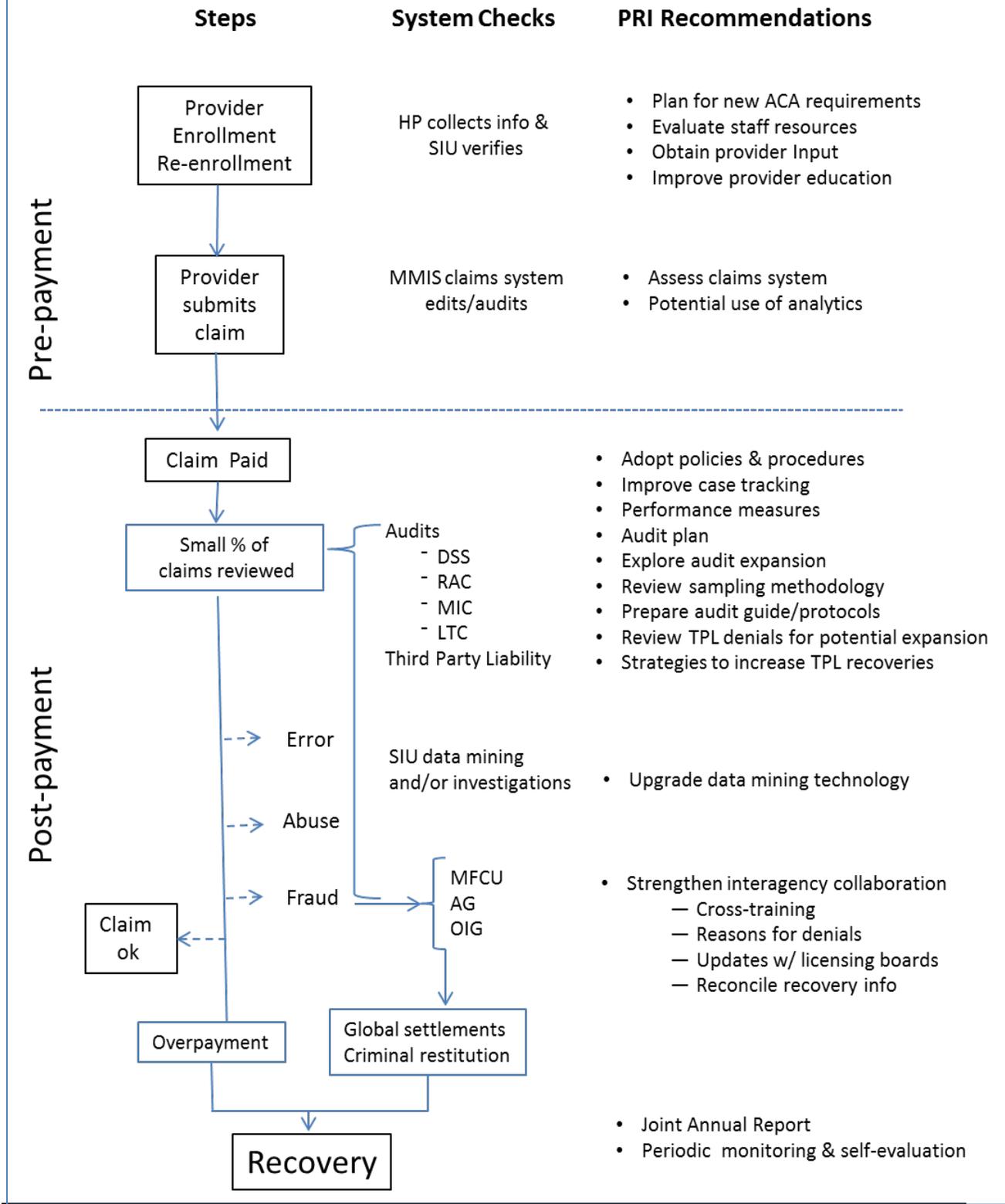
Post-payment - refers to how Medicaid claims are reviewed after payment is made and dollars are recouped from providers if a claim was inappropriately paid. This chapter examines the processes in place to check the accuracy of payments already made to providers. Among the areas discussed are DSS and contractor audits as well as fraud investigations. It also discusses what happens when Medicaid provider fraud is suspected and how matters are referred to civil and criminal law enforcement agencies.

Third party liability - reviews the process the state has in place to ensure that Medicaid is the "payer of last resort." It examines how payments of third-party claims are avoided to the extent possible and the methods used to recover reimbursement from third parties after Medicaid payment. Third parties include health insurers, casualty coverage for an accidental injury, workers' compensation insurance, and Medicare.

Interagency Collaboration - examines the coordination and communication efforts among the major state agencies involved in controlling Medicaid errors, abuse, and fraud. It discusses the implementation of the federally required memorandum of understanding and use of best practices recognized by the federal government.

Figure I-1 provides an overview of this report's focus by illustrating how the PRI committee recommendations relate to the steps in the pre- and post-payment processes and the various system checks. Each of the findings and recommendations are explained in detail in the following chapters of the report.

Figure I-1. PRI Staff Recommendations by Pre- and Post-Payment System Checks



General Conclusions

Overall, the state has had success in identifying and reducing improper payments; however, the PRI committee found opportunities where substantial improvements could be made to strengthen the state's ability to detect, reduce, and collect these payments. The PRI committee recommends a number of strategies to avoid improper payments from being made through provider education and improvements in technology, as well as enhancing efforts to recoup Medicaid dollars for erroneous payments made.

The PRI committee concludes the Office of Quality Assurance within the Department of Social Services performs well on a case-by-case basis, but implementing basic management oversight and tools could lead to better identification and targeting of improper payments. In particular, the PRI committee finds two areas where Medicaid recoveries could increase - ensuring legally liable third parties pay for the cost of medical services, since Medicaid is required to be the payer of last resort, and increasing the number of provider audits to recoup improper Medicaid payments.

Although DSS is primarily responsible for program integrity efforts for the state's Medicaid program, various entities are also involved. While the independent authority and jurisdiction of each state agency must be recognized and respected, the entities should also acknowledge their role as part of an overall system. To operate effectively a system must be able to resolve policy issues, reduce duplication and gaps, and identify mutually beneficial resources and solutions. Deficiencies in any one area can impact the whole system. As such, interagency collaboration must be strengthened and opportunities need to exist for better collection and sharing of information and monitoring to diminish fragmentation in the system.

What is Medicaid?

Medicaid is a government health care insurance program for certain income eligible individuals and families with children. The Department of Social Services (DSS), as the federally required single state Medicaid agency, makes payments directly to health care providers for services delivered to eligible beneficiaries. As of July 2012, Connecticut has over 37,000 providers participating in the Medicaid program, serving more than 664,000 beneficiaries. With expenditures over \$5 billion, Connecticut's Medicaid program is one of the state's largest expenditures, representing over one-fifth of the state budget.

The program must comply with federal Medicaid law (Title XIX of the Social Security Act) and regulations in order to receive 50 percent reimbursement from the federal government. Within federal limits, DSS decides eligibility, benefit coverage, administrative practices, reimbursement levels, and operational resource requirements. DSS is also responsible for maintaining program integrity. To accomplish this, the federal government provides program guidelines, technical assistance, and periodic program assessments.

What is an Improper Payment?

A provider must submit a claim for Medicaid payment. As defined by federal law, an improper payment: 1) means any payment that should not have been made or that was made in an incorrect amount; and 2) includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received, and any payment that does not account for credit for applicable discounts. Improper payments can result from:

Error: inadvertent actions resulting from mistakes, misinterpretation of rules, or poor recordkeeping;

Fraud: intentional deception or misrepresentation made to obtain unauthorized benefits (which may violate civil and criminal law); and

Abuse: actions inconsistent with sound fiscal, business, or medical practices that result in unnecessary costs.

Examples of improper Medicaid payments are those based on claims that:

- Have missing or insufficient documentation;
- Bill for more expensive procedure than performed known as upcoding;
- Separately bill for services that should be billed together called unbundling;
- Bill recipient for difference between provider charge and Medicaid rate; and
- Fail to properly bill a third party since Medicaid is the payor of last resort.

Due to the size and nature of the program, the state's liability exposure for improper payment is significant. With a Medicaid budget of approximately \$5 billion, even a small percentage of loss due to improper payments has a significant impact.

What is Program Integrity?

Program integrity refers to the proper management and function of the Medicaid program. Program integrity activities focus on two areas: 1) preventing improper Medicaid payments from being made for ineligible clients or to providers; or 2) identifying and recovering improper payments that have already been made, and imposing sanctions, if applicable.

In the past, the focus of the Medicaid program integrity efforts has primarily been on the recovery of funds. However, recent initiatives focus more on prevention and early detection of error, abuse, and fraud rather than recovery known as the "pay and chase" model. Program integrity is the responsibility of both the federal and state government and encompasses a variety of administrative, oversight, and law enforcement strategies. Multiple agencies at both the federal and state level work to ensure Medicaid program integrity.

Overview of the Major Entities

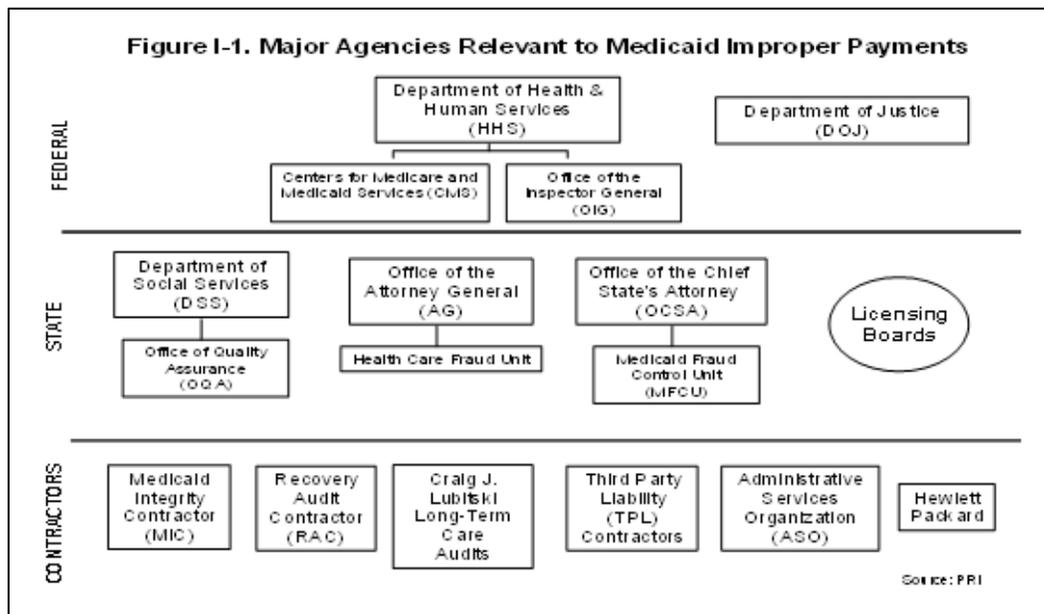
The single state Medicaid agency, DSS, is primarily responsible for conducting program integrity activities, but shares this responsibility with other agencies. The following provides an overview of the various entities involved in the pre- and post-payment activities for Medicaid improper payments. As illustrated in Figure I-1, these include:

- **Federal level** – Center for Medicare and Medicaid Services (CMS) and Office of the Inspector General (OIG) within the Department of Health and Human Services (HHS); Department of Justice (DOJ)
- **State level** – Office of Quality Assurance (OQA) within the Department of Social Services (DSS); Health Care Fraud unit within the Office of the Attorney General (OAG); Medicaid Fraud Control Unit (MFCU) within the Office of the Chief State's Attorney (OCSA); and various licensing boards
- **Contractors** – Medicaid Integrity Contractor (MIC); Recovery Audit Contractor (RAC); Third-party Liability Contractors (TPL); and Long-term Care Audits (LTC)

Federal Level

The Department of Health and Human Services (HHS) is the federal agency responsible for the oversight of the Medicaid program and providing 50 percent of funding for the program's administration. The two major units within HHS involved in Medicaid integrity efforts are CMS and OIG. When Medicaid civil or criminal fraud is detected, the federal Department of Justice (DOJ) will also be involved.

Center for Medicare and Medicaid Services (CMS). CMS is responsible for the administration, policy formulation, and various operational aspects of the Medicaid program. The Center for Program Integrity (CPI) within CMS promotes program integrity through provider/contractor audits and policy reviews, identification and monitoring of program vulnerabilities, and by providing support and assistance to states. CMS operates a training institute to educate state staff about program integrity best practices. CPI also oversees all CMS interactions and collaboration with key stakeholders relating to program integrity (i.e., DOJ, OIG, state law enforcement agencies, other federal entities) for the purposes of detecting, deterring, monitoring, and combating fraud and abuse, as well as taking action against those that commit or participate in fraudulent or other unlawful activities.



Office of Inspector General (OIG). Two units within the OIG are responsible for conducting and coordinating activities related to allegations of fraud, waste, abuse and mismanagement in the Medicaid program. The Office of Investigations (OI) is the law enforcement arm of OIG that conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. It operates an OIG hotline, which allows the public, industry stakeholders, and others to report suspected fraud, waste and abuse. It also coordinates with the DOJ and other law enforcement authorities to leverage resources and to support anti-fraud efforts.

The OIG's Office of Evaluation and Inspections (OEI) oversees and annually certifies the state Medicaid Fraud Control Units (MFCUs), which investigate and prosecute providers for Medicaid fraud as well as for patient abuse and neglect. On occasion, OIG issues policy transmittals to provide guidance and instructions to MFCUs. The transmittals may also provide interpretations of federal regulations, statutes, and other policies relevant to MFCUs. OIG conducts onsite reviews to determine whether units meet the performance standards and comply with laws, regulations, and policy transmittals. OIG uses performance standards as guidelines to

assess the MFCUs and to determine whether they are carrying out their duties and responsibilities in an effective and efficient manner.

Department of Justice (DOJ) – The Department of Justice is the principal agency for the enforcement of federal laws. With regard to Medicaid, DOJ monitors and enforces federal fraud and abuse laws and prosecutes violators. Several offices within DOJ are involved in Medicaid program integrity activities, including the Office of the U.S. Attorneys, the Criminal Division, and the Federal Bureau of Investigations (FBI).

Since 2009, HHS and DOJ began working together on the Health Care Fraud Prevention and Enforcement Action Team (HEAT). This jointly led effort is comprised of top level law enforcement agents, prosecutors, attorneys, auditors, evaluators, and other staff from DOJ and HHS and their operating divisions. There are nine Medicare Fraud Strike Force teams that are a key component of HEAT. These strike force teams are composed of federal, state and local investigators and are designed to combat Medicare fraud through the use of Medicare data analysis techniques and an increased focus on community policing. Though the focus of the strike force teams is on Medicare, often these providers are also caught defrauding Medicaid.

State Level

There are a number of state agencies involved in the identification and collection of improper Medicaid payments.

Department of Social Services (DSS). DSS, as the single state Medicaid agency, is responsible for the administration and supervision of Medicaid funds including the prevention, detection, and elimination of error, abuse, and fraud by providers. The initiation of administrative proceedings concerning provider fraud and/or abuse is also a DSS responsibility.

The Office of Quality Assurance (OQA), composed of four divisions, is responsible for ensuring the fiscal and programmatic integrity of all programs administered by DSS, including Medicaid. The four divisions are:

- *Audit Division* – conducts the federally mandated audits of medical and health care providers that are paid through the various medical assistance programs funded by the DSS. It coordinates and directs audits conducted by contractors mandated by federal law. It also reviews financial reporting of activity for various grants and contracts that DSS has with non-profit agencies and municipalities.
- *Special Investigations Unit* – coordinates and carries out activities to prevent, detect, and investigate fraud, waste, abuse, and overpayments in the DSS medical assistance programs. It enrolls providers and performs internal DSS audits.
- *Fraud and Recoveries Division* – investigates potential client and employee fraud; ensures that Medicaid is the payor of last resort for covered medical services; pursues all available assets and recoveries; and the timely distribution and operability of all electronic benefit transfer (EBT) (cards for cash and “SNAP”), and medical cards.

- *Quality Control Division* – performs reviews of Medicaid, SNAP, the Temporary Assistance for Needy Families and childcare programs.

Medicaid Fraud Control Unit (MFCU). MFCU is the federally designated enforcement agency responsible for monitoring the state’s Medicaid program. Housed within the Office of Chief State’s Attorney (OCSA), MFCU’s primary function is to investigate Medicaid fraud and prosecute individuals for violation of criminal laws. MFCU may also review complaints of patient abuse or neglect in facilities receiving Medicaid funds as well as the misappropriation of patient private funds in such facilities.

The unit receives 75 percent of its costs from the federal government with the remaining 25 percent funded by the state. This federal funding subjects the MFCUs to certain requirements. The unit must be annually recertified by OIG. As part of the recertification process, the OIG reviews the unit's application for recertification and may conduct on-site visits. The MFCU also has annual reporting requirements. These reports consist of specific statistical data mandated by federal legislation including: the number and type of cases under investigation; the number of convictions obtained; and the number of dollar recoveries to the Medicaid program.

Office of the Attorney General (OAG). As the chief civil legal officer of the state, the Attorney General (AG) represents Connecticut’s interests in all civil legal matters and serves as legal counsel to all state agencies including DSS, the single state agency for the Medicaid program. In this capacity, the OAG advises DSS in all matters that require legal interpretation or guidance. This usually consists of representing DSS in various forums such as administrative hearings, negotiation sessions, or courtroom proceedings.

The OAG also has a Healthcare Fraud Unit which is responsible for conducting investigations and initiates state civil proceedings concerning Medicaid provider civil fraud. The unit’s primary mission is to identify and take action concerning provider fraud that results in financial loss to the state. The unit may develop cases independently or in conjunction with other state and federal law enforcement and state agencies that pay, directly or indirectly, for health care benefits.

Memorandum of understanding (MOU). Pursuant to federal law, DSS must enter a memorandum of understanding (MOU) with the various entities charged with investigating Medicaid fraud – MFCU, OAG, and the federal OIG. The MOU outlines the respective responsibilities of each party with respect to the Medicaid program. The MOU is intended to foster cooperation and coordination among the parties. In particular, the MOU requires the parties to jointly coordinate activities to avoid impairing the effective prosecution as well as civil and/or administrative enforcement actions against fraudulent activities.

Contractors

Medicaid Integrity Contractors (MICs). MICs are private companies under contract with CMS to: 1) conduct audits of providers to identify Medicaid overpayments using claims data; and 2) to educate providers and beneficiaries about program integrity issues. MICs

coordinate their efforts with DSS and conduct post-payment audits of all types of medical providers and where appropriate identify overpayments and refer suspected fraud cases to law enforcement.

Recovery Audit Contractors (RACS). Initially designed for the Medicare program, the use of RACs were expanded to Medicaid under the Affordable Care Act (ACA). RACs review claims after payment to identify under and overpayments and recoup overpayments. Under the law, states are required to contract with RACs and pay the RACS a contingency fee for identification of overpayments. The state also defines the scope of work the RAC will examine. In Connecticut, Health Management Systems (HMS) has been selected as the RAC contractor.

Third Party Liability Contractors. DSS also contracts with HMS to conduct data matches for Medicaid clients who potentially have third party resources. This is done to ensure that Medicaid is the payor of last resort. DSS also contracts with the Center for Medicare Advocacy (CMA) which files appeals on behalf of dually-eligible clients (i.e., persons eligible for both Medicaid and Medicare) for certain services the department believes should have been paid for by Medicare.

Cost Report Auditors. DSS contracts with the accounting firm, Craig J. Lubitski Consulting LLC, to assist in the review of annual cost reports, rate setting, and field audits of long-term care facilities receiving medical reimbursements.

Administrative Services Organization (ASO). Since January 2012, DSS has replaced its managed care delivery system for the Medicaid program with a single administrative services (ASO) model operated by Community Health Network (CHN). Unlike the managed care model, the state is self-insured and absorbing the risk or exposure of the medical claims. The ASO is responsible for certain member and health provider services including: referral assistance and appointment scheduling; provider recruitment; health education; utilization management including prior authorization; case management including intensive care management; quality management; and health data analytics and reporting.

Hewlett Packard. DSS contracts with Hewlett Packard (HP) to be the fiscal agent responsible for developing and maintaining the Medicaid Management Information System (MMIS), which is the department's claims processing and information retrieval system. HP is also under contract for several other Medicaid related functions.

National Association of Medicaid Fraud Control Units (NAMFCU)

All state MFCUs are members of the National Association of Medicaid Fraud Control units (NAMFCU). Founded in 1978, NAMFCU is instrumental in coordinating multistate/federal investigations and global settlements, primarily involving pharmaceutical companies. The association fosters cooperative working relationships between state and federal agencies to combat fraud and abuse in the Medicaid programs of the various states.

Cost Avoiding Improper Payments through Prevention

To reduce losses, the Centers for Medicare and Medicaid Services and the health care industry in general have been trying to evolve their fraud and abuse strategies from “pay and chase” to “prevent and save.” This shift will result in greater savings because there is a cost associated with having to recoup Medicaid dollars once they have been paid out, i.e., the “pay and chase” model. CMS and some states are trying to strengthen existing programs and implement new ones to prevent improper payments from even occurring. Newer approaches for prepayment fraud detection rely heavily on technology solutions to collect the necessary data and identify suspicious activity.

Although the DSS Medicaid Integrity Program still relies primarily on the “pay and chase” model, there are three activities - called prepayment review - conducted by DSS that prevent improper Medicaid payments from even occurring.¹ The thrust of prepayment review is to prevent erroneous claims from even being submitted by providers or barring that, ensure the MMIS system rejects claims that are inaccurate for a variety of reasons. These activities include:

- provider enrollment and re-enrollment in the Medicaid program with a screening process that excludes unqualified providers;
- provider education to prevent improper billing by offering programs and materials on the complexity of Medicaid billing policies, procedures, and appropriate coding of claims; and
- automatic checks (“edits and audits”) by the Medicaid Management Information System (MMIS) that prevent payment of provider-submitted health care claims because of inaccurate, incomplete, conflicting, or contra-indicated information.

This chapter provides a description of DSS efforts in each of these areas and contains recommendations on ways to improve prepayment strategies to avoid improper Medicaid payments. The PRI committee believes that a greater focus on education, particularly through the use of audit findings, would reduce common errors made by providers in claim submissions. Also, routinely obtaining provider input at the time of enrollment or re-enrollment would offer an easy way in which education could be targeted around topics identified through a provider survey. Finally, a new type of technology is being touted by CMS and other states as a way to identify problematic providers and closely scrutinize their claims to ensure they are proper before they are paid.

¹ Under federal law, Medicaid programs must have a claims processing system that identifies any liable third party prior to Medicaid paying the claim. The Medicaid program is required to reject such a claim and return it to the provider, with information for the provider to bill the liable third party. Often a liable third party is not known and therefore, Medicaid pays the claim. Monthly data matches are performed by a DSS contractor to recoup these dollars improperly paid when third party resources are identified. The contractor also inputs the correct information into the MMIS system so that future improper payments will be avoided. This process is discussed in Section IV.

Planning for New Provider Screening and Enrollment Requirements

Application requirements. State program integrity activities related to preventing provider Medicaid abuse and fraud are performed at the provider enrollment and re-enrollment stage by requiring providers to disclose certain information on an application form. In Connecticut, DSS requires providers to complete an extensive application detailing a variety of information, such as enrollment, entity type, and demographic profile; service location information; provider organization/ownership, including information on managing employees; and criminal background disclosures. The same application is completed for initial enrollment into the program and for re-enrollment.

DSS contracts with Hewlett Packard (HP), to offer an on-line application process for most providers and to ensure the application packet is complete for all providers before forwarding it to the Special Investigations Unit (SIU) within the Office of Quality Assurance for review. HP validates that a provider has a current/active state provider license and if any disciplinary actions have been taken, HP will note it for SIU review. There is one staff person within SIU who verifies the accuracy of all provider disclosures during the Medicaid enrollment screening process before a Medicaid provider number will be issued and the provider is accepted into the program.

As of July 1, 2012, there were more than 37,000 health care providers enrolled in Connecticut's Medicaid program. For providers to receive reimbursement for services provided under the program, the provider must first be enrolled in the program by DSS, with re-enrollment required every two years for risky providers² and five years for all other providers. In FY 12, SIU enrolled or re-enrolled almost 5,500 providers.

States must check two federal databases to ensure providers, or any person with an ownership or controlling interest or who is an agent or managing employee of the provider, have not been excluded from federal programs, which automatically triggers a state exclusion. The List of Excluded Individuals/Entities (LEIE) contains only exclusion actions taken by the federal HHS-OIG. The second database, the General Services Administration's Excluded Parties List System (EPLS), contains debarment actions taken by various federal agencies, including exclusion actions taken by the HHS-OIG.

The Special Investigations Unit must report to the federal government any adverse action taken against providers by DSS.³ The unit also maintains, updates, and uses its own "Administrative Actions List," available on its website, to ensure providers that are excluded do not participate or receive reimbursement from the Medicaid program. As of October 12, 2012, OQA had 25 providers under payment suspensions and 9 providers had been excluded from Connecticut's Medicaid program. The list dates back to February 2000.

²DSS uses the CMS process for Medicare to rank risky providers, who have been identified as high risk for Medicare fraud/abuse.

³ 42 CFR 455.17

The Affordable Care Act (ACA), adopted in 2010, contains several provisions related to abuse and fraud protections that enhance provider screening and enrollment for Medicare, Medicaid, and the Children's Health Insurance Program. The final rule implementing the provisions of the act was published in February 2011 and became effective for states on March 25, 2011, although states continue to receive guidance from CMS. In addition, all states were required to submit a state Medicaid plan amendment that gives assurances related to the new federal requirements for provider enrollment and screening by April 1, 2012. The amendment does not require states to identify how each of the new provisions will be implemented, but only to attest to the fact that each provision will be in compliance.

Under the Affordable Care Act, the provisions that enhance program integrity efforts through provider screening and enrollment are shown in Table II-1.

Although DSS did submit an implementation plan to CMS on March 30, 2012, much of the plan involves making changes to MMIS to ensure appropriate checks are in place. While the PRI committee agrees that many of the ACA provisions require MMIS modifications to ensure applications are in compliance with the new requirements, there are other areas that need to be addressed. Also, since the decision was made to eliminate Medicaid managed care in January 2012, and move all Medicaid recipients into a fee-for-service payment system, there are many more providers that have to be screened and enrolled by OQA.

The PRI committee believes DSS needs to specify how each of the new provisions under ACA will be implemented and identify who will be responsible for implementing and monitoring each provision - DSS or its contractor, HP. For example, it is unclear how the federal mandate for low/mid/high risk provider screening will be done. Furthermore, unless most functions are contracted out, it is unrealistic to think that the one DSS staff currently assigned to provider enrollment and re-enrollment activities is sufficient to implement the new ACA requirements, which includes on-site visits and fingerprinting for some providers.

Strong provider enrollment provisions prevent providers who should not be in the Medicaid program from being enrolled or re-enrolled. Therefore, the PRI committee recommends:

Based on the state Medicaid plan submitted to the Centers for Medicare and Medicaid Services, the Office of Quality Assurance within the Department of Social Services should identify each provider screening and enrollment requirement and identify how it will be met. In addition, the department should evaluate if the staff resources needed to meet the new requirements are adequate.

Table II -1. Provider Screening and Enrollment and Re-Enrollment Provisions under ACA
<i>Screening and Enrollment Requirements</i>
<ul style="list-style-type: none"> • Checking multiple federally maintained files at the time of enrollment and re-enrollment and two separate federal provider exclusion databases at least monthly. • Screening providers according to limited, moderate, and high risk categories, with screening procedures increasing, as the level of risk increases: <ul style="list-style-type: none"> ○ the high risk category requires criminal background checks be performed on providers falling into this category, including fingerprinting. Federal regulations designate the specific provider types within the three categories. • Requires re-enrollment at least every five years but states can rely on the results of provider screening performed by Medicare contractors and Medicaid or CHIP programs of any state to fulfill this requirement. • Enrolling all providers as participating providers (applies to providers who order health services or refer but do not directly bill Medicaid): <ul style="list-style-type: none"> ○ all claims for services ordered or referred must contain the National Provider Identifier (NPI) of the provider.
<i>Denial or Termination of Provider Enrollment</i>
<ul style="list-style-type: none"> • Beginning January 1, 2013, states must deny or terminate providers for a number of new causes: <ul style="list-style-type: none"> ○ if excluded from Medicare, Medicaid, or the Children's Health Insurance Program of any other state, the provider must be excluded in all other states; ○ provider, agent, or managing employee fails to submit timely and accurate information and does not cooperate with screening procedures; ○ failure to submit fingerprints within 30 days of CMS or state Medicaid request; or ○ failure to permit access to provider locations for any site visits.
<i>Application fees for certain providers</i>
<ul style="list-style-type: none"> • Collecting application fees from institutional providers to be used to pay for the screening process from all enrolling or re-enrolling providers, along with provisions for waivers.
<i>Temporary Moratoria on Certain Providers</i>
<ul style="list-style-type: none"> • Allows CMS to establish Medicaid-wide temporary moratoria on the enrollment of new providers or provider types unless it would create an access to care issue. • Allows state Medicaid agency to impose moratoria, numerical caps, or other limits on the enrollment of new providers when CMS has identified the provider type as "high risk."
<i>Credible Allegation of Fraud and Payment Suspension</i>
<ul style="list-style-type: none"> • State may not receive Federal Financial Participation (FFP) payments if it fails to suspend payments to a provider or supplier during any period when there is a pending investigation of a credible allegation of fraud, with some "good cause" exceptions.
Source: Federal Register, Vol. 76, No.22, February 2, 2011.

Enrollment Process Presents an Opportunity to Obtain Provider Input

In addition to having some responsibilities related to provider enrollment and re-enrollment, the Department of Social Services contracts with HP to serve as the Fiscal Agent to support Connecticut's Medicaid program. HP's contractual responsibilities related to Medicaid include:

- processing provider claims, financial refunds, and recoupments;
- issuing provider payments;
- operating a provider call center dedicated to assist providers with billing questions;
- offering dedicated provider relations teams to perform provider training and respond to complex program issues; and
- providing prior authorization for pharmacy services, including a call center.

As part of its operations, HP maintains the provider web portal which allows for real-time claim submission and adjudicating claims that have been denied, on-line provider enrollment and re-enrollment, inquiries regarding prior authorization approval, status of claims submissions, and an automated client eligibility verification system.

Medicaid provider input. The PRI committee staff interviewed members from two associations representing Medicaid providers regarding DSS' Medicaid program integrity activities and the performance of its contractor, HP. Both provider groups voiced concerns about having their questions answered inconsistently by HP when a claim needed to be adjudicated. One provider group had issues around the provider enrollment and re-enrollment process, and the actions taken by HP if an application is incomplete. Providers also indicated that when they had questions and accessed the provider hotline, they were often given conflicting answers by HP personnel staffing the hotline.

Under the Affordable Care Act, provider screening and enrollment requirements will become much more complex. It is likely that providers will have questions related to the new application process and comply with the additional requirements under ACA. The PRI committee believes that provider feedback into various HP operations would prove valuable and could be easily obtained by HP by including an optional provider survey as part of the provider re-enrollment process. Obtaining provider input at the time re-enrollment applications are submitted would allow HP to have routine input into meeting providers needs and allow for any issues to be quickly addressed on an on-going basis. Any survey results could also be shared with DSS, so that it can assess HP's performance in meeting providers' needs. Therefore, the program review committee recommends:

At the time providers must re-enroll in the Medicaid program, an optional survey should be included in the on-line application packet. The survey should solicit provider input on the various activities performed by the current vendor on behalf of the Department of Social Services so that the

vendor can improve its operations and be more responsive to providers' needs. In addition, the results of the survey should be shared with the Office of Quality Assurance so it can also assess HP performance.

Sharing Audit Findings with Providers Would Reduce Improper Payments

Provider education on properly billing Medicaid, and maintaining adequate medical records and documentation of health services delivered, is important due to the complicated nature of the Medicaid program. Improper Medicaid payments are not only due to provider abuse or fraud, but also can be a result of unintentional error.

HP is the primary point of contact for responding to provider questions on various aspects of the Connecticut Medical Assistance Program. HP offers a variety of general educational workshops and on-line presentations on correctly submitting Medicaid claims. According to HP, training topics are primarily selected based on changes to existing billing and reimbursement rules. Payment error data is also reviewed and the top reasons for claim denials are a standard topic in training sessions offered by HP.

The Department of Social Services sends out provider bulletins on how to submit a Medicaid claim differently if a policy change occurs that impacts claim submissions and their acceptance by the Medicaid Management Information System (MMIS). However, the PRI committee found that there is no targeted provider education program based on commonly found improper payment errors based on DSS provider audit findings.

Although provider audits find common Medicaid overpayment errors, which are often unique to a particular provider type, DSS does not electronically compile and aggregate these audit findings. The PRI committee believes identifying the most common findings across the various provider types would provide an opportunity to target training to particular provider types. This could be an invaluable and easily implemented approach to prevent improper payments since, as discussed in Chapter III, many providers never even get audited by DSS but may be unintentionally committing the same common errors identified by the small number of audits performed on similar providers. Based on discussions with OQA staff, they indicated that they have provided this type of information to two provider associations in the past, but do not offer this assistance to providers routinely.

Another way to increase provider education efforts around program integrity issues is to improve the DSS provider website by offering more web-based links to national and government materials. There are several governmental and national organizations that offer educational materials for providers and staff describing how to accurately submit Medicaid claims and prevent fraud and abuse on their websites. For example, the Centers for Medicare and Medicaid Services (CMS) has published provider toolkits on ways to maintain Medicaid program integrity that were published in 2012. Other federal government and national organizations also offer training materials on Medicaid billing and claim submissions. Except for the links to HP workshops and presentations, however, there are no other links to educational resources on the DSS provider website. One state, North Carolina, on its Department of Health and Human

Services website, has a number of links for providers to access educational and other materials. The website also has links pertinent to its own state policies and procedures regarding basic Medicaid billing procedures.

Opportunities are missed to educate providers and prevent improper payments that may or may not be recovered, depending on whether the provider is audited. Therefore, the PRI committee recommends:

DSS should compile audit findings into a single database and identify the top ten most common audit findings by provider type. This information should be distributed to provider associations so that they may educate their members and also posted on the DSS website under a provider education tab.

DSS should also include on its website for providers links to other government and national organizations that are concerned with Medicaid program integrity and offer educational materials on this topic to provider's knowledge.

DSS Claims Payment System May Not be Sufficiently Preventing all Improper Payments

The program review committee have concerns regarding the effectiveness of the controls within the Medicaid claims processing system. The Medicaid Management Information System (MMIS) is a state-owned and federally-certified claims processing and information retrieval system for health services provided under the Medicaid program. As noted, the Department of Social Service contracts with Hewlett Packard to be the fiscal agent responsible for designing, developing, implementing and maintaining the system. HP and its predecessor organization, EDS, have provided these services to DSS for about the last two decades. In the last fiscal year, over 30 million claims were processed with a total value of about \$5 billion.

There are specific controls in place within the MMIS system that are intended to ensure the completeness, accuracy, and validity of submitted claims. When a provider submits a claim, it is automatically reviewed for compliance with administrative, medical, and Medicaid-specific requirements by applying an extensive series of automated error checking routines.

These routines consist of hundreds of individual "edits and audits" that test claims according to criteria established in federal and state Medicaid policies and regulations. The "edits" review the claim for information such as format, provider and recipient eligibility, consistency, and reasonableness. Some edits may just provide information back to the provider – for example, two prescriptions have been filled for a client that shows a potential drug interaction. "Audits" review the claim against historical information to prevent payment for duplicate services and to ensure service limits are not exceeded. By submitting each claim to this process, it prevents certain improper payments from occurring by rejecting it.

In addition, to comply with provisions under the Affordable Care Act, DSS has recently adopted the Centers for Medicare and Medicaid Services National Correct Coding Initiative (NCCI) standard payment edits, in addition to those that the department created and

implemented. The NCCI edits are designed to promote correct coding and to control mistakes in coding that could lead to inappropriate payments. They are defined as edits applied to services performed by the same provider for the same beneficiary on the same date of service. The NCCI edits were originally implemented by Medicare carriers on January 1, 1996 and with some adjustments, now apply to Medicaid claims.

In reviewing MMIS, the program review committee found that:

- Information regarding the effectiveness of MMIS and the costs avoided due to MMIS processing is not fully captured and is apparently difficult to develop. For example, often a provider who has received a notice of a rejected claim corrects an initial claim denial and will eventually be reimbursed for services provided. DSS does not, and apparently cannot, track the number of times specific claims have been submitted or the reason for denial. There is no aggregate information available on reasons for denial because a claim is rejected when it encounters the first edit (and does not continue to run against subsequent edits or audits). No one can currently ascertain the number or dollar value of claims rejected because of provider error (or purposeful misstatement) and not resubmitted versus those legitimate claims initially rejected that were corrected, resubmitted, and paid.
- HP updated MMIS in 2008 by incorporating the InterChange system. Existing program integrity business rules were transferred from the legacy MMIS to the "new system," which was a modification of a base system used in another state. According to HP, the advantage of this upgrade was that the new MMIS is more configurable and changes can be made more easily than the legacy system. However, no specific program integrity audit routines were added during this upgrade. While the primary emphasis of DSS' recent efforts has been on ensuring that the processing of claims payments are in accordance with DSS policy, there has not been as much focus on additional steps to prevent fraud and abuse at the prepayment stage through MMIS, except for the federally mandated NCCI,;
- There have not been any periodic or recent attempts by DSS to *assess* MMIS' ability to specifically capture more contemporary billing/fraud schemes. The most recent payment error review by the federal government in FY 2009 revealed that the second costliest error was caused by an edit not being operational (See Appendix C regarding a description of the PERM process and findings).

DSS' Administrative Services Organization (ASO) has reported that it has shared with DSS certain prepayment procedures that would assist in

preventing improper payments that have not been implemented.⁴ For example, the ASO has suggested that certain large providers be required to use a specific type of code that would give DSS a more detailed description of a particular service rendered. Currently, providers use a general code that results in a higher reimbursement than this more specific code that has a lower reimbursement.

- Both DSS staff and the ASO have suggested that DSS implement stronger prepayment claims edits in its processing system to reduce the number of post-payment recovery efforts and have explained to the PRI committee staff that more robust prepayment systems are available.

New approaches. As noted earlier, newer approaches for prepayment fraud detection efforts are coming to rely heavily on technology solutions to collect the necessary data and apply the routines that identify suspicious activity. Because fraud perpetrators continually modify their schemes to escape detection, fraud detection systems must evolve too.

More contemporary approaches to prepayment claims review that are currently being piloted incorporate complex techniques.⁵ Claims that are put through the normal edit process to ensure proper coding and identify overpayments can serve as the foundation for uncovering improper payments through the use of predictive modeling, provider profiling, trend analysis, and variance reporting. Predictive modeling applications rank or score providers based on indicators that reveal whether providers are engaging in abusive or fraudulent practices. Indicators identify aberrant behavior in procedures, visit levels, place of service, units of service, and other pertinent data to pinpoint where problems may occur.

Traditional rules-based fraud detection systems that analyze claims and identify outliers, as used in Connecticut, tend to be most frequently deployed post-payment. Moving this operation to the front-end of the claims payment process and complementing it with predictive modeling techniques is key to changing the pay and chase model. Combining rules-based analytics with predictive modeling techniques, it is contended, is a far more effective way to detect sophisticated fraud schemes than relying on rules-based analytics alone. Integrating traditional editing with predictive modeling enhances both processes, and so both are important in having a rigorous program integrity process.

⁴ Beginning with dates of service as of January 1, 2012, DSS replaced its managed care delivery system with a single administrative services organization (ASO) model. This model of care covers all of the department's medical assistance clients, including all HUSKY Health and Charter Oak members. The ASO is responsible for certain member and health provider services, including: referral assistance and appointment scheduling; provider recruitment; health education; utilization management including prior authorization; case management including intensive care management; as well as quality management and health data analytics and reporting.

⁵ See for example, *Bending the Cost Curve: Analytic Driven Enterprise Fraud Control*, LexisNexis Risk Solutions White Paper, 2011, and *Prepayment Fraud, Abuse, and Error Detection: Identifying Inappropriate Claims Before They are Paid*, Fair Issac Corporation, White Paper, 2011.

Prepayment analytics under development. The program review committee staff have reviewed available literature and interviewed industry representatives regarding the use of more advanced prepayment analytics with regard to Medicaid claims. While each vendor stresses the potential high return on investment (ROI) for making such changes, the current available evidence on ROI is unclear. Several states and CMS are beginning to develop this capacity.

As noted in a recent Health Affairs Journal article, CMS began its advanced data analytics program in July 2011, using fraud detection technology similar to that used by the credit card industry. These tools range from simple "rule-based" programs (as described above) to "anomaly-based" programs, which focus on providers who stand out from their peers based on some metric, for example, billing far more hours for the same procedure. Although CMS is optimistic about the potential of these new techniques, thus far few payments have been suspended as a consequence of use of advanced analytics. CMS officials have acknowledged a lag time between discovering violations and reporting them in public documents. But CMS also points out that every line in each of Medicare's daily 4.5 million fee-for-service claims is now examined through some form of analytics, and that new analytical models are introduced each quarter, which should lead to better results from use of this technology over time.

Within the last year, IBM implemented a prepayment solution as part of its installation of two software products to help the North Carolina Department of Health and Human Services (DHHS) detect fraudulent or abusive billing practices by health care providers. This contract was recently criticized by the North Carolina Office of State Auditor as not delivering the amount of recoupments that were promised by IBM. DHHS officials responding to the findings, noted that the auditor only looked at the first year of returns and that the system will produce enhanced benefits over the life of the product. The total costs avoided though the prepayment software are unclear and were not provided by IBM to committee staff.

Another developer of fraud detection systems, HP, has a contract with Pennsylvania to build a prepayment analytics functionality into its MMIS system. To date, the PRI committee staff were not provided any estimates on what it will save.

In addition, Dynamics Research Corporation, has recently announced that is has been selected to develop predictive models for the Commonwealth of Massachusetts. These models will provide real-time transaction risk-scoring and will present information on selected claims that will provide a basis for analysts to review, investigate, and approve or deny claims.

HMS has noted that it is in the process of piloting some prepayment analytics in Maine to help the state understand the extent of problems that could be identified and the system's potential benefits. Other vendors have noted that they have used a "proof of concept" approach for various data mining initiatives - that is, the use of a pilot similar to HMS. This appears to be a sensible approach to determining if certain information technology solutions are worth the investment. The program review committee recommends:

The Department of Social Services: 1) develop a method to determine the effectiveness of the current claims processing system in identifying

improper payments and avoiding unnecessary costs; 2) assess current claims routines used to capture improper payments and ensure they are updated; and 3) assess if and how the use of prepayment analytics and reviews could strengthen prevention efforts. This assessment should contain a return on investment determination that compares the additional resources necessary to perform these activities, and the extent to which enhanced federal participation (90 percent reimbursement) would be available to reduce state costs.

A robust prepayment claims system that identifies improper claims before they are paid can be more cost-effective than retrospective recovery efforts. Properly configured, fraud-detection systems can handle the high volume of claims that the state receives and comb through the potentially hundreds if not thousands of data elements contained in each claim. In addition, the actual and perceived success of an anti-fraud program is largely dependent upon the metrics used to measure its effectiveness. A reliable metric is to measure the dollars that are never paid due to identification of error, fraud, and abuse as a percentage of the otherwise allowable payments.

Post-Payment Review of Medicaid Claims

Post-payment review processes examine the accuracy of payments that have already been made to providers. Federal regulations require that DSS have a post-payment process to ensure the integrity of the Medicaid program. The purposes of post-payment processes are to detect and recover improper payments made to Medicaid providers, enforce appropriate sanctions against providers, and refer suspected fraud cases to other agencies for further legal action, as appropriate.

This chapter primarily focuses on two post-payment areas of investigations and audits. (A third post-payment area of third party liability is covered in Chapter IV). This chapter also discusses the need to improve management practices across various units within OQA and provides an overview of Medicaid fraud prosecution and outcomes.

Error Estimates

Investigations, audits and third party liability determinations are the principal conduits thorough which DSS will review a claim after it has been paid. One other way an improper payment will come to the attention of DSS is through the Payment Error Rate Measurement (PERM) program conducted by CMS. PERM is a comprehensive, ongoing federal audit designed to estimate the national proportion of Medicaid and Children's Health Insurance Program payments made in error. CMS conducts PERM reviews of state Medicaid programs on a three-year cycle. Unlike the above areas and by design, PERM does not focus on areas suspected or known to be at risk for improper payments. Thus the purpose of PERM is different than the other post-payment tools as it is intended to provide an estimate of the rate of improper payments across the program as a whole.

CMS found in 2009 that Connecticut had an error rate for 2.8 percent overall, which is much lower than the national average of 8.98 percent. CMS cautions, though, that PERM is designed to produce precise error rates at the national level, but sample sizes are relatively small, making the precision of state-specific error *much less reliable*. Appendix C provides further explanation of the PERM program.

The Office of Quality Assurance does not have Sufficient Policies and Procedures in Place to Guide Operations

The Department of Social Services has been cited twice (2007 and 2011) in reviews conducted by the Centers for Medicare and Medicaid Services (CMS) for not having adequate written policies and procedures to support its program integrity operations. In October 2011, the department responded to CMS' 2011 review and agreed to complete the development of written policies and procedures covering all program integrity processes within the following six months.

In July 2012, the program review committee requested from OQA copies of all policies and procedures related to the Medicaid integrity program. OQA complied and after a review of the documentation provided the program review committee found:

- there still is not an overall program integrity manual that describes the operations and processes of the office to understand how potential cases are identified, developed, and move between units or to other departments or agencies;
- most units in OQA do not have any specific procedures governing their operation; however, two procedure manuals were provided to the PRI committee staff regarding the Special Investigations Unit (SIU) and the Fraud Early Detection Program (FRED).
- the SIU manual is dated June 2010 but has not been formally adopted and is still in draft form:
 - it contains language that makes it difficult to distinguish between a routine audit and an investigation into potentially fraudulent billing practices; and
 - it is unclear regarding the process that should be followed when conducting an investigation and at what point a referral should occur; and
- although the unit maintains audit review programs for some specific provider types, the audit manual shown to PRI committee staff was outdated and is not relied upon by OQA staff.

The purpose of policies and procedures is to provide consistent and appropriate guidance to staff in performing their duties. All organizations, especially public ones, should have policies and procedures that guide how decisions are made and how the work is done in that organization. Well-written policies and procedures increase organizational accountability, transparency, and effectiveness.

The office has had some staff turnover due to retirements and has added staff recently. In addition, two components of the office have been reorganized in the last two years. Given these changes, the lack of written policies and procedures could lead to inconsistent implementation of laws and regulations, miscommunication about responsibilities, and less effective functioning.

The department has been cited by CMS since 2007 about its inadequate policies and procedures governing its program integrity program. Management has engaged in an on-going

process to develop policies and procedures but has failed to complete the documents in a timely manner. The program review committee recommends that:

The Department of Social Services complete the development of policies and procedures that include all aspects of the program integrity program within the next 18 months.

Deficient Case Management and Information Systems Hinders Effective Oversight

OQA has an inadequate case management and information system that limits management's understanding of program operations. The office maintains three separate databases that contain listings of: 1) complaints; 2) audits and integrity reviews; and 3) referrals to law enforcement agencies for suspicion of fraud.⁶

Federal law requires that DSS be able to track and report specific information to CMS. This includes the number of integrity reviews undertaken arising from complaints of fraud and abuse and the number that lead to a full investigation based on the initial complaint. In addition, for full investigations, the information must include the:

- provider's name and number;
- source of the complaint;
- type of provider;
- nature of the complaint;
- approximate range of dollars involved; and
- legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred.

The program review committee found the following deficiencies with the DSS case management and information systems:

- information regarding dates, nature of complaints or audits, outcomes, and certain other data are not consistently entered or are missing in all three databases;
- the documentation of case activity is fragmented because each case is entered into a separate database, which are not linked, and management cannot readily track a case from initial complaint to final resolution;
- although two of the databases contain recoupment amounts, for cases where recoupment is expected, it is unclear if the amount recorded is what is ultimately recovered;

⁶ An integrity review is a preliminary investigation conducted by OQA if it receives a complaint alleging Medicaid fraud or abuse from any source or if it identifies any questionable practices to determine whether there is sufficient basis to warrant a full investigation. These reviews are discussed further in Appendix B.

- the overall accuracy of data was not always checked; and
- the system is not an effective management tool for tracking compliance with statutory timelines in conducting various aspects of the department's work or for measuring the performance of each subunit, activity, and contractor.

A good case management and information system is designed to support the operations, management, and decision functions of an organization. It should allow for the efficient processing of cases and produce essential information about organizational accomplishments in a readily useable format. Further, management should be able to monitor the performance of the organization, evaluate any deviations from expected or desired results, identify necessary improvements, and implement corrective actions in a timely manner.

The consequence of an ineffective case management and information system is that it can be difficult to track cases and understand current status. In addition, decision makers, at all levels, fail to receive an accurate understanding of program operations and the degree to which a program is meeting its intended goals. For example, not all referrals to MFCU were contained in the integrity review database (the audit and investigation database), but were maintained in a separate "referral" database. Of the 32 MFCU referrals made from FY 09-FY 12, the PRI committee staff identified only 18 cases in the audit and integrity review database, making it impossible to ascertain the source for the 14 cases that were missing.

Management has taken an improvised approach to developing a case management and information system. In the absence of a thoughtful, coordinated effort, the department has allowed a fragmented and disconnected system to develop. The program review committee recommends:

The Department of Social Services design and implement a uniform, automated case management and information system that captures essential case information and results in the production of valid and reliable data.

In addition, DSS should develop and track performance measures to ensure the work of the OQA is performed according to statutory timeframes, ensures that staff is optimally deployed and productive, contains all the required fields required by federal regulation, tracks estimated and actual recoupments received, and indicates when a case is closed once all the dollars are recouped.

Office of Quality Assurance Does Not Have a Formal Audit Plan

Audits are a formal post-payment examination of a Medicaid provider's records and documentation to determine program compliance, the extent and validity of services paid for under the Medicaid program, and to identify any inappropriate payments. The Office of Quality

Assurance's audit unit is responsible for performing audits of Medicaid health care providers. Each audit is based on a sample of claims and the department has the authority to use statistical methods to project the amount of overpayment based on errors found in the sample. A detailed discussion of the audit unit is located in Appendix A.

While the audit unit has been relatively successful, changes could be made to strengthen the unit's audit selection approach and address potential vulnerabilities in its selection process. An initial review of audit productivity looks positive. The number of audits performed by DSS has declined but the error amounts identified for collection and costs avoided have increased. For example, the number of audits has dropped from 149 in 2008 to 86 in 2012 (42 percent drop), but at the same time the average error amounts discovered per audit increased from about \$5.6 million to \$13.6 million (143 percent increase). Even so, the method of audit selection can be formalized to ensure better coverage of the scope of providers selected.

The audit unit of OQA does not develop a risk-based annual audit plan to direct the unit's work efforts. Instead it relies on the judgment of the director of the Office of Quality Assurance and the director of the audit unit to determine which providers should be audited. Their decision is typically guided by the experience of the directors. They may informally consider trends that may be happening on the national level about known schemes and potential significance in terms of dollar impact. Such a casual methodology may raise concerns about how resources are targeted.

To understand the vulnerabilities that the current selection process may produce, the program review committee examined the extent and types of providers that OQA has audited in the last 10 years. In general, the unit can only audit a small part of its provider universe. In the last five years, the average number of audits conducted is about 116 per year of a potential pool of over 30,000 billing providers. These providers are categorized into 41 different provider types.⁷

An analysis of the audit activity data over the last 10 years reveals that:

- OQA audits a very small percentage of its total providers (less than one percent);
- OQA audit unit has performed 80 percent of its audits on 12 percent (five of 41) of the *provider types*.
 - those *provider types* represent 8 percent of all *providers* and 35 percent of all reimbursements paid in 2012;

⁷ There are also thousands of providers who are called performing providers, whose services are billed through another provider type. There are provider type and sub-provider type codes. Provider types include hospitals, physicians, therapists, etc. Sub-providers would include specialists within a provider code.

- further, there were 20 provider types (49 percent) that represent about one-fifth of all providers that were not the subject of a single audit in the 10-year time span; and
 - collectively, these 20 provider types were paid over \$430 million in reimbursements (7 percent) in 2012. While many of those are smaller providers, at least four of those provider types have billed the state on average over \$2 million last year.

An audit selection process that relies on a risk-based assessment would identify, measure, and prioritize risks posed by different provider types and providers, so that audit activities are focused on the areas with the greatest significance. After various provider types are analyzed, individual providers should be selected for audit using outlier analysis and other risk-based analytical techniques. In addition, other states, such as Virginia, have reported that the use of risk-based approaches to guide audit activities has led to an improved audit process.⁸

It appears that a more rigorous audit selection process has not been considered by DSS management. Without a more systematic method, gaps in audit selection could allow improper payments to go undetected. Employing a more formal annual audit planning approach that is more risk-based provides an additional assurance that the audit activities are properly targeted within DSS and helps to ensure appropriate allocation of limited staffing resources. The program review committee recommends that:

The Department of Social Services develop a more formal risk-based audit planning process that identifies, measures, and prioritizes risks posed by different provider types and providers to establish which will be reviewed on an annual basis.

This approach should include a variety of factors that define the potential risk providers may pose and should include but not be limited to the size of the provider-type, the total monetary reimbursements for that provider type, average value per claim, extent of specialization, level of claims processing sophistication, history of fraud, experience of management, and any other elements that are related to the risk of improper payments being submitted.

DSS Should Provide Additional Audit Guidance to Providers and the Validity of the Sampling and Extrapolation Methodology Should be Examined

⁸ See for example, *Mitigating the Risk of Improper Payments in the Virginia Medicaid Program*, Joint Legislative Audit and Review Commission, January 2012, page 55. See also, the New Jersey Office of the State Comptroller, *Medicaid Fraud Division Audit Guide Book*, page 2.

A lack of transparency of DSS' audit process for the Medicaid program has been a concern of providers for some time. There have been recent changes in the law made by the legislature to formalize the audit process (including the development of timeframes and provider appeal rights) and require the adoption of detailed regulations to carry out the auditing statute. Still, the PRI committee believes there are opportunities for DSS to provide additional guidance to providers to reduce audit findings and also to clarify the audit sampling and error projection (i.e. extrapolation) methodologies.

Formal audit process. Both historically and more recently, providers have complained about the lack of written standards and administrative guidance regarding DSS' audit process. Also, some providers have voiced concerns about formally criticizing DSS' audit process because of the potential for department retaliation.⁹

Prior to 2005, state statutes did not contain a structure for the audit process but instead DSS relied on federal policy to guide its audit work. In 2005, in response to provider concerns, the legislature established a statutory procedure for audits of service providers, including:

- timeframes and notice requirement for various aspects of the process;
- provision that clerical errors do not, themselves, constitute a willful violation;
- authorized the use of extrapolated projections to calculate overpayments under certain circumstances. (See below for an explanation of extrapolation);
- required issuance of a preliminary written report, exit conference, and final report; and
- an internal DSS review process for any provider aggrieved by an audit.

Additional measures were implemented by the legislature in 2010 that gave the provider the right to appeal the final audit decision to the Superior Court and required the DSS commissioner to adopt regulations related to the audit process that ensure fairness of the process and "the sampling methodologies associated with the process." The law was effective on July 1 2010. The Notice of Intent to promulgate the regulations was published in October 2012 and a public hearing was held on December 10, 2012.

The program review committee staff interviewed two provider groups and received testimony on this issue from various providers at its public hearing on June 29, 2012. Some providers are still reluctant to discuss their problems with the process in public or complain to DSS individually. In general, they have expressed frustration with trying to understand the audit

⁹ See for example the case of Dr. Richard Weber who complained to a legislator about the audit process, was subsequently prosecuted by the state's attorney (charges later dismissed), and sued the state in federal court alleging violation of First Amendment rights. The case was settled in 2008 with a monetary settlement of \$725,000.

process and the expectations of them during an audit. In addition, they have complained that the policy provisions against which they are being judged are too general, vague, or insufficient. Several providers have stated that the first time they hear about an interpretation of a particular Medicaid policy is during an audit. Some termed the administrative requirements as "overwhelming" and "ever-changing."¹⁰ Others have cited concerns regarding some DSS auditors' knowledge of the regulations and varying interpretations of those regulations.

The lack of timeliness in completing an audit and the extent of the look-back period for audits was also criticized. There is no statutory limitation regarding the length of the audit period under review. Typically, DSS has a look-back period for two years and more recently has extended the period to three years. One provider noted a 10-year look back in at least one case and the difficulty in locating the proper documentation to comply with the audit request.¹¹ There are, however, record retention requirements of about five to seven years scattered in the regulations according to provider type.

Opportunities afforded by DSS to providers for educating them about the audit process have been extremely limited. As noted earlier, DSS does not regularly compile common audit findings and distribute this information to providers. Further, DSS is required by statute (C.G.S. Sec. 17b-99(c)) to distribute to providers the rules regulations, standards, and laws that govern the Medicaid program, but DSS' Director of Quality Assurance says DSS does not do so.

The PRI committee have noted that other states publish guidance to providers to educate them about audit procedures and other guidance to help prevent improper payments. For example, the state of New York issues audit protocols to assist Medicaid providers in developing programs to evaluate compliance with Medicaid requirements. They make clear that the protocols are intended solely as guidance in this effort and in the event of a conflict between statements in the protocols and either statutory or regulatory requirements, the requirements of the statutes and regulations govern. Several states also publish guidance documents that explain the Medicaid audit process and outline expectations of providers.

Sampling and extrapolation. DSS has a responsibility to assure both state policy makers and the federal government that providers are in compliance with Medicaid rules and regulations. Millions of claims are paid to thousands of providers annually. Sampling and extrapolation techniques are necessary and accepted tools for DSS to use because it would be impossible to manually review every claim on a case-by-case basis in detail. The department relies on samples of audit claims and extrapolation (or projection) of error amounts to determine the number of payment errors and the amount of overpayments to collect from providers when conducting audits.

The department generally uses a standard sample size of 100 claims for all provider audits, though the sample size may be somewhat larger for hospitals in certain cases.

¹⁰ Submitted testimony of the Connecticut State Medical Society to the Legislative Program Review and Investigations Committee, June 29, 2012

¹¹ Submitted testimony of Mag Morelli, President of LeadingAge Connecticut, to the Legislative Program Review and Investigations Committee, June 29, 2012.

Extrapolation is the practice of taking the results of a sample and applying it to a larger population and, in this case, for DSS the population is claims. In practice, extrapolation works by: 1) dividing the total number of payment errors found in a sample of claims by the sample size to arrive at average errors per sample; and 2) multiplying this by the total number of claims to arrive at a presumed extrapolated number of payment errors for all payments to the provider during the audited period.

The provider must make repayments to DSS based on these extrapolated error amounts, which can grow to be quite large. For example, in one audit reviewed by committee staff, a random sample of 100 claims was selected from a claims universe of 70,092. Forty-three of the 100 claims contained an overpayment totaling \$2,331.89. The average dollar error per selected claim was \$23.32 (\$2,331.89 (total error amount) divided by 100 (claim sample size)). The average dollar error per claim is then multiplied by the total paid claim universe for an extrapolated error amount of \$1,634,545. At times, the department will stratify (separate) the error amount for certain procedures that are unusual compared to the rest of the sample but this is only *after* the sample has been selected. There are no written procedures that guide this stratification practice. Providers have expressed concerns about the fairness of using extrapolation and the statistical methods used.

As noted above, DSS has extended the length of the audit period under examination to from two to three years. This has the effect of increasing the size of the claims universe against which errors will be extrapolated by 50 percent (and increasing the amount of potential recoupments) while maintaining the same sample size.

The legal validity of using extrapolation in Connecticut has been upheld by the Connecticut Supreme Court in *Goldstar Medical Services Inc. v. Department of Social Services* (288 Conn. 790, 955A.2d 15). However, it does not appear that the court actually endorsed the precise statistical methodology used by DSS. Although proposed regulations speak to the necessity of ensuring a representative sample, the department is not restricted by any statute or regulation in determining the size of the sample.

There are also concerns about the statistical appropriateness the methods used by DSS. First, setting a standard sample size of 100 claims for each provider in an audit could be problematic. Establishing a standard size of 100 claims for nearly all providers regardless of the type of provider, the diversity of the claims, the value of the claims, or the range in the value of claims, may not result in a representative sample. A representative sample should be large enough to reflect the characteristics of the members of the entire population.

In addition, the department does not calculate the precision or reliability of its sample estimates through the use of commonly accepted statistical measures such as a confidence intervals and confidence levels.¹² A conservative approach would be to use the lower end of the confidence interval for extrapolation purposes. Finally, the use of an arithmetic mean (average)

¹² Confidence level is a measure of the reliability of a result. A confidence level of 95 percent means that there is a probability of at least 95 per cent that the result is reliable and not because of chance. A confidence interval is a statistical range with a specified probability that a given parameter lies within the range.

to determine average error per sample is misleading when there are extreme values. The use of a median number (i.e., half above and half below) is often used to guard against such a possibility.

CMS has used different sampling approaches depending on the type of audit project. One method used by CMS in determining the sample size for the Payment Error Rate Measurement program is to use stratified sampling by dollar amount of claims to ensure that various dollar size of claims are properly represented. In its Medicare program integrity manual, CMS requires the sampling methodology used to project overpayments for Medicare audits be reviewed and approved by a statistician to ensure a statistically valid sample is drawn and statistically valid methods for projecting overpayments are followed. CMS notes that if the sampling methodology is applied routinely, the original approval may be used for conducting subsequent reviews.

DSS maintains that a former CMS employee examined the department's methodology; however the documentation verifying the review and approval was scattered among numerous emails and not readily available for PRI committee review.

Given the critical nature of any audit and the high stakes outcome for providers, there may always be some complaints about how audits are conducted. However, audit programs must be fair and not unduly burdensome. Providers report that the administration of audits can be disruptive to their practices, absorb staff time and resources, and at times, can delay the provision of medical care. If the audit process is considered too onerous and is combined with the fact that Medicaid pays substantially less than Medicare and private insurers, it could diminish providers' desire to participate in the Medicaid program. To address these concerns, the program review committee recommends that:

The Department of Social Services develop an audit guide book with accompanying protocols to assist providers in complying with Medicaid program requirements and prevent improper payments.

The guide book should provide more detail than the requirements in regulation and include, but not be limited to, the department's expectations of providers during an audit, how an audit will be conducted, how the sampling and extrapolation processes are implemented, the expected timeframes for DSS to complete each phase of the audit, the exit conference process, and how the appeal process works.

The protocols should contain information by provider type that describes DSS' application of articulated Medicaid agency policy and assist the Medicaid provider community in determining if they are in compliance with Medicaid requirements under federal and state statutory and regulatory law. The protocols should be phased in over a five-year period.

In addition, DSS should have its overall sampling and extrapolation methodologies reviewed by a statistician to ensure that statistically valid methods are used to draw samples and for projecting overpayments.

DSS Should Consider Expanding its Audit Program

The program review committee staff performed a rudimentary examination of both the costs of and dollars collected through audits. When this information is combined with the finding that DSS only manages to audit a small percentage of providers (less than 1 percent, as noted earlier), a case may be made for expanding DSS' audit program.

Return on investment. As shown in Table II-1, it appears the audit unit maintains a positive return on investment. For each dollar invested in the audit unit, it returns between \$2.99 and \$5.09 in dollars identified as paid errors available for collection, with a 4-average return of \$3.86. When an estimate is included for costs avoided the total rises to between \$4.83 and \$8.15, with a four-year average of \$5.91. Put another way, the costs of the audit unit represent on average about 26 percent of what it collects.

Table III- 1. Return on Investment: Amount Returned for Each Dollar Invested in Audit Unit, 2009-2012 and Four-Year Average									
2012		2011		2010		2009		4-Year Average	
Error Amt. Only	w/ Cost Avoided	Error Amt. Only	w/ Cost Avoided	Error Amt. Only	w/ Cost Avoided	Error Amt. Only	w/ Cost Avoided	Error Amt. Only	w/ Cost Avoided
\$5.09	\$8.15	\$3.41	\$4.92	\$3.96	\$5.75	\$2.99	\$4.83	\$3.86	\$5.91

Source: PRI calculations based on DSS, Core-CT, and State Comptroller data

To calculate the return on investment, program review committee staff obtained salary information for the 22 employees (identified through Core-CT and organizational charts) as working in the provider audit area of the audit unit in 2011-2012. This was the most conservative approach to determining ROI as this yielded the highest cost of staffing for the four-year period under review. An amount was also apportioned for the supervisor's and secretarial time. A standard percentage (38 percent) calculated by the state comptroller was applied to each salary to account for employee benefits. These costs were compared to the amount identified for collection (and the cost avoidance estimate) for each year by the audit unit. Missing from the cost estimation are other overhead expenses such as office space, utilities, and other miscellaneous administrative costs, though personnel expenses are usually the biggest component cost by far.

Caveats. Although ROI estimates based on the initial numbers seem promising, additional analysis would have to be completed to arrive at a more precise calculation, such as the impact of recently added staff to the DSS audit unit as well as any effect that training time

may have on the return on investment. In addition, the nature of the provider pool and the increase of the number of audits would have to be carefully examined because of principal of diminishing returns.¹³

Finally, the program review committee would also caution that any expansion of the number of audits should *only* occur after the previous recommendations regarding a risk-based audit plan, provider education, and guidance protocols be implemented. It is critically important that DSS first put an emphasis on ensuring there are appropriate processes and tools in place to help providers comply with Medicaid program rules and regulations first before increasing the number of audits.

Recovery Audit Contractor (RAC). Any evaluation of expanding the number of audits should include a consideration of using a private contractor to perform additional audits as well. Recently, Health Management Systems was hired to be the state's Medicaid Recovery Audit Contractor. The RAC program is federally mandated and requires state Medicaid agencies to hire a contractor to audit claims of providers in the program. RACs operate on a contingency fee basis but the state has flexibility in designing and implementing the program and how the RAC will be paid. DSS has negotiated a two tier fee structure of 9.3 percent and 10.5 percent based on the type of audits performed. (Appendix A has additional detail as to how the RAC program will operate in Connecticut).

HMS will perform two types of reviews: automated reviews, which are mostly desk type audits; and complex reviews, which are similar to DSS field audits. The complex audits will include reviews of medical records and/or billing and financial records. The RAC is a new concept for Medicaid and the state. It is unclear how successful the RAC vendor will be as the audits have only just begun and to date have been limited to a few providers. The program review committee recommends:

The Department of Social Services evaluate the potential to expand its audit program. It should estimate the potential for improper payments through a risk-based analysis. This assessment should contain a return-on-investment determination that compares the additional resources (both in-house and private contractor) necessary to perform these activities to its potential benefits.

Data Mining Technology Used to Identify Potential Fraud is Obsolete

The Department of Social Services uses two data systems, along with ad hoc queries accessing what is called the Data Warehouse, to detect Medicaid providers whose aberrant claims submissions require further review to examine whether fraud, abuse, or errors have

¹³ As more investment in an area is made, overall return on that investment increases at a declining rate, assuming that all variables remain fixed. To continue to make an investment after a certain point (which varies from context to context) is to receive a decreasing return on that input.

occurred. The first system, called the Surveillance and Utilization System (SURS/Profiler), required by federal regulation, provides statistical profiles of health care delivery and utilization patterns of providers and recipients. The system can examine procedure codes, provider types, diagnosis codes, or other characteristics to identify potential fraudulent activity. Reports are run quarterly.

Surveillance and Utilization System/Profiler. HP is responsible for running the SURS/profiler update cycle every quarter and maintaining the application. However, HP does not define the parameters that are used to aggregate the data or the analysis of the data to determine potential fraud cases. According to DSS staff, the SURS/Profiler is outdated and the majority of its investigations are initiated because a complaint was received by the unit, not from its data mining activities.

The system is more than 20 years old and was adapted at that time from software in use in Pennsylvania. Thus, DSS has never received the full benefit of the SUR/profiler system because DSS did not clearly understand imported case types and case groups may have been unique to the Pennsylvania Medicaid program. This was compounded by the lack of dedicated resources to really learn and use the profiler tool effectively.

Fraud, Abuse, and Overpayment System. The Fraud, Abuse and Overpayment System (FAO) comprises 31 targeted queries to also identify patterns of abuse using the Data Warehouse. During the implementation of the Data Warehouse in 2005, HP worked with a third party vendor and OQA to define the FAO reporting criteria. At that time, the 31 targeted queries were defined and implemented to detect fraud and abuse. Because these queries were written specifically for Connecticut they were more useful than the SURS/Profiler. However, over time, some of these targeted queries have become obsolete as state medical assistance programs were added or changed. The queries required maintenance and modification to stay current with the changing programs and HP's scope of work did not include the ongoing modification and maintenance of the targeted queries. According to DSS staff, only six of the thirty-one targeted queries are useful in profiling potential provider fraud or abuse.

Ad hoc queries. Ad hoc queries are also performed by DSS staff, usually to target a provider for a known or suspected event or circumstance. Examples of ad hoc queries would include an examination of billing patterns for services that cannot logically occur or should not be billed together. In addition, DSS staff indicated that the unit has developed its own ad hoc queries to examine conflict claims submissions rather than using the targeted conflict queries. DSS staff said another helpful tool that would be most useful would be to have access to a library of algorithms that would keep pace with changing trends.

These three approaches to data mining provides for electronic analysis of Medicaid claims by using statistical models to uncover patterns and relationships contained within Medicaid claims activity and history to identify aberrant utilization and billing practices that are potentially fraudulent. More recently, the federal government and a number of states have begun to use predictive analytic technology that predicts potential provider billing prior to payment to identify aberrant and suspicious billing patterns.

Outcomes from data mining activities. Each year, CMS surveys state program integrity agencies regarding their activities. In its response to the CMS' 2010 State Program Integrity Assessment, the Office of Quality Assurance indicated that only one percent of cases opened for review because of suspected fraud or abuse were identified as a result of data mining activities. Furthermore, recoveries identified because of data mining activities amounted to only \$53,430 in the previous year.

Better technology exists. More sophisticated technology exists and other states, such as North Carolina and Iowa, have implemented it in order to better identify potentially abusive or fraudulent providers. The federal government, along with several states, is moving towards better identification of potentially fraudulent or abusive providers in the prepayment stage of claims submission. They are preventing payment from being made in the first place by predicting potential billing that may be improper, while maintaining the "pay and chase" model by using claims data to identify improper payments made to providers. (See Chapter I for related recommendation for prepayment technology).

Technology can quickly become obsolete and using a system that is more than 20 years old, like the SURS/Profiler is problematic. Even the FAO that is seven years old, is not identifying potentially more sophisticated acts of Medicaid fraud. Because of the inadequacy of Connecticut's SURS/Profiler and DSS' failure to update the FAO system, it is unlikely that all questionable claims submissions are being identified. Thus, the unit must rely on complaints received rather than proactively detect abusive or fraudulent behavior. If DSS upgrades its technology, it is likely that a greater number of improper payments will be discovered.

The PRI committee acknowledges that investment in new technology can be expensive. However, there is an opportunity to adopt new better data mining software, given that 90 percent of design and implementation is supported by the federal government. However, training staff in learning how to manipulate new software can be costly. Thus, another feasible way in which DSS could improve its data mining capabilities is to contract this function out to one of several entities that have already developed more sophisticated technology to look for aberrant billing patterns and already employ skilled staff with the ability to manipulate large amounts of data. Either of these two approaches is feasible and therefore the PRI committee recommends:

The Department of Social Services should explore software in use in other states to identify those states with the best data mining results and determine the reasons why their data mining functions yields better results. Based on this information, DSS should issue an RFP to either purchase state-of-the-art data mining software or contract out this function to an entity that specializes in this area. The goal should be better targeting of providers engaging in potentially abusive and/or fraudulent practices and therefore, identify more improper Medicaid payments for recovery. If the department contracts for this function and potentially fraudulent or abusive practices are discovered by the contractor, the Office of Quality Assurance should conduct an investigation to determine if the provider should be referred to the Medicaid Fraud Control Unit.

Fraud Prosecution and Outcomes: Criminal and Civil

Most Medicaid improper payment situations do not lead to investigations for criminal or civil law violation. Once an improper payment is detected, a determination must be made whether fraud or abuse exists. The Special Investigations Unit within the Department of Social Services (DSS) conducts its own preliminary investigation of any suspected misconduct. As noted earlier, the unit determines whether it will proceed with administrative action and/or refer the matter on to other governmental entities for further investigation and possible prosecution.

The Medicaid Fraud Control Unit (MFCU) within the Office of the Chief State's Attorney cannot initiate cases itself and is responsible for reviewing the referrals it receives from DSS and other sources to determine if the issues merit criminal investigation and prosecution. Similarly, the Office of the Attorney General (OAG) is responsible for determining whether civil action is warranted in these matters. Described below are activity measures related to procedures used to investigate providers suspected of Medicaid fraud. (Appendix E provides a more comprehensive description of the MFCU and OAG's processes and activities.)

Fraud Activity Measures

The PRI committee submitted data requests to each of the state entities charged with investigating Medicaid fraud. For various reasons, the information provided by each agency has several limitations that preclude much comparative analysis. To the extent possible, the following presents snapshots of activity statistics for investigations and outcomes.

MFCU Criminal Enforcement Activity Measures

As part of its annual federal recertification, MFCU is required to submit an annual report to its federal oversight agency, HHS-OIG. The report contains various case activity measures as specified by federal regulation. Some of the measures, as reported to the federal government for the last four reporting periods, are presented below. The program review committee also requested certain data from MFCU that is not compiled for the federal annual reports.

MFCU investigations. Table III-2 break downs the number of MFCU investigations initiated and closed during the four annual reporting periods. It is important to note that investigations closed during a particular year often have no relationship to the investigations opened during the same year.

As shown in the table, the majority of investigations initiated by MFCU relate to Medicaid fraud with substantially fewer investigations opened for issues of Medicaid patient abuse and neglect or patient funds. A large portion of the fraud investigations involve medical support (e.g., durable equipment or transportation vendors) and practitioners.

Table III-2. MFCU Statistics: Number of Investigations Initiated and Closed (2008-2012)								
Reporting Period	April 2008-March 2009		April 2009-March 2010		April 2010-March 2011		April 2011-March 2012	
	Initiated	Closed	Initiated	Closed	Initiated	Closed	Initiated	Closed
Total Fraud Investigations	45	62	57	48	56	50	35	41
Facilities	8	19	6	4	4	5	2	2
Practitioners	8	8	11	11	12	7	13	13
Medical Support ¹⁴	9	22	33	22	34	33	17	22
Program Related ¹⁵	20	13	7	11	6	5	3	4
Total Patient Abuse & Neglect	17	17	22	24	19	21	5	4
Total Patient Funds	0	0	4	3	0	0	0	0
TOTAL All Investigations	62	79	83	75	75	71	40	45
Source: MFCU Annual Reports								

Overall, the total number of all investigations initiated over the four years has fluctuated with the lowest number of investigations initiated in the most recent reporting period. Similarly, the total number of all investigations closed has substantially decreased. This trend is also reflected in the fraud investigations with a sharp contrast in the last two reporting periods. MFCU initiated fewer total fraud investigations (35) in the latest reporting period than in the previous one (56). The total number of fraud investigations closed (41) also decreased in comparison to the earlier year (50). However, the unit closed more total fraud investigations (41) than it opened (35) in the most recent reporting period compared to the previous reporting timeframe. In other words, MFCU opened more cases than it closed in 2010-2011 but then the following year closed more cases than it opened.

MFCU notes in its 2012 annual report that its production was hampered by the abrupt retirement of two senior staff. The positions were filled in April 2012 with the anticipation of hiring additional staff in the near future.

MFCU case outcomes. Among the possible case outcomes for MFCU investigations are arrests, prosecution, dismissals, convictions, or closed without prosecution. As Table III-3 shows, the number of arrests has decreased over the four reported years as well as the number of dismissals. The number of cases prosecuted since 2008-2009 timeframe had substantially

¹⁴ "Medical Support" refers to an individual, facility, or organization, whether licensed or unlicensed that provides medical support services such as durable medical equipment or transportation.

¹⁵ "Program Related" refers to a person or organization providing Medicaid program related services such as a billing company or other program administration.

decreased but an increase is seen in the most recent reporting period along with more convictions.

Federal regulation also requires MFCU to annually report the number of cases closed without prosecution due to insufficient evidence. MFCU has closed a total of 209 cases due to insufficient evidence during the last four reporting periods.

Table III-3. MFCU Statistics: Number of Arrests, Prosecutions, Dismissals, and Convictions					
MFCU Outcomes	April 2008- March 2009	April 2009- March 2010	April 2010- March 2011	April 2011- March 2012	TOTAL
Arrests	15	10	9	5	39
Prosecutions	16	6	4	10	36
Dismissals	2	4	1	1	8
Convictions	4	13	2	8	27
Closed w/o Prosecution	41	66	66	36	209
Source: MFCU Annual Reports					

MFCU also reported to the program review committee additional detail regarding convictions for a three-year period. From July 1, 2009 through June 30, 2012, MFCU reports the following conviction results:

- 13 defendants sentenced to prison,
- 6 defendants had prison time to serve,
- 9 defendants received probation,
- 3 defendants given community service, and
- 1 defendant must give disclosure to future employers.

OAG Civil Enforcement Activity Measures

Unlike MFCU which has a well-developed computerized database that provides access to real time information about the status and progress of cases, the OAG's case tracking system has limited abilities. The PRI committee intended to review similar measures as reported by MFCU but the OAG's Health Care Fraud Unit's database is not capable of generating specific reports such as separating matters by type of referral sources (e.g., state agency, federal government, private individual). As result, the committee requested the OAG staff to develop much of the data through a review of actual case files. Due to the demands that would place on staff time and resources, the committee focused its request on one year of data. The committee selected information from FY 2009 to allow enough time for cases to have been resolved.

Referrals to OAG. The Health Care Fraud Unit’s primary mission is to identify and take action concerning provider fraud that results in financial loss to the state through civil law enforcement. The unit may develop cases independently and in conjunction with other state and federal law enforcement and state agencies that pay, directly or indirectly, for health care benefits. An overview of the fraud matters received by OAG in FY 2009 is presented in Table III-4.

Table III-4. Fraud Matters Received by OAG in FY 2009					
Type	Number Received	Number Closed	Number Still Active	Average Length of Time to Close	Recovery Ordered
Global	24	16	8	2 years	\$21,500 to \$11 million
Non-Global	7	6	1	3 years	*
Total	31	22	9		\$42,274,717.60
* One non-global matter was incorporated into a global case.					
Source: OAG					

Referrals to the OAG are either global or non-global matters. Global matters involve multi-state providers and are referred by the National Association of Medicaid Fraud Control Units (NAMFCU) in cooperation with the federal government. Non-global matters tend to involve local providers or issues specific only to Connecticut.

Global cases. In FY 2009, the OAG handled 24 global matters referred by NAMFCU. Twenty of the cases involved drug companies while the remaining four concerned a home health provider, a managed care company, a nursing home pharmacy, and a wholesale pharmacy distributor. There were several allegations investigated such as misrepresentation of a drug, raising average wholesale prices, unauthorized marketing practices (e.g., off-label marketing), rebate fraud, billing fraud, falsifying documentation, and quality of care.

Sixteen of the 24 cases have been closed. On average, each case took two years for completion. Global settlements resulted in the vast majority of the cases with one case receiving a separate carve-out settlement for Connecticut. Three cases were declined - one due to a prior litigation settlement by the state of Connecticut; one closed at the preliminary investigation phase; and another one closed after U.S. DOJ declination. Eight cases are still active awaiting various settlement discussions and/or court action. According to OAG reports, the global settlements for these cases ranged between just over \$21,500 to approximately \$11 million. The total recoveries for these cases were \$42,274,717. (Additional information on global settlements is provided in E.)

Non-Global referrals. In FY 2009, the OAG received seven referrals that were non-global (i.e., specific just to Connecticut). Of the seven, four complaints were received from the

public, two were from DSS, and one referral was from a provider. The referrals involved a broad range of provider types including: behavioral health, dental, emergency transportation, home health, orthotics and prosthetics, pharmacy, and a rest home.

The list of allegations was also varied including: billing for medication never dispensed; failing to participate in DSS audit; providing medically unnecessary services; having phantom employees; double billing; or being identified as part of a global case. Of the seven cases, only one case remains open. The rest were closed, on average, within three years. The outcomes of the cases were as follows: DSS addressed issues with the provider through a rate agreement and receivership; there was federal criminal prosecution and conviction; the provider was excluded from Medicaid program; and the matter was incorporated into a global case. Financial recovery was made in one case as part of a global matter.

Third Party Liability Recoveries Could Increase

Federal law and regulations require Medicaid to be the “payer of last resort.” This means that states are responsible for having plans in place to identify Medicaid beneficiaries’ other sources of health coverage, determine the extent of the liability of such third parties, avoid payment of third-party claims, and recover reimbursement from third parties after Medicaid payment if the state can reasonably expect to recover more than it spends in seeking reimbursement.¹⁶ Third parties include health insurers, casualty coverage for an accidental injury, workers' compensation insurance, and Medicare.

The main goal of third party liability (TPL) programs operated by state Medicaid agencies is to avoid improperly paying Medicaid claims if the Medicaid beneficiary has third-party insurance coverage. Improper Medicaid payments are "cost avoided" in two ways: 1) when a health care provider knows the patient has third party insurance, and bills and collects from liable third parties before sending a claim to Medicaid; or 2) if a provider submits a claim to DSS for Medicaid reimbursement, but the client's DSS electronic file identifies an actual third-party insurer, the claims payment system (i.e., MMIS) denies payment and notifies the provider there is another insurance source.

Sometimes a claim is improperly paid for a Medicaid beneficiary with other third party coverage but that is not known until after the fact. This can happen for a couple of reasons:

- a Medicaid beneficiary will not report that he or she has another insurance source to DSS; or
- the source may have changed since it was reported it but the record was not updated in MMIS.

When this occurs, a provider bills Medicaid, the claim is paid, and under federal law, states must then attempt to recover the improperly paid claim from the third party.

Furthermore, the Deficit Reduction Act of 2005 sought to strengthen the ability of states to recover improperly paid Medicaid claims from third party insurers. The act mandated states, as a condition of receiving federal Medicaid matching funds, to enact laws that require insurers to provide client name, plan eligibility and coverage information to the Medicaid program so that states can conduct data matches to identify third party insurance. Connecticut implemented this requirement in 2007 (C.G.A. Sec. 17b-265g - see Appendix D for the Office of Legislative's Research bill summary of the law).

Third Party Liability Unit

The Office of Quality Assurance, through its Third Party Liability Unit along with its contractor Health Management Systems (HMS), operates a Third Party Liability Benefit

¹⁶ 42 C.F.R. part 433, subpart D (2005).

Recovery Program to reduce Medicaid expenditures by identifying all other resources available to Medicaid beneficiaries to pay for all or part of their medical needs, both pre- and post-payment. The unit also oversees a contract with the Center for Medicare Advocacy, which files Medicare appeals on behalf of dually-eligible clients (i.e., persons eligible for both Medicaid and Medicare) for certain services the department believes should have been paid by Medicare but were paid by Medicaid.

Improper payments avoided. The MMIS system allows the Third Party Liability Unit within OQA to track the number and dollar amount of claims that are cost avoided (i.e., not paid by Medicaid) because TPL has been identified. This occurs in two ways. First, a client may correctly identify any third party insurance information when an application for Medicaid is first filled out or at reapplication. When this occurs, the third party insurer is billed for all appropriate services and the TPL pays the provider. Second, HMS not only identifies TPL and recovers improperly paid Medicaid claims (discussed later), but it also has the authority to populate the client's DSS electronic file with correct TPL information if it has been identified during a data match so that future improper payments are prevented from occurring.

Table IV-1 shows the number of Medicaid claims and dollars that have been identified as cost-avoided, with a 258 percent increase from FY 07 to FY 12. Two caveats are associated with the information in the table: 1) providers may resubmit claims if TPL information is inaccurate and Medicaid should have paid the claim; or 2) providers may have correct TPL in their own client medical record and submit a claim directly to the third-party (so the claim never is submitted to MMIS).

Table IV-1. Number and Dollar Amount of Claims Cost-Avoided because TPL Identified Prior to Payment.		
<i>Fiscal Year</i>	<i>Total Claims</i>	<i>Total Dollar Amount of Claims</i>
FY 07	106,430	\$58,255,230
FY 08	135,483	\$77,412,892
FY 09	193,757	\$162,705,795
FY 10	175,517	\$121,659,052
FY 11	225,597	\$146,020,010
FY 12	147,929	\$208,683,424
Source: Office of Quality Assurance		

A portion of the dollars in the table reflect that HMS identified third-party insurance during a data match (i.e., to recover Medicaid dollars), and updated a client's DSS electronic record with the correct insurance information. By doing so, future improper Medicaid payments are prevented because the updated insurance information will be contained in the client's electronic file. Thus, if a provider submits a claim, Medicaid will not pay it. In addition to its contingency fee, HMS is reimbursed on a per-policy basis for providing these services, such as verifying another insurance source exists, and updating a client's electronic DSS record.

Improper payments recovered. DSS contracts with HMS to conduct third party liability matches in four areas, including:

- **commercial health insurance and Medicare Part A, B, and D recoveries:** monthly client matches with data files provided by over 400 insurers and other health plans, including Medicare, are conducted to identify legally liable third party resources for all clients who receive Medicaid;
- **hospital and nursing facility audit recoveries:** audits of long-term care claims submissions to ensure Medicaid long-term care payments were reduced for the number of days a client was hospitalized (bed holds), or assure a long-term care client's monthly income was appropriately applied to the cost of care, which is used to reduce Medicaid payments;
- **workers' compensation recoveries:** a limited number of data matches are reviewed to recover health services provided and covered by workers' compensation ; and
- **duplicate/overlapping claims recovery:** identifies and verifies health insurance for non-custodial parents with Medical Support Orders (over 600 policies verified in 2012).

Table IV-2 shows the cost of the HMS contract for the four types of TPL and the amount of Medicaid dollars recovered by fiscal year. Overall, HMS recoveries totaled \$240,440,849 over the seven years examined - about \$8.5 Medicaid dollars recovered for every \$1 dollar HMS is allowed to retain through its contracted contingency fees.

<i>State Fiscal Year</i>	<i>Recovery Costs</i>	<i>Recoveries</i>
FY 07	\$2,455,130	\$30,035,265
FY 08	\$2,702,093	\$26,389,702
FY 09	\$3,341,036	\$32,591,511
FY 10	\$5,582,069	\$48,304,375
FY 11	\$5,614,504	\$41,303,814
FY 12	\$5,763,579	\$40,786,077
FY 13 (to date)	\$2,823,871	\$21,030,106
Total	\$28,282,283	\$240,440,849
*These HMS costs are based upon its contingency-fee reimbursement for the TPL recovery scope of work. These costs do not include a per-case fee that HMS receives for client health insurance verifications that OQA estimates to be between \$500,000 - \$1,000,000 per year. Source: DSS, Office of Quality Assurance.		

Although cost avoidance is the main goal of the TPL program, this approach only works if recipients' private insurance information is identified correctly within the MMIS system at the time a claim is processed. Since the status of Medicaid recipients' insurance coverage can

change over time, HMS may identify other health insurance after a claim has been paid, and then must try to recover the amount from the insurer that Medicaid erroneously paid. According to HMS, on average, nationwide about 10 to 12 percent of a state's Medicaid population also has private insurance and about 20 percent have Medicare. HMS stated that an acceptable recovery rate, nationwide, is between 8 and 25 percent depending on the type of claim submitted and the carrier being billed by HMS, although comparative information on a state-by-state basis was unavailable.

According to HMS, a claim billed to a third party can be paid as quickly as two weeks or as long as over one year from the bill date, due to various reasons. HMS indicated that there are many complex components involved in the TPL claim selection, billing, and recovery processes, including:

- the interpretation and cleansing of data;
- crosswalking of code sets;¹⁷ and
- multiple carrier-specific billing platforms and nuances.

Table IV-3 shows Connecticut-specific information provided by HMS on Connecticut's overall recoverable claims for FY 10. There were over 2 million claims billed and HMS received reimbursement for about 13 percent of them. In terms of dollars, slightly more than \$127 million were billed to third parties to recoup Medicaid dollars and \$26.3 million (21 percent) was recovered. It is important to note, the TPL recoveries for Medicaid claims in FY 10 occurred between SFY 2010 - 2013 since it can take several years to get a claim resolved and paid by a third party.

Table IV-3. Third Party Collections by HMS for FY 10			
<i># Claims Billed</i>	<i>Total Claims Recovered</i>	<i>Total Billed Claims</i>	<i>Total Claims Recovered</i>
2,070,873	270,553	\$127,145,286	\$26,340,343
Source: HMS			

HMS indicated the gap between the number of DSS Medicaid claims selected by HMS for TPL billing and the number actually paid are often considered valid denials by third-party insurers and most are not re-submitted by HMS. In Table IV-4, the percent of claims denied by denial category is shown, with the most common reason being eligibility-related issues.

¹⁷ The term “crosswalking” is generally defined as the act of mapping or translating a procedure code in one code set to a code or codes in another code set.

Table IV-4. Percent of Claims Submitted for TPL but Denied: Reasons	
Denial Category	Percent of denied claims
Eligibility -Related Issues <ul style="list-style-type: none"> • Member/group not eligible • Employer/plan has not authorized TPL processing 	48%
Documentation Issues <ul style="list-style-type: none"> • Authorization not obtained • Provider information needed • Itemized bill/medical record/Medicare EOB required 	17%
Data Issues <ul style="list-style-type: none"> • Missing/invalid codes • Invalid values 	13%
Benefits/Coverage Issues <ul style="list-style-type: none"> • Service not covered • Maximum benefits reached/exceeds plan limits • Patient responsibility • Contractual allowance • Timely filing 	10%
Provider-Related Issues <ul style="list-style-type: none"> • Not covered/out of network • Provider paid instead of Medicaid • Address/FEIN issues 	9%
Source: HMS.	

The PRI committee believes that there are several "denial categories" in the table above that require further exploration by the Third Party Liability Unit within OQA as to the reasons why certain claims were not re-submitted to maximize third-party recoveries. For example, denials because the "employer/plan has not authorized TPL processing," does not appear to the PRI committee to be a valid denial, given that state law requires health plans, including those that are self-funded, to reimburse if claims were erroneously paid by Medicaid but the service was covered by the third party. Another example of a denial category that needs further explanation is for claims that were submitted but had "data issues" so recovery could not be completed. To address these concerns, the PRI committee recommends:

The Third Party Liability Unit within the Office of Quality Assurance undertake a review of the reasons for TPL denials to determine if program or system changes could be implemented that would allow for a greater percentage of denied claims to be re-submitted by HMS to the responsible third party and therefore, increase Medicaid recoveries.

In addition to analyzing reasons for denials by third parties, the PRI committee believes another key piece of data that HMS should report to the Third Party Liability Unit is information on the number and dollar amount of claims submitted for recovery compared to the number and

dollar amount of claims that were actually collected. By obtaining these data, OQA could compare actual recoveries and evaluate whether recoveries around particular types of claims or insurers are more problematic. The unit could then use this information to develop strategies on how to improve the actual recovery rate. Therefore, the PRI committee recommends:

The Third Party Liability Unit within the Office of Quality Assurance should complete an analysis of the recovery of Medicaid dollars through third-party liability to determine if procedures used for recovery maximize collection efforts. If deficiencies are found in those procedures, the office should develop strategies to address any gaps.

HMS should report to DSS, on a monthly basis, the status of the number and dollar amount of claims: selected for recovery; billed; paid; denied; resubmitted; and outstanding. Such reported statistics could be analyzed by the unit for the purposes of establishing benchmarks to compare HMS performance overall and from year-to-year.

Based on the information provided by HMS, DSS should continuously analyze the success of the Third Party Liability Program by examining all claims billed in one year and the amount collected in that year and future years to determine the actual collection rate.

Center for Medicare Advocacy and Medicare Appeals

DSS also contracts for TPL work with the Center for Medicare Advocacy (CMA), a non-profit entity located in Mansfield, Connecticut. The CMA files Medicare appeals on behalf of older adults and persons with disabilities who have Medicare and Medicaid (dual beneficiaries) and have been denied Medicare coverage for services provided by skilled nursing facilities, chronic disease hospitals, and licensed home health care agencies. As part of its contract, the center also conducts training for home health agencies to educate them about correctly documenting services for Medicare billing. This program is overseen by the Third Liability Unit within OQA.

For cases that are appealed, CMA follows the Medicare Administrative Appeals Process, defined under federal regulation, which provides due process rights for beneficiaries. Called the Medicare Maximization (MMX) Program, it ensures that DSS dual eligible clients receive all Medicare coverage for which they are entitled to under the law. This means Medicaid then as the payor of last resort, is billed only for the services Medicare does not pay for. like skilled nursing facility, chronic disease hospital, and licensed home health care services.

DSS reimburses CMA on a per-case basis, up to a maximum allowed (\$2,194,156 in FY 12). DSS also limited, in FY 12, the total number of cases that CMA may appeal to: 2,000 home health cases annually; 686 SNF cases per month; and 12 chronic disease hospital cases per month. Payment is \$302 per case for nursing home and chronic disease hospital appeals and \$450 per case for home health appeals. There was an additional \$22,500 allocated to conduct

training for home health agencies. In interviews with CMA staff, they indicated that they could handle twice the number of appeals if OQA increased the annual limit.

The Third Party Liability Unit provided PRI committee staff with information on how successful CMA had been in appealing Medicare denials from FFY 08 through January 2012. However, because of the lengthy appeal process, the outcome of a Medicare appeal filed in one year might not be known for several years later. For this reason, PRI selected FFY 08 as the most complete year that would reflect CMA appeal outcomes (shown in Table IV-5).

Table IV-5. CMA Experiences Regarding Appeals of Medicare Denials.	
<i>Medicaid Service Period</i>	<i>FFY 08</i>
1. Initial Medicaid Cases Selected for Appeal	3,002
2. Initial Medicaid Dollars Selected for Appeal	\$28,755,110
3. Net Cases Going Forward to Medicare Appeal*	2,469
4. Net Medicaid Dollars Going Forward to Medicare Appeal	\$23,847,071
5. Medicaid Dollars Recovered through appeal process	\$2,229,385
6. Medicaid Dollars Recovered that were unable to go through Medicare Appeal Process due to HHA non-compliance	\$922,995
7. Medicaid Dollars Not Yet Recovered that were unable to go through Medicare Appeal Process due to HHA non-compliance	\$2,431,946
8. Medicaid Dollars removed from Medicare Appeal Process Due to Contractor Decision**	\$16,148,696
9. Total Medicaid Dollars Closed (Lines 5 + 6 + 7 +8)	\$21,733,022
10. Medicaid Dollars Remaining in Medicare Appeal	\$2,114,050
11. MMX Contractor Cost	\$1,275,850
*533 cases were removed from appeal due to Medicare ineligibility rules requiring a recipient be homebound to receive reimbursement. The amount for these cases was \$4,908,038.	
**These cases were closed and removed from the appeal process only after the cases had progressed through 3 of the 4 levels of the Medicare appeal process.	
Source: DSS	

PRI committee staff calculated the return on investment for the CMA contract and found that for the amount actually recovered thus far (\$2,229,385) from successful Medicare appeals for FFY 08, for every \$1 spent by DSS for the CMA contract, they recover \$1.75 dollars. Thus, of the total amount recovered through *Medicare appeal*, CMA receives 57 percent. In addition, the federal government receives 50 percent of the recovery and reimburses the state 50 percent of the CMA contract.

CMA also identified an additional \$3,354,941 in claims. These claims were ineligible for Medicare or Medicaid reimbursement because the home health agencies failed to have accurate

documentation. CMA forwards this information to DSS so they can initiate recoupment under Medicaid rules. To date, \$922,995 has been collected for claims incurred in FFY 08 and \$2,431,946 is expected to be recovered for FFY 08. Thus, if you include this additional amount with the amount received through Medicare appeals, for every \$1 spent for the CMA contract, the state receives \$4.38 dollars back.¹⁸ However, according to DSS, the department has educated providers on ensuring proper documentation is maintained and therefore, it expects recoveries to be only \$38,773 for claims incurred from July 2011 through January 12. Therefore, the return on investment for the CMA contract will be greatly reduced.

Beyond filing Medicare appeals, CMA is a national advocacy organization and recent litigation will likely result in more Medicare coverage being obtained for Medicaid-paid home health care. The case was decided in favor of the plaintiffs, which should positively affect outstanding Medicaid appeals, in addition to future cost-avoiding.

In 2011, CMA brought a class action case, *Jimmo vs. Sebelius*, which sought to loosen the Medicare Improvement Standard, a major reason for Medicare denials in all care settings for people with long-term and chronic conditions, which affect dually eligible people disproportionately. These standards are used to deny Medicare coverage on the grounds that the individual will not improve, need "maintenance services only," have "plateaued" or are "chronic and stable." The plaintiffs claimed that Medicare contractors were using an improvement standard to base coverage decisions on whether patients were expected to get better, despite the practice being prohibited by federal law.

Although OQA provided PRI committee staff with data that accounts for the time lag for appeals to be decided, it does not routinely analyze the data to match the appeals that were filed in one year, with the number of them that were granted and the amount of the recovery in the same year or future years. Rather, information is shown by year and therefore, comparing the appealed amount to the recovered amount within the same time period can be misleading. For instance a large percentage of claims billed in late 2011 could be recovered in 2012 or later and so these would not be reflected in the yearly account of number filed and amount recovered. It is difficult to determine the CMA success rate because there are multiple levels of appeals that can be filed and often can take many years to resolve. The PRI committee believes outcomes should be calculated to determine the value of contracting out this function and therefore, the PRI committee recommends:

The Third Party Liability Unit within the Office of Quality Assurance should identify and evaluate the outcomes of CMA efforts based on the number and dollar amount of Medicare claims appealed and the number and amount recovered for those claims. If the office determines that the total amount recovered through the Medicare appeal process exceeds the Department of Social Services cost of the contract, it should consider expanding the number of claims it allows the contractor to appeal. Furthermore, when the contract

¹⁸ Since the federal government pays 50 percent of the CMA contract and receives 50 percent of the recoveries, the net effect is the same for the state.

is rebid in 2017, the department should consider reimbursing the contractor on a contingency fee basis rather than a per-case fee.

Other Appeals of Medicaid Denials

The Office of Healthcare Advocate (OHA) received four new positions in the FY 13 revised budget to enhance Medicaid recoveries for claims that HMS had attempted, but failed, to collect from a legally liable third party. OHA was given funding of \$447,118 to add four positions, which would allow OHA to pursue these denied claims. Selection of the claims to be provided to OHA (after HMS attempted recovery) is based on Memorandum of Understanding between DSS and OHA.

The first data transfer of claims from DSS to OHA occurred in October 2012, and contained 7,000 claims associated with approximately 163 unique health plans. According to OHA, the claims require a lot of "scrubbing" with many having inaccurate third party information listed. To date, there have not been any recoupments.

OHA staff also indicated that the total annual dollar amount of denied claims they will receive will be approximately \$4 million, not the \$20 million included as part of the budget savings. OHA is required to provide the legislature with a Result Based Accountability report concerning the success of its efforts and the potential to expand private insurance recoveries.

Interagency Collaboration Could Be Strengthened

Interagency collaboration is essential when multiple entities are critical to the overall performance of a system. The federal government has noted the importance of interagency collaboration through regulation and guidance documents. Specifically, the federal government requires the development of a memorandum of understanding (MOU) between the different Medicaid agencies and has also issued a best practices document aimed at improving interagency relationships and increasing cooperation between the Medicaid entities.¹⁹

Among the suggested federal best practices are:

- regular meetings,
- education and cross-training,
- referral standards,
- ongoing updates, and
- reconcile activities.

Communication, Coordination, and Transparency

Below is a discussion on Connecticut's implementation of the MOU required among the major Medicaid partners and potential use of some of the federal best practice suggestions to build strong collaborative relationships and strengthen program integrity efforts within the state Medicaid program.

Development of MOU. Federal regulation requires that the Medicaid single state agency, DSS, enter into a MOU with its partners. The parties to the Connecticut MOU include DSS, MFCU, OAG, and the federal OIG. The current MOU took effect in 2007 and is up for renewal in 2012. Federal regulation requires that the MOU be reviewed at least every five years and it reflects existing practice, policy, and legal requirements. The MOU must be consistent with up-to-date federal and state policy including any policies issued by the federal OIG and CMS.

The current agreement outlines the respective responsibilities of each party with regard to the Medicaid program. One primary MOU objective is to facilitate and promote communication, coordination and cooperation among the agencies. Specifically, the MOU establishes procedures for sharing information and referring cases. The MOU requires the parties to jointly coordinate activities to avoid impairing the effective prosecution as well as civil and/or administrative enforcement actions against fraudulent activities. Interviews with the various agency staff suggests that each is respectful of the others jurisdiction and authority and when asked they will cooperate or step aside as necessary while the lead agency completes its work.

¹⁹ *Best Practices For Medicaid Program Integrity Units' Interactions With Medicaid Fraud Control Units*, Centers for Medicare and Medicaid Services, Medicaid Integrity Group, September 2008.

Regular meetings. The federal best practices report recommends regular meetings between the entities to promote a high level of communication and develop a close working relationship between the Medicaid partners. A lack of coordination and communication may lead to overlaps in investigations and a potential for compromised investigations. The Connecticut MOU includes a provision that each party must send designees to meet at least quarterly for purpose of discussing potential new referrals and the status of existing referrals and pending cases.

In 2011, the MOU group met five times and, as of November 2012, four meetings were held. Committee staff interviews indicate there is regular attendance by representatives of all the parties. On occasion and as needed, the MOU meeting group is joined by representatives of various federal and state law enforcement and regulatory entities. Given the confidential nature of potential or ongoing criminal matters, the PRI committee staff was not allowed to observe these meetings nor examine meeting minutes. Interviews with each of the MOU participants indicate satisfaction with the quality and outcomes of these meetings. However, one general characterization regarding the meetings was that while they are informative, participants tend to "hold cards close".

Meetings between the entities to discuss pending cases are important for preventing agency actions that could compromise other investigations and/or to alert officials to cases the others agencies are developing. Another benefit of regular meetings is that the level of communication established by this close coordination of efforts facilitates the identification of new fraud trends, increases accountability, and generally improves the productivity of the agencies. In addition, the meetings could also serve as forum for broader issues such as discussion of direction, goals, leveraging of resources, and general investigative topics. Therefore, the program review committee believes the regular meetings pursuant to the MOU serves an essential purpose and can provide the foundation for further interagency collaboration.

As discussed below, the meetings can provide the forum for developing cross-training, additional information exchange, and ongoing monitoring and self-evaluation for system improvements.

Education and cross-training. Another opportunity for interagency collaboration is education and joint training. Federal regulation requires the MFCU to develop a training plan and to participate in cross-training with the fraud detection staff of the Medicaid agency. As part of the cross-training, MFCU staff must provide instruction on the elements of successful fraud referrals as well as receive education on the role and responsibilities of the Medicaid agency. DSS reports it has provided training, on occasion, regarding rules, procedures, methods, and assistance on electronic queries and data interpretations. MFCU states it periodically conducts training for DSS to improve the quality of available information and their assistance in preparing prosecutable cases. It was unclear whether OAG staff is regularly invited to participate in these training sessions. Therefore, the program review committee recommends:

The OAG staff should be included in any cross-training sessions on Medicaid fraud offered by DSS or MFCU.

Training opportunities should be coordinated and interagency protocols for information sharing and case coordination must be established. The state entities should develop cross-training designed to educate all program integrity personnel on procedures, case referrals, and best practices. The productivity of agencies may be enhanced by making each participant aware of other ways of conducting operations and activities.

Referral standards. To address the quality and number of fraud referrals, the federal best practices report encourages states to develop and consistently apply one standard for deciding when to refer a matter. PRI committee staff examined 32 DSS referrals made to MFCU since FY 2009 (see Appendix F).

The program review staff analysis found that DSS has not been a significant source of referrals to MFCU. The low number of referrals was also noted in a 2007 federal comprehensive program integrity review of the Connecticut Medicaid program conducted by CMS. According to the 2007 report, "the low number of referrals directly relates to a lack of communication and trust between DSS and MFCU".²⁰ The number of referrals was again noted in the next CMS comprehensive review report in 2011. Although the CMS report acknowledged improvement in the relationship between DSS and MFCU, it also concluded that "the State does not refer all suspected provider fraud cases to the MFCU."²¹

The 2011 CMS report indicated concerns with the processing of some of the case referrals to MFCU. In general, CMS found that DSS thoroughly investigated referrals internally within its own Office of Quality Assurance (OQA) before submitting them to MFCU. CMS recommended that DSS modify the process of referral of suspected fraud to the MFCU so that referrals are made as soon as OQA's preliminary investigation reveals an issue which needs further investigation.²² CMS suggested that this could be simultaneous with DSS own review of the matter but would need to clear any action with MFCU before proceeding with an investigation or a recovery action.

DSS disagreed with the CMS finding. The department contends that its referral process complies with CMS's best practices as well as the CMS recommendation that a fraud referral is made wherever there is reliable evidence that is corroborated. The department maintains that it will not refer uncorroborated allegations of suspected fraud. However, the department acknowledged improvements can be made in the timeliness of some referrals. It also should be noted that DSS developed an enhanced comprehensive fraud referral process for its referrals to MFCU which was recognized by the most recent CMS report as an effective practice.

Similar to the stance taken by DSS, MFCU reported to its federal oversight agency OIG in June 2012 that there are a sufficient number of referrals being received from the single State

²⁰ Department of Health and Human Services, Centers for Medicare & Medicaid Services, Medicaid Integrity Program, Connecticut Comprehensive Program Integrity Review Final Report, November 2007, p. 9

²¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services, Medicaid Integrity Program, Connecticut Comprehensive Program Integrity Review Final Report, August 2011, p. 5

²² Federal regulation has replaced the term "suspected fraud" with "credible allegation of fraud".

Medicaid agency.²³ However, a low number of referrals to MFCU is not a problem unique to Connecticut. Program review staff found similar concerns in studies and evaluations of the Medicaid program in other states.²⁴

Upon closer examination of the 32 DSS referrals made to MFCU since FY 2009, staff analysis showed that 14 of the 32 DSS referrals (44 percent) were referred back to DSS by MFCU. (Appendix F provides further discussion on the returned cases.) According to DSS, the department does not always receive formal notice of MFCU's reasons for not prosecuting a case. Reasons are often relayed through informal communications among agency staff. Among the reasons most commonly cited is that there is not sufficient evidence of a criminal act. To the extent more guidance to DSS would assist as to what constitutes an acceptable referral, the program review committee recommends:

MFCU should provide written notice to DSS explaining the specific reasons for declining or not prosecuting a Medicaid referral.

For example, the reasons could include:

- the allegation of fraud is not clear,
- the allegation is not developed enough to determine if it is an isolated instance or a pattern of practice,
- policies and/or correspondence at state agency is not clearly written therefore adversely impacting on establishing provider intent, or
- the hard copy documentation needed to prove the fraud is not available.

If the reasons are documented and monitored, the agencies will be better informed to assist with the development of successful cases. The federal best practices report suggests that a significant difference between effective and ineffective referral systems was how closely Medicaid agencies and fraud units cooperated.

Ongoing updates. The MOU clearly sets out provisions for access to information. It specifies that DSS must provide documents and other information as needed by MFCU, OAG, and OIG. The groups must also share all information and/or documents for matters being worked jointly. In addition, MFCU is provided electronic access to DSS Medicaid records pursuant to federal regulation. In all instances, the entities must comply with all applicable state and federal law regarding the use of the information. Program review staff interviews with the various agency personnel indicate that access and sharing of information among the MOU parties has been satisfactory.

²³ MFCU Application For Recertification and Annual Report (April 1, 2011 through March 31, 2012), Question 4a, p. 6.

²⁴ Department of Health and Human Services, Office of Inspector General, New Hampshire State Medicaid Fraud Control Unit: 2012 Onsite Review, October 2012

The program review staff did note one aspect of agency information-sharing that could be strengthened. Pursuant to federal law, DSS is obligated to report to the federal OIG both convictions related to the Medicaid program and sanctions imposed by the state Medicaid agency on Medicaid providers. In addition, DSS posts information regarding providers excluded from the Medicaid program on its website. However, committee found that licensing boards are not being directly notified of providers who are found in violation of DSS program rules, regulations, standards, and laws as required by C.G.S. §17b-99.

According to DSS, there is also no direct communication from licensing boards (i.e., Department of Public Health) notifying DSS that a provider's license has been revoked or suspended. DSS states that, in many instances, this information is provided by other units within the department or obtained through the local news. Long ago, DPH would provide DSS with a paper copy of their Quarterly Regulatory Action Report but this practice was discontinued. DSS has since attempted to obtain this report directly electronically but was informed that the information was available on the DPH website. Even though website information is available, direct and timely notification of agency action is essential for efficient and effective detection and deterrence of provider misconduct. Relying on website postings or media outlets for information may unnecessarily delay actionable items or allow them to go completely unnoticed. Updates can easily be communicated directly through email. As such, the program review committee recommends:

DSS should comply with the provisions of C.G.S. §17b-99(c) to notify the proper professional society and licensing agency of any program violations. The Department of Public Health shall directly notify the Office of Quality Assurance within DSS of enforcement actions against providers.

Reconciliation activities. Another best practice recommended by the federal government is to reconcile program activities to promote coordination and prevent the flow of conflicting data. A fundamental challenge in conducting this study was the variation in the electronic case management or tracking systems at each agency.

The limitations of the DSS computerized databases have been described throughout this report. The OAG staff has also acknowledged its need for electronic case management improvements. The OAG's Health Care Fraud unit has recently merged into the Antitrust division within the department and will ultimately benefit from having its own computer module within the larger division. Meanwhile, MFCU has a proprietary computerized system that allows for real time access to case files.

As expected, each agency captures the data and information that it deems appropriate and is required by federal agencies. The program review committee encountered numerous examples where case information contained in one database did not correspond to data maintained or reported elsewhere, sometimes within the same agency. Perhaps due to their relatively small unit size, the agencies seem to rely upon individual staff knowledge of cases, institutional memory, and anecdotal references. Better efforts should be made to coordinate databases to ensure that program information is reliable and consistent across all entities.

Reconciling activities and data may lead to more accurate, consistent, and timely information being shared. Reconciling activities also promote interagency collaboration by allowing the entities to: 1) develop a common language, 2) benefit from the knowledge and experience of others, and 3) expose the group to potentially diverse perspectives. The need and importance of reconciling information is illustrated in the discussion of Medicaid recoveries provided below.

Medicaid Recoveries

The program review committee attempted to identify the magnitude of Medicaid improper payments and amounts recovered each year with limited success. Due to the multiple reporting sources, there is no single reliable estimate of the extent of improper payments and recoveries throughout the Medicaid program.

Given their authority over different aspects of Medicaid, all three state entities - DSS, MFCU and OAG - have some involvement in the recoupment and reporting of Medicaid improper payments. As illustrated in Table V-1, each agency has different reporting requirements on different cycles.

Table V-1. Reporting Requirements for Connecticut Medicaid Recoveries			
	DSS	OAG	MFCU
Primary Recovery Responsibility	Collects and refunds overpayments to federal government	Recoveries from civil matters and global settlements	Recoveries from criminal matters
Reports	Form CMS 64	CT False Claims Act & Health Care Fraud Report Card	Quarterly Statistical Reports & Annual report
Submitted to	Federal CMS	CT General Assembly & Appropriations Committee	Federal OIG
Reporting Cycle	Quarterly basis	Calendar year & SFY	Quarterly basis and an annual recertification year (April to March)
Source: PRI			

DSS recovery reports. In theory, DSS should be able to provide comprehensive information on the amount of recoveries as a result of improper payments that are due to the state from Medicaid program integrity activities, the amount collected, and costs avoided. As the single state Medicaid agency, DSS is responsible for identifying, collecting, reporting, and refunding overpayments to the federal government. Connecticut receives 50 percent

reimbursement from the federal government for expenditures of the Medicaid program. Federal regulation requires each state to report collections of Medicaid overpayments on Form CMS-64 and return the federal share of those overpayments.

Specifically, states are required to provide detail about the fraud, waste, and abuse collection efforts that reflects overpayments that have been collected. As part of the Form CMS-64 submission, states are asked to report amounts collected from various state program integrity activities including:

- data mining activities;
- program integrity provider audits;
- MFCU investigations;
- overpayments collected from settlements or judgments;
- civil monetary penalties;
- CMS Medicaid Integrity contractors; and
- other program integrity activities.

The program review staff examination of five years of Form CMS-64 submissions indicates that DSS does not provide detailed accounting of recovery amounts from the various program integrity activities. In addition, cost avoidance figures from different contracted components (e.g., third party liability, long-term care) are not routinely compiled.

Consequently, the staff encountered several difficulties reconciling the recovery information based on the data available from the different entities including:

- it is unclear whether recoveries identified are ever fully collected;
- each entity compiles and reports recovery information for its own purposes due in part to statutory reporting requirements;
- the reporting period used for each entity is different. For example, the OAG reports false claims activity on a calendar year while MFCU's reporting period is tied to its annual federal recertification;
- restitution is typically not recovered all at once and is not always repaid at the same time it is ordered. This complicates reconciling the different timeframes used in the reports;
- although DSS, as the single state Medicaid agency, is ultimately responsible for repaying the federal government share of any improper payments, it does not breakdown overpayments by recovery source.

As a result of these challenges, the PRI staff was only able to produce a snapshot of Medicaid recoveries *identified for collection* as shown in Table V-2. PRI staff could not obtain

or calculate a comprehensive picture of the amounts *collected* by type of recovery source or of costs avoided.

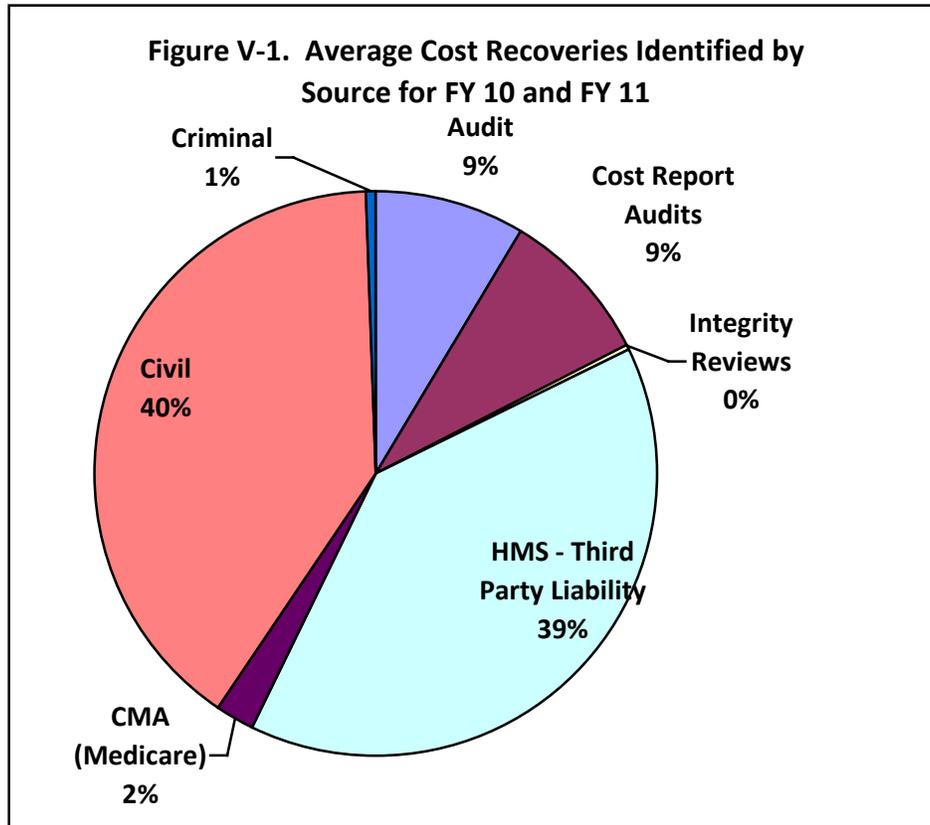
As the table shows, total Medicaid recoveries identified from all sources amount to about an average of \$113 million per year based on FYs 10 and 11 for which data could be obtained. These are gross numbers before the federal government is reimbursed for its share of recoveries.

Table V-2. Total Medicaid Recoveries Identified (FYs 2009- 2012)				
Recovery Source	FY 2009	FY 2010	FY 2011	FY 2012
Integrity Reviews	\$ 523,952	\$ 39,082	\$ 491,970	\$ 419,622
DSS Audits	7,974,083	10,582,891	9,107,967	13,580,817
Cost Report Audits	11,477,069	8,327,569	11,519,498	5,874,301
HMS - Third Party Liability	n/a	49,389,980	39,888,132	40,755,902
CMA- Third Party Liability (Medicare)	n/a	2,365,294	2,969,735	2,036,119 *
Civil	5,283,114	41,047,073	49,471,353	5,455,387*
Criminal	7,791	1,127,048	227,000	188,177*
Total	\$25,266,009	\$112,878,937	\$113,675,655	\$68,310,325
Source: DSS, Craig J. Lubitski Consulting, MFCU Annual Reports (quarter statistics)				
* Through 3/31/2012				

Figure V-1 shows the two-year average (FYs 2010 and 2011) of recoveries identified for collection by recovery source.

- The source of the largest identified Medicaid recoveries (41 percent) is from third party liability efforts, including appeals to Medicare. PRI staff made recommendations in Chapter III on how to improve collections in this area.
- The second highest area of identified recoveries (40 percent) is from civil settlements. Most of those recoveries are the result of global settlements involving the pharmaceutical industry. Global settlements involve complex multi-state litigation efforts and can have large fluctuations year to year. (See Appendix E for a discussion of global settlements).

- Identified recoveries from audits and cost report audits (for long-term care) are at about 9 percent each, while monies from criminal prosecution and DSS integrity reviews contribute 1 percent or less.



Given the disparities in reporting recoveries, the program review committee recommends:

A final accounting of identified, ordered, collected and outstanding recoveries should be part of the joint annual report (recommended next).

In addition to reconciling recovery amounts, tracking uncollected recovery amounts is important because not only does the state not recoup the money it is owed, but it also faces an additional loss because it has already, in effect, paid the federal government its share of the anticipated collection. The need for the agencies to accurately collect, compile, and share information becomes critical in the monitoring and reporting requirements discussed below.

Monitoring and Reporting Requirements

Each state agency involved in deterring Medicaid improper payments has separate monitoring and reporting requirements from different oversight groups. This includes:

- DSS is subject to comprehensive integrity reviews by the federal CMS. The CMS conducts program integrity audits in each state once every three years to assess the effectiveness of a state's program, including its compliance with federal law and regulatory requirements.
- MFCU is required to submit various quarterly statistical reports and is annually recertified by the federal OIG. The MFCU reports are submitted to OIG and not made available for public viewing.
- The OAG is statutorily mandated to prepare an annual report on its Connecticut False Claims Act activity to the state legislature. It must also produce a Health Care Fraud Program Report Card for the legislature's Appropriations committee.

It became evident as the program review committee examined these reports that the agencies compile various pieces of information on their efforts. However, the results are not compared nor, in some cases, made available to anyone except the oversight entity. In addition, the reports are issued on different reporting cycles. As such, it is impossible to produce an overall picture of how the state is succeeding at controlling Medicaid fraud from the individual reports.

In the course of examining the strategies in other states, the program review committee noted the state of Florida has statutorily required a comprehensive annual report prepared jointly by its single state Medicaid agency and the Florida MFCU. Issued since 2003, the Florida annual report entitled "The State's Efforts to Control Medicaid Fraud and Abuse" provides a wide range of information covering among other things, complaints, case investigations, disposition of cases, data mining, total recoveries, training, significant case highlights, prevention activities, interagency coordination and cooperation initiatives, and policy recommendations.

The program review committee believes this type of joint reporting has several benefits. It allows for transparency in the state's investment and efforts in deterring Medicaid fraud, abuse, or errors. It helps monitor case flow progress and trend performance. It provides an opportunity for agency self-evaluation. It also may assist to redirect strategies and resources when needed.

Furthermore, the agencies should be accountable not only to the federal government but to the state to keep the legislature and public apprised of how well the units are doing in eliminating fraud in the state Medicaid program. The measures reported should address outcome factors that are of interest to agency managers as well as legislators and the public. Therefore, the committee recommends:

Beginning January 1, 2014 and annually thereafter, a joint report shall be prepared by the Department of Social Services, as the lead Medicaid agency, in consultation with the Office of the Attorney General, and the Medicaid Fraud Control Unit, documenting the effectiveness of the state's efforts to control Medicaid fraud, abuse, or errors and to recover Medicaid overpayments during the previous fiscal year. At a minimum, the report shall contain the following on:

DSS Audits-

- **Number of audits completed by provider type**
- **Amount of overpayments identified due to audits**
- **Amount of avoided costs identified due to audits**
- **Amount of overpayments recovered due to audits**
- **Number of audits resulting in referral to MFCU**

DSS Investigations-

- **Number of complaints received, source and reason**
- **Number of investigations completed by source (e.g., complaints, data mining, etc.), provider type, and outcomes (e.g., closed - no recoupment, closed- recoupment, open, referred to law enforcement, other)**
- **Amount of overpayments identified due to investigations**
- **Amount of overpayments collected due to investigations**
- **Number of investigations resulting in a referral to MFCU**
- **Number of investigations resulting in payment suspension by provider type**
- **Number of investigations resulting in provider exclusion by provider type**

Third Party Liability-

- **Total claims selected for billing by commercial health insurance and Medicare**
- **Total amount billed for those claims**
- **Total claims reimbursement**
- **Total amount collected**
- **Total amount cost avoided in the future because DDS client file updated with third party insurance information**

MFCU and OAG fraud investigations-

- **Number of cases opened and investigated each year**
- **Source or origin of the cases opened**
- **Summary of the types of allegations by provider type**
- **Breakdown of reasons for not accepting referrals**
- **Number and disposition of the cases closed each year**

- **Length of time between cases opened and closed**
- **Recovery from MFCU criminal investigations**
- **Recoveries from settlements or judgments**
- **Civil monetary penalties**

Recovery amounts from-

- **Data mining activities**
- **CMS Medicaid Integrity Contractor**
- **Recovery Audit Contractor**
- **Other recovery contractors**

The report shall also document new initiatives taken to prevent overpayments and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment.

Each agency must develop detailed unit-specific performance standards, benchmarks and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year. The report shall be submitted to General Assembly as well as the Human Services committee and Appropriations committee.

Self-evaluation. Poor performance or issues in one area of the system may affect functions in another part or the whole system. As noted above, there is no comparison, linking, or evaluation of each agency's information to gauge how well the system to address Medicaid error, abuse, or fraud is working overall. Based on staff interviews and examination of the certain elements of the case tracking systems, it appears that each agency had only a general sense of case activity or outcomes once the matter was out of its purview. This was especially evident in the DSS referral database where basic information for each agency regarding acceptance or closure dates, outcomes, and sanctions was, at times, limited, inconsistent, or missing.

Using the agency-specific benchmarks, performance standards, and metrics developed for the annual report, the committee further recommends:

DSS, OAG, and MFCU shall establish routine monitoring and evaluation processes to ensure the Medicaid partners receive regular and relevant information regarding the impact of their efforts.

The PRI committee believes this is the next step in developing a successful system to deter Medicaid improper payments. Reporting on these activities can help the key decision-makers within the agencies to obtain feedback from their partners for improving both policy and operational effectiveness. In addition to transparency and accountability, the various collected pieces of information in the recommended joint annual report provides the state entities the opportunity to periodically monitor and evaluate efforts to enable them to identify areas for improvement.

Drawing upon the measures compiled for the joint annual report, the agencies can periodically use the information as the basis for making improvements and focusing or redirecting their efforts. In developing information for self-evaluation, the program review committee is cognizant of adding more work to an already burden staff. As such, evaluation efforts should, at least initially or at the onset, be based on existing data sources or items already collected or readily available to agencies. Additional evaluation items may be phased in or added at later time.

Furthermore, given the complexity and duration of many cases, a single year as a frame of reference is probably too short a time to serve as a reliable indicator of performance. To be useful, self-evaluation data should focus on performance over a two-or three-year period. Then, the data could provide a good overview of performance and serve as a useful guide to more detailed analysis of the particular operations.

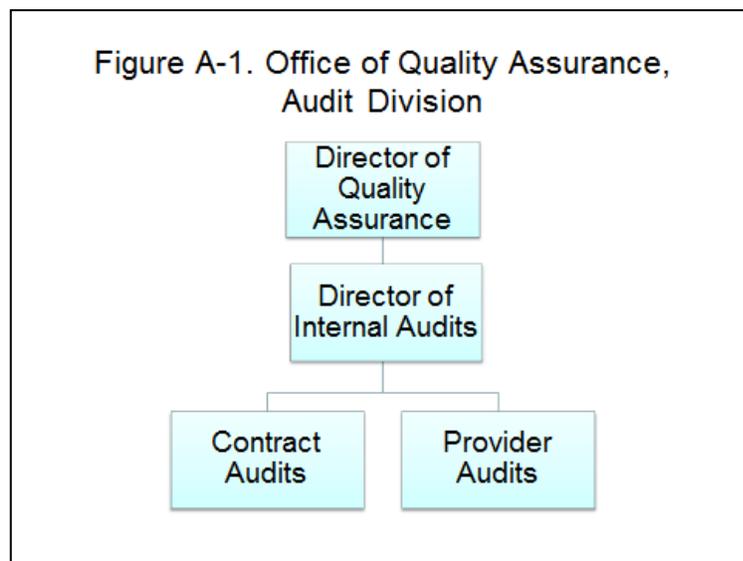
Program review committee also acknowledges that numerical indicators alone do not offer definitive assessment of any particular agency's overall performance. The recommended self-evaluation analysis should also incorporate other aspects in a narrative form (e.g., individual case experience) not directly reflected in the numerical indicators. Together, the narrative and indicators can help the agencies ask better or more strategic questions as part of its evaluation. It can help gain a more accurate determination of which functions are performing well and which are not and why. It can also help determine whether the state is gaining ground compared with past performance and where it is falling behind and why.

Appendices

Medicaid Audits

Auditing is an important and vital element in the post-payment process that helps insure the fiscal integrity of the Medicaid program. There are essentially four different entities that conduct audits for DSS or in consultation with DSS. They are: 1) the DSS Audit Division; 2) Recovery Audit Contractor (RAC); 3) Medicaid Integrity Contractor (MIC); and 4) a cost report auditing contractor. Below is a brief profile of each organization.

DSS Audit Division



Purpose. The DSS Audit Division is divided into two main areas: contract audits and provider audits. The contract audit unit is responsible for reviewing federal and state single audit reports, as well as reviewing financial reports for various grants and contracts that DSS has with non-profit agencies and municipalities.

The provider audit unit is responsible for the federally mandated audits of medical and health care providers that serve the various medical assistance programs funded by the department.

Organization of division and resources. For Medicaid program integrity purposes, the focus here is on the provider audit unit. As shown in Figure A-1, this unit is headed by a Director of Internal Audits, who reports to the Director of Quality Assurance. The unit is presently composed of 26 employees, it recently added 4 net new employees. There are four separate audit teams that contain one supervisor and three to eight staff. One team specializes in pharmacy audits and the other teams perform audits of other providers, though individual auditors tend to specialize in particular types of providers.

Process. There are two slightly different audit processes that the unit engages in depending on the type of provider. Most of the audit process is the same for all providers except certain long-term care facilities may avail themselves of a different appeal process. Based on a database provide by DSS, the median amount of time to complete an audit takes about 44 weeks (see below for further analysis). The steps are briefly outlined below and are based on, in part, a framework that is outlined in statute.

- *Selection of providers to audit.* Deciding which providers should be audited is a decision made by the Director of Internal Audits in consultation with the

Director of Quality Assurance. Their decision is typically guided by the experience of the directors, trends that may be happening on the national level about known schemes, and potential significance in terms of dollar impact. The PRI committee have raised some concerns about the audit selection process.

- *Audit notice.* The department is required to give at least 30 days written notice of the audit to the provider. This notice is not required if the audit agency makes a good faith determination that: (1) a service recipient's health or safety is at risk; or (2) the provider is engaging in vendor fraud.
- *Field work.* Auditors will conduct the audit and usually a part of that audit will be conducted at the provider's location. Auditors use a variety of techniques including interviews, observations, record examinations, and data analysis. Providers have at least 30 days to provide any documentation in connection to any discrepancy found. The auditor's primary concerns are determining if there are procedural inadequacies, rule violations, or lack of adherence to state and federal policies. There are no limitations in statute regarding the length of the period being reviewed, though the audit period is has been two years and has recently been increased to three years.
- *Sample.* Typically, the auditors will request a sample of 100 claims from the providers to test procedures. On occasion a larger sample size is used in the case of hospitals.
- *Preliminary report and exit conference.* The department is required to produce a preliminary written audit report and give it to the provider within 60 days after the audit's conclusion. DSS must hold an exit conference with the provider to discuss the preliminary report once it is issued.
- *Final report.* The department must produce a final written report and give it to the provider within 60 days after the exit conference unless the department and the provider agree to a later date or there are other pending referrals or investigations concerning the provider.
- *Appeals (other than long-term care facilities).* A provider aggrieved by the findings in a final report can request a rehearing within 30 days after receipt of the final report. A designee of the commissioner who presides over the hearing shall be impartial and shall not be an employee of the Office of Quality Assurance. The designee of the commissioner must issue a final report. There is no time frame in statute of when this must occur. The final decision is appealable to the Superior court.

- *Appeals for certain long-term care facilities.*²⁵ The process for an appeal by certain long-term care facilities (LTC) is different than that for other providers. A LTC provider aggrieved by the findings in a final report can request a rehearing within 90 days after receipt of the final report. The rehearing must be held within 30 days after the filing date of the appeal and a decision shall be issued by the later of 60 days after the close of evidence or the date on which final briefs are filed. Items not resolved at the rehearing to satisfaction of either party must be submitted to binding arbitration by an arbitration board consisting of three members. The appointment process for the board members and rules of proceedings are outlined in statute.

Audit appeals. Table A-1 shows the number of administrative appeals of DSS audits for SFY 2008-2012. None of the appeals were on behalf of long-term care facilities. The data show that there were 30 appeals over the last five years and most cases (63 percent) were withdrawn, dismissed or denied, while 13 percent were settled through negotiation and 23 percent were granted in part by the hearing officer.

Table A-1. Administrative Appeals of Audits, SFY 2008-2012								
	2008	2009	2010	2011	2012	Unknown Year	Total	Percent
Denied	1	2	2	1	1	1	8	27%
Granted In Part	1	3		3			7	23%
Settled		2		1		1	4	13%
Withdrawn			3	5	2		10	33%
Dismissed				1			1	3%
Total	2	7	5	11	3	2	30	100%

Source: PRI tabulation of DSS data

Willful violation. The law states that a clerical error discovered in a record or document produced for the audit does not by itself constitute a willful violation of DSS medical assistance program rules unless proof of intent to commit fraud or otherwise violate program rules is established. Under the law, a clerical error includes recordkeeping, typographical, writer's or computer error.

Extrapolation. Another important feature of DSS audits that has been criticized by providers is the ability of DSS to extrapolate or project the amount of overpayment based on a sample of claims. Extrapolation is the practice of 1) dividing the total number of payment errors found in a sample of documents by the sample size to arrive at average errors per sample; and 2) multiplying this by the total number of claims to arrive at a presumed extrapolated number of payment errors for all payments to the provider during the audited period. The provider must

²⁵ Nursing homes, residential care homes, intermediate care faculties for people with mental retardation that receive Medicaid or other state payments.

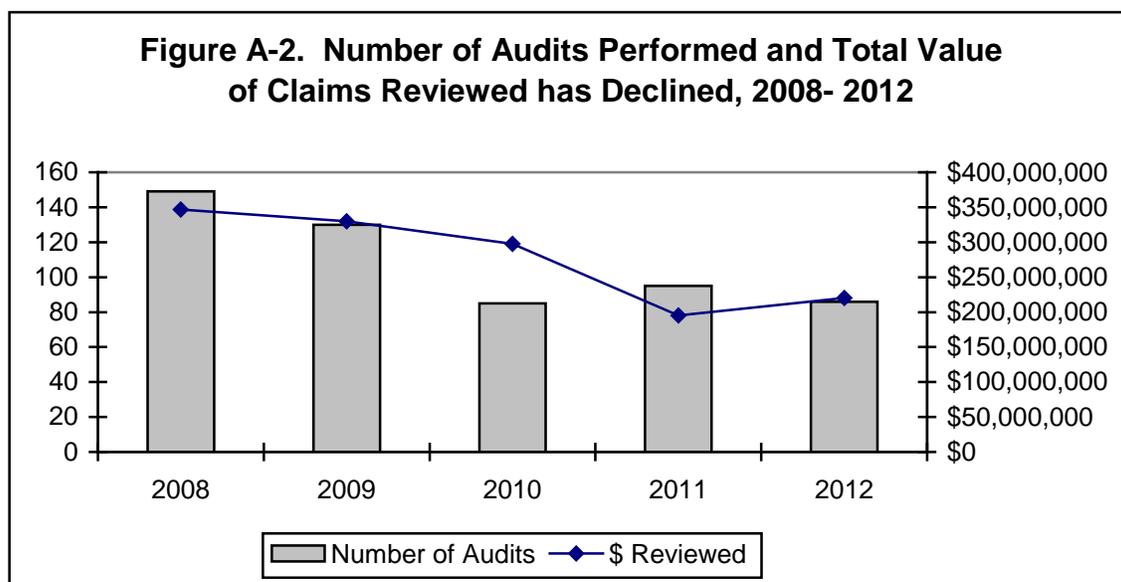
make repayments to DSS based on these extrapolated errors. Providers have expressed concerns about how the fairness of using extrapolation and the methods used.

In response to providers' concerns, the legislature has established certain limitations on extrapolation. DSS is prohibited from finding that an overpayment or underpayment was made to a facility based on extrapolated projections, unless (1) the facility has a sustained or high level of payment error; (2) documented educational intervention has failed to correct the error levels; or (3) the aggregate claims' value exceeds \$150,000 on an annual basis. It is unclear how much of a limitation this imposes on DSS as it can use any *one of the three* criteria to support the use of extrapolation. The majority of audits appear to qualify for extrapolation based on the fact that nearly all provider audits have annual paid claims over \$150,000.

Regulations. In 2010, the legislature required the DSS commissioner to adopt regulations related to the audit process that ensure fairness of the process and "the sampling methodologies associated with the process." The law was effective on July 1 2010. The Notice of Intent to promulgate the regulations was published in October 2102 and a public hearing was held on December 10, 2102.

Results of audits. The results of an audit will typically contain a listing of any violations program rules, regulations, standards, and laws along with an amount of overpayments made to the provider. There is also a possibility that the audit would find no overpayments to the provider.

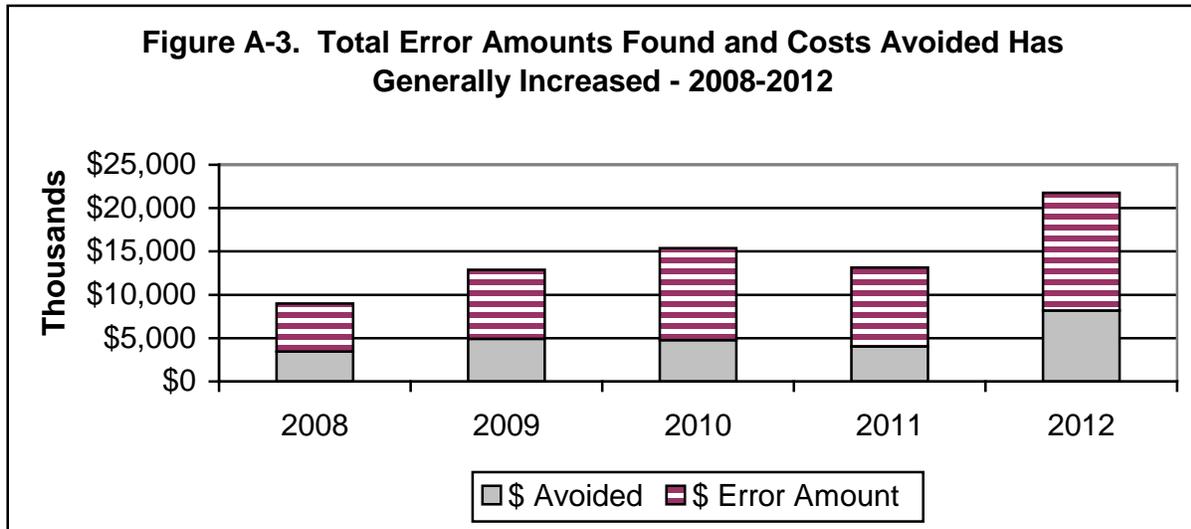
Activities/outputs. Figure A-2 shows the number of audits performed by the provider audit unit and the total amount of claims reviewed between SFY 2008 and 2012. Both have declined over the five-year period. The number of audits has declined by about 43 percent and the total value of claims reviewed has declined by about 36 percent.



The dollar outcomes of audits are measured in two ways: 1) the total identified dollar amounts that were paid in error; and 2) the costs avoided. Generally, DSS calculates costs

avoided at about one-half of the dollars paid in error, though the average overall often works out to a little more than that as noted in Chapter III. Although there is certainly a cost savings as a result of errors found and corrected in audits, it is unclear whether this is the best way to estimate this figure.

Even though the number of audits has declined, the actual total error dollars identified and costs avoided through audits have increased as illustrated in Figure A-3. In 2008, the total identified as error and costs avoided was about \$9 million and by 2012 it was nearly \$22 million. This represents a 144 percent increase.



Similarly, when the actual error dollar amounts identified and costs avoided per audit were examined, they too showed a general increase in the last five years. For example, Figure A-4 shows that the error amounts identified has increased from about \$37,400 per audit in 2008 to \$158,000 per audit in 2012.

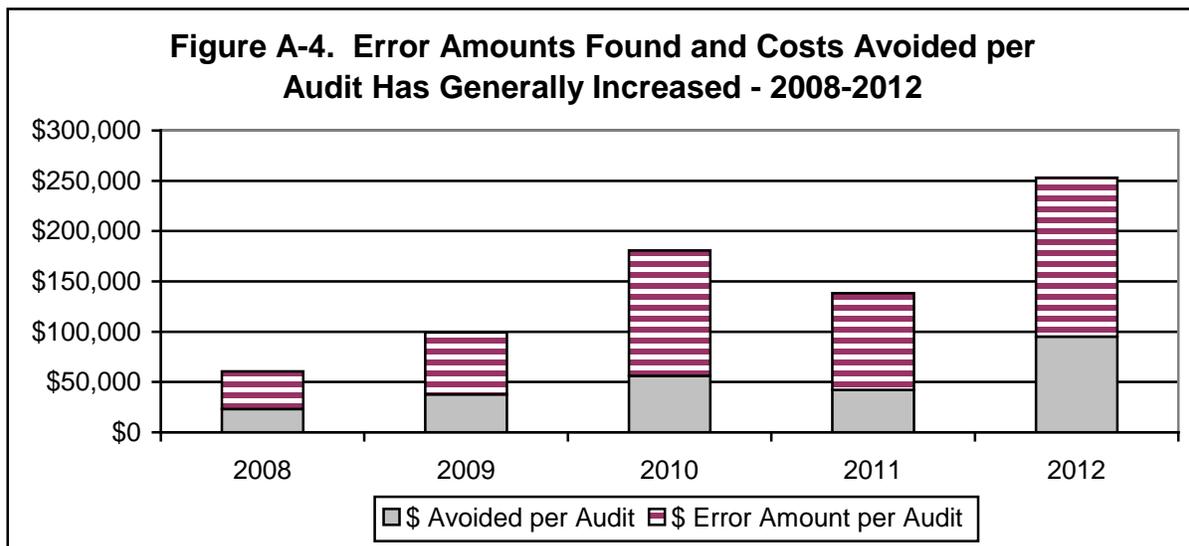
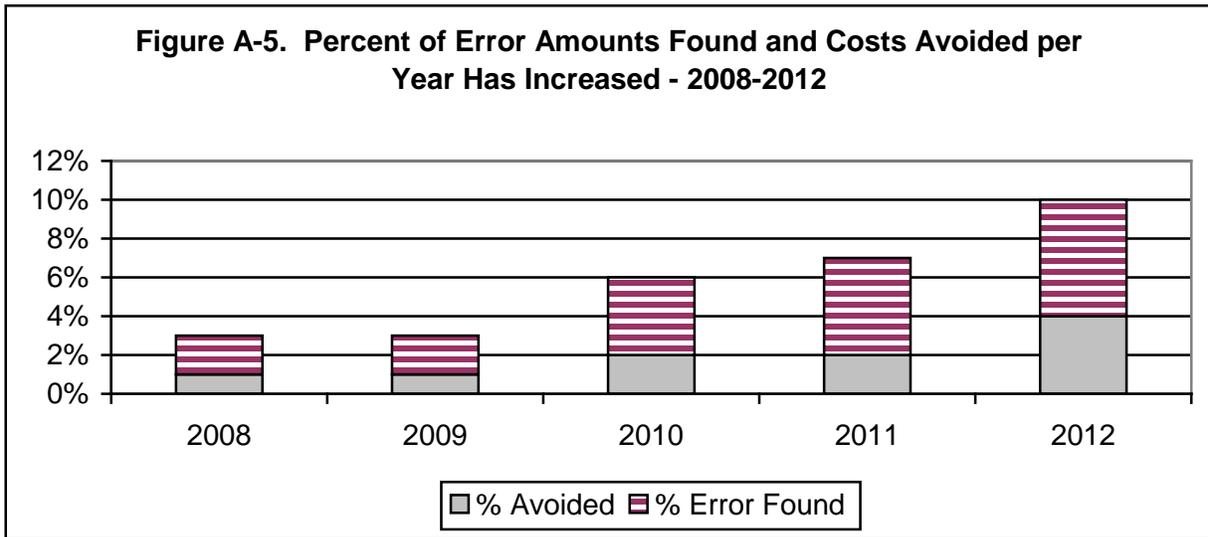
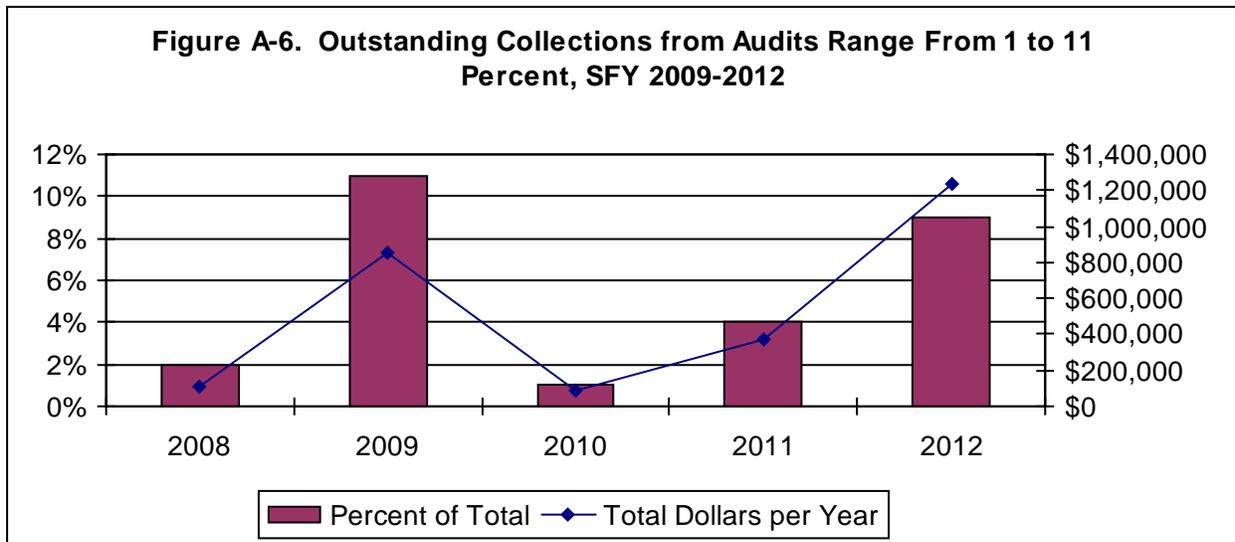


Figure A-5 illustrates one reason why the number of audits has declined while the dollar amounts identified in error and costs avoided have increased. The figure shows that the percent of errors amounts found and costs avoided has increased in total from 3 percent in 2008 to 10 percent in 2012. It could mean that the current audits are better focused, the amount of actual errors has been increasing, or auditors are identifying more errors. OQA does not typically compile or analyze the most common audit findings overall or by provider.



Recoupment/collections. The PRI committee asked DSS to provide a listing of outstanding collections for amounts identified for recoupment in audits for SFY 2008 through 2009, including any amounts written off. Figure A-6 shows on a percentage basis the amounts still to be collected ranges from 1 to 11 percent. DSS reports it has not written off any amounts since 2008.



Fraud referrals. If potentially fraudulent or abusive practices are suspected during the course of an audit, the audit unit will generally refer the case to the Special Investigations Unit for further investigation and preparation of a referral packet if warranted. (See Appendix B for further explanation of the referral process.)

During the last five years (SFYs 2008- 2012), three cases were referred to the State's Attorney's Medicaid Fraud Control Unit (MFCU) that originated as the result of an audit - that is about 1/2 of one percent of all audits completed during the time period. (Note that the cases were also referred to the federal Office of Inspector General for the Department of Health and Human Services, which declined the cases).

Table A-2. Audits Referred for Suspected Fraud, SFY 2008-2012					
Year	Provider Type	Date Audit Began	Date Referred to MFCU	Date Closed	Outcome
2010	Home Health Agency	Not Found	7/16/2009	4/11/2011	Returned to DSS, Evidence did not support a criminal complaint but DSS did recoup on claims
2011	Medical Equipment Supplier	11/06/2009	2/28/2011	4/23/2012	Restitution (\$16,554); Accelerated Rehabilitation; Exclusion Pending
2012	Dentist*	11/01/2010	8/26/2011	Open	
* Case was associated with other providers Source: DSS Referral and MATS databases					

All of the cases are related to various services or medical equipment that was billed and paid for but not actually provided. Table A-2 shows some case details for the audits that were referred for suspected fraud. The DSS databases did not have complete dates for every case. For the audit referrals for which a date could be obtained:

- it took from 298 days to 479 days from the date an audit began to the date it was referred to MFCU;
- it took from 420 days to 634 days from the date an audit was received by MFCU to the date the case was closed;
- for the one case for which there is complete data, it took 899 days from the date an audit began to case closure. Thus, for this case, the amount of time that DSS developed the case for referral (479 days) was just a little more than the amount of time to adjudicate the case through MFCU (420 days);

- the case that was referred and eventually prosecuted by MFCU took 171 days longer for DSS to complete than the typical (median) audit;
- one of the three cases ended in prosecution for larceny, one was returned to DSS, and one is still open.

Time to complete audits. The PRI committee staff examined the time it takes DSS to complete audits for audits completed in SFY 2009-2012 using DSS' database, in which audit activity is recorded. It takes about 44 weeks on average (median) from the beginning of an audit (when an audit assignment is entered into DSS' tracking system) until the audit is completed and there is recoupment of any amounts paid in error.

Table A-3 contains the results of PRI committee staff analysis of the mean, median, and maximum number of weeks that elapsed between the various stages of completed DSS audits for those years. As expected, most of an auditor's time is spent in the field and writing the audit report- with a median time of about 35 weeks (that is reflected in the time period between when an auditor is on-site and the exit conference).

Time (weeks) Elapsed From	Audit Entered into System to Assignment to Auditor	Assignment to Auditor to Start of Audit	Start of Audit to Auditor is On-Site	Auditor On-site to Exit Conference	Exit Conference to Recoupment (Collection)	Total Time
Mean	1.87	.43	8.04	40.35	7.00	48.08
Median	1.00	0.00	7.00	35.00	4.00	43.50
Maximum	41	21	57	156	60	208

Source: PRI analysis of DSS' MATS database

Audit productivity. Most of DSS auditors complete five or less audits in a single year. Using DSS' database, PRI committee staff calculated the number of audits completed by auditor for SFYs 2009-2012. The results are displayed in Table A-4. In the last year, there were five staff who completed six or more audits, with one person completing 14 during the course of the year. The median number of audits completed was four. Most auditors tend to specialize in one or two provider types. The auditors who completed the most audits tended to focus on hospitals or pharmacies.

Number of Audits Completed	2009	2010	2011	2012
1 to 5	8	10	15	12
6 to 11	7	5	6	4
12 or more	3	1	1	1
Total Staff	18	16	22	17

Source: PRI analysis of DSS' MATS database

Recovery Audit Contractors (RACs)

Purpose. Recovery audit contractors were originally designed for the Medicare program, the idea was expanded to Medicaid under ACA. Under the ACA, states were required to contract with RACs as a supplement to their current audit efforts by January 1, 2012. These organizations review claims after payment has been made to identify under and overpayments and recoup overpayments. States are required to pay the RACs a contingency fee for identification of overpayments.

Organization. Health Management Systems (HMS), the state's current Third Party Liability (TPL) contractor, was recently selected to be the RAC for Connecticut through an amendment to their current TPL contract. HMS is a company that has over 2,000 employees in 35 offices throughout the nation. They are the RAC provider in 26 states. They have 240 employees in Connecticut.

HMS will be paid on a contingency basis, meaning that for every dollar in audit adjustments reported, they will keep a percentage as their fee. There is a dual rate system in place based on the type of audit performed. For complex audits, HMS will be paid a 10.5 percent contingency fee, and for automated audits HMS will be paid 9.3 percent. The two types of audit are described below.

Process. Because HMS has only recently been selected to be the RAC, there has not been a lot of actual audit activity. HMS has had to familiarize itself with the state process, and perform some provider education. The Office of Quality Assurance is responsible for assisting in identifying the areas or providers that HMS will be auditing. DSS is also responsible for coordinating all audits with other state and federal agencies.

Generally, the timeframes and provider responsibilities under the RAC audit process will closely mirror the existing DSS audit process. In addition, the appeal process will be same that DSS must follow under law as described above. However, there are two types of audits that HMS will be conducting.

Automated audit. The automated audit will identify overpayment and underpayments based on a review of provider claims in DSS' data warehouse. The department will determine the frequency and number of individual claims and providers to be reviewed by HMS. Once the incorrect payments are identified the providers will receive a preliminary list of those claims and will have 30 days to provide documentation to support the claims billed. A final claims list will be issued by HMS within 60 days of the provider's response. DSS will initiate recoupment after 30 days of the final claims list being issued.

Complex audits. In a complex audit, HMS will typically perform audits at a provider's location and will be reviewing medical, billing, and/or financial records to identify and calculate improper payment amounts. HMS is limited to a request of 100 records from a provider over a two-year period. This limitation may be waived by DSS if circumstances warrant it. Generally, the process the contractor must follow and the appeals of complex audits are similar to the requirements imposed on DSS in performing its audits.

Activities/outputs. There have not yet been any audits completed by HMS to date. There are complex audits in process in the dental, acquired brain injury areas, and certain institutional facilities. HMS is also assessing a number of other areas through data mining.

Medicaid Integrity Contractors (MICs)

Purpose. The Deficit Reduction Act (2005) required CMS to contract with entities to review provider claims; audit providers and others; identify overpayments, and educate providers, managed care entities, beneficiaries and others with respect to payment integrity and quality of care. MICs conduct post- payment audits of all types of Medicaid providers and, where appropriate, identify overpayments. As part of that effort, MICs are supposed to ensure that paid claims were:

- for services provided and properly documents;
- for services billed properly, using correct and appropriate procedure codes;
- for covered services; and
- paid according to federal and state laws, regulations, and policies.

Organization. The MIC contractors are selected by CMS. There are five MIC contractors that are divided by region throughout the nation. The MIC contractor for the area that includes Connecticut is IRPO. It is a non-profit independent quality improvement and evaluation organization with 400 employees.

Process. MICs operate under the direction of CMS but are required to coordinate their activities with DSS. The process includes the following steps:

- *Audits.* The MICs may perform desk audits, focused field audits, and comprehensive audits. The desk audits are conducted at the auditor's desk and are based on the findings from data algorithms that generate problem claims and on reviews of medical records. Focused field audits are based on findings of algorithms but differ from desk audits because these reviews may also have several questions generated with respect to the type of issues and number of claims. A field visit will be necessary to resolve these types of issues. Comprehensive audits are detailed investigations of all areas relevant to proper payment of Medicaid funds. These audits will also take place on-site at a providers premise.
- *Draft and final report.* The MIC will prepare a draft audit report. Draft audit comments are sent to the DSS for a 30-day review and comment period. State comments will be considered by CMS and MIC and the audit comments can be revised as necessary. The provider will have 30 days to review and submit comments. Additional review time is given to DSS to review any revisions suggested by the provider. CMS, the MIC contractor, and if necessary, DSS are to reconcile any issues with the revised draft. After that, the MIC will produce the final report.

- *Collection.* The state then has the responsibility to adjudicate the audit findings with the provider and has one year to recover any overpayment from the provider.
- *Appeal.* The MIC audit appeal process for the provider is the same as the state audit appeal process. However, states can challenge the findings of the MIC audit through the U.S. Health and Human Services Departmental Appeals Board Appeal Division.

Activities/outputs. According to CMS, there have been 12 audits that are in draft form or in process, and eight audits that have been discontinued with no findings, for a total of 20 audits. The draft audits have identified about \$64,000 in overpayment thus far.

The MIC program has come under criticism lately. The Government Accountability Office has found the MIC audits were costing more than what they were generating. Apparently, the MIC audits have not been very effective because they have relied on Medicaid Statistical Information System (MSIS) data. MSIS is an extract of states' claims data and is missing key elements, such as provider names, that are necessary for auditing.

Cost Report Auditing Contractor

Purpose. The state establishes rates for certain long-term care facilities. Both the Department of Developmental Services and DSS uses a private contractor to assist in the review of annual cost reports, rate setting, and field audits for these facilities. The focus of these audits is on assuring the proper costs have been included on a cost report and are unlike a DSS audit, though if fraud is suspected the cost report auditor will report that to DSS.

Organization. The firm of Craig J. Lubistky Consulting L.L.C. (CJL) has been performing cost report audits on behalf of DSS since 2001. The contract is set to be competitively bid in 2013.

Process. The rates for nursing facilities are based upon annual cost reports filed by the facilities and are subject to allowable cost limits and rates setting formulas established in statute. These cost report audits can identify where costs have been improperly applied according to allowable limits.

CJL is responsible for performing both desk and field audits. The desk audits are reviews of each annual cost submitted by nursing facilities to CJL. The cost reports are checked for compliance with applicable regulatory and statutory cost allowances.

The field audits are more elaborate and time consuming and generally follow the audit procedure described above. The breadth of the audit is still focused on cost allowances and is narrower than a typical audit performed by DSS. The providers who are subject to field audits are selected in conjunction with DSS.

The contractor will schedule an audit with the facility, giving the facility approximately one month notice. A document request is sent to the facility and when received, a sample of selected items is sent to the facility to ensure the supporting documentation is available at the start of field work. Field work takes about one week.

At the end of the field work, the facility receives a listing of any outstanding document requests. Within three months the audit is technically reviewed and additional documentation may be requested by the CLJ. Within 3 months after that phase, a draft audit report is sent to the facility and an exit conference is scheduled. The facility has 30 days to respond to the draft findings. The report is finalized and revised rates are sent to DSS (or DDS). DSS sends a copy of the final report to the facility and a rate letter detailing the revised rates. Nursing facilities have appeal rights and follow the long-term care audit appeal process described above.

Activity/outputs. Table A-5 below shows the number of field audits completed by CJL by provider type and estimated recoupments for SFY's 2008-2012. CLJ estimates that it identified adjustments that amounted to cost savings to the state of about \$8.3 million in 2010; \$11.5 million in 2011; and \$5.8 million in 2012. The contractor is paid based on a set number of hours the contract. For FY 2013, the contractor is authorized to perform up to 41,892 hours for desk reviews and audit services. In SFY 2010 and 2011, the state paid CJL about \$3.6 million in each year and in SFY 2012, it paid the firm about \$3.7 million. The table shows the amount attributable to field audit expenses and the net cost savings.

Table A-5. Audits Issued by CJL Consulting, SFY 2008-2012					
	2008	2009	2010	2011	2012
Nursing Facilities	34	49	55	46	34
Residential Care Homes	7	11	26	35	17
ICMFR	5	10	0	5	25
Estimated Recoupments*	\$7,146,857	\$11,477,069	\$8,327,569	\$11,519,498	\$5,874,301
Contract Costs Related to Audits	n/a	n/a	\$1,837,027	\$1,733,714	\$1,811,551
Net Cost Savings	n/a	n/a	\$6,490,542	\$9,785,784	\$4,062,751
Note: Other activity not included above includes 13 audits of community living arrangements in 2008 and 2009, reviews of development agreements, and of long-term care management companies.					
*Estimated recoupments are based on rate changes provided to DSS					
Source DSS and Craig J. Lubistky, LLC					

Special Investigations Unit

Created in FY 10, the Special Investigations Unit (SIU) is responsible for coordinating and conducting activities to prevent, detect, investigate Medicaid fraud, waste, and abuse. The unit has three major functions:

- enrolling and re-enrolling providers in the Medicaid program;
- conducting data analysis in order to detect possible fraud and abuse; and
- investigating Medicaid (and CHIP) providers suspected of fraud and abuse prior to referral to Medicaid Fraud Control Unit within the Office of the Chief State's Attorney or the Office of the Attorney General.

Previously, these functions were handled under a different organizational structure.

Resources. The unit has nine staff, in addition to a manager and secretary. Of the nine:

- one is responsible for overseeing the Medicaid provider enrollment process;
- five perform data mining activities to assist in identifying aberrant provider billing patterns that suggest fraud or abuse may be occurring; and
- three staff conduct investigations based on complaints received about potentially fraudulent or abusive providers or patterns identified through data mining.

Federal regulation identifies the steps that state Medicaid agencies must follow if provider fraud or abuse is suspected. The regulations require a state's Medicaid agency have:

- methods and criteria of identifying suspected fraud cases;
- methods for investigating these cases that do not infringe on suspected persons legal rights and afford due process; and
- procedures developed in cooperation with state legal authorities, for referring suspected fraud cases to law enforcement officials.

Each state must conduct a preliminary investigation (called an "integrity review" by OQA) if it receives a complaint alleging Medicaid fraud or abuse from any source or if it identifies any questionable practices, to determine whether there is sufficient basis to warrant a full investigation. If the findings of an integrity review indicate suspected fraud or abuse has occurred, then DSS must refer the case to the state Medicaid Fraud Control Unit under the terms of its Memorandum of Understanding agreement, discussed in detail in Chapter IV. In cases where no referral is required, DSS must conduct a full investigation until:

- appropriate legal action is initiated;

- the case is closed because of insufficient evidence to support the allegations of fraud or abuse; or
- the matter is resolved between the agency and the provider.

The regulations also lists possible outcomes of investigations, but does not limit states to those listed and provides for: (1) sending a warning letter to the provider or beneficiary, giving notice that continuation of the activity in question will result in further action; (2) suspending or terminating the provider from participation in the Medicaid program; (3) seeking recovery of payments made to the provider; or (4) imposing other sanctions provided under the state's Medicaid plan.

DSS is required to report specific information to CMS. This includes the number of integrity reviews undertaken arising from complaints of fraud and abuse and the number that lead to a full investigation based on the initial review. In addition, for full investigations, the information must include the:

- provider's name and number;
- source of the complaint;
- type of provider;
- nature of the complaint;
- approximate range of dollars involved; and
- legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred.

Process for data analysis. The SIU uses technology to identify potential fraud, abuse or overpayments through the operation and maintenance of two information technology systems – the Surveillance and Utilization Review System (SURS/Profiler) and the Fraud, Abuse, and Overpayment System (FAO) – both based on technology that is almost twenty years old. The unit conducts initial analysis through both routine and ad hoc reports and on-going analysis during preliminary and full investigations. However, based on data reported to CMS, the department estimated that only about 1 percent of its investigations were opened as a result of their data mining activities. Instead, the majority of reviews conducted are because a complaint was received. In a few instances, the department reviewed a provider because of audit findings.

In most cases, SIU will conduct a preliminary review first, to determine the validity of a complaint. If warranted, the case may be forwarded directly to MCFU or for a full scale review by the department. Preliminary investigations of fraud or abuse complaints determine if there are sufficient bases to warrant a full investigation. The department does not have definitions of what activities take place under each type of review although the director of OQA indicated a full scale review is a more-in-depth examination of providers billing activities and, on occasion, a full scale review will be the first level of review.

SIU has a Data Analysis Section with four staff assigned who profile different providers using data analysis techniques to identify any aberrant patterns that require a closer examination of providers billing practices. A number of data reports are run including:

- routine monthly reports
- targeted reports on specific types of providers;
- law enforcement requests; and
- google alerts from other states who have identified fraudulent providers.

If DSS determines there has been a possible overpayment based on its data analysis, SIU sends a “demand letter” to the provider who has 30 days to respond and submit documentation. Some examples that may trigger further review are:

- a high dollar volume billed for particular procedures;
- duplicate payments;
- too many hours billed; or
- medically illogical dosage given.

Source of referrals. SIU receives referrals of suspected Medicaid fraud or abuse from several sources for which they initiate a preliminary investigation to determine whether to investigate more fully. In FY 12, the unit received 187 allegations of fraud or abuse by telephone, facsimile, written correspondence, and e-mail from the following sources:

- 81 fraud alerts and through its hotline;
- 57 from other DSS divisions and DSS contractors;
- 16 from other state agencies;
- 11 providers;
- 8 clients;
- 8 federal agencies; and
- 6 miscellaneous complaints, including anonymous, local law enforcement, and media.

The unit does maintain a complaint database, which does not always contain all the complaints received by the unit. When the unit receives a complaint about a Medicaid provider, it will conduct a review and depending on what it finds, it can refer it for an integrity review, to another division or agency within the state, or close it if it has no merit. Chapter III discusses the importance of case management to determine outcomes of all complaints received, as well as integrity and full scale reviews conducted by the department.

Outcomes of reviews. There are several actions that DSS takes as a result of an investigation, including:

- no action because no material findings;
- recoupments and withholdings against providers it believes are billing Medicaid inappropriately even when possible criminal actions are on hold or not yet determined;
- referral to state AG for providers not currently billing Medicaid but DSS wants to take collection action; and

- referral to MFCU for suspected fraud (which are discussed in Appendix E).

PRI committee staff examined a database that contained integrity reviews conducted by the unit and their outcomes for FY 09 - FY 12 (shown in Table B-1). According to SIU staff, the reason why so many more reviews were performed in FY 11, was a result of four additional staff assigned to the unit. Prior to FY 10, reviews were performed under the Audit Division and may have been classified differently.

<i>Outcome</i>	<i>FY 08</i>	<i>FY 09</i>	<i>FY 10</i>	<i>FY 11</i>	<i>FY 12</i>
Open	-	-	1	25	-
Integrity Review - no material findings	1	6	-	170	1
Integrity Review - with findings	-	17	2	462	38
Integrity Review - referred for full-scale	2	2	-	22	-
Integrity Review - recovered claims & referred for Full Scale	-	-	-	8	-
Full scale with findings	-	-	-	1	4
Full scale referred to CSAO or MFCU	7	1	1	-	-
MFCU	-	-	-	-	13
Global Settlement*	-	-	-	-	5
Closed no review	-	-	-	1	-
Missing				1	-
Total	10	26	4	690	61

*SIU provides data analysis of claims for MFCU and the Office of the Chief State's Attorney, so a portion of SIU staff time is spent on Global Settlement cases (i.e., multi-state abuse and fraud cases).

There was limited information in the integrity review database about cases that had recoupment action taken and the database may not be complete (as noted in Chapter III, case management and the ability to track cases from complaints to final outcomes need improvement). Table B-2 shows the number of reviews that resulted in Medicaid recoupments for those cases that were in the database, with over \$400,000 in recoupments initiated in each of the last two fiscal years.

<i>SFY</i>	<i>Cases</i>	<i>Minimum</i>	<i>Maximum</i>	<i>Average</i>	<i>Total</i>
FY 08	10	\$0	\$0	\$0	\$0
FY 09	26	\$0	\$96,496	\$20,152	\$523,952
FY 10	2*	\$2072	\$37,010	\$19,541	\$39,081
FY 11	479	(\$419)	\$24,078	\$758	\$491,970
FY 12	56**	\$0	\$203,391	\$7,493	\$419,622

*2 out of 4 cases had dollars recouped
 **Excludes 5 Global Settlement Cases
 Source: DSS

Return on investment. PRI examined return on investment based on the integrity reviews contained in the database for FY 11 and FY 12. There are eight staff devoted to this

function, along with manager and secretary (calculated at 70 percent of their salaries), with salaries totaling \$549,933. When a 38 percent fringe rate is added in, the total cost of the staff devoted to this function is \$758,908. This cost does not include any data mining activities performed by SIU staff for global settlements since SIU staff could not estimate the amount of time they spent on these types of cases and therefore, PRI could not apportion a percentage of those settlements to SIU.

In addition, as noted earlier, not all of the cases that were referred to MFCU could be found in the integrity review database, therefore recoupments are likely underreported. However, since DSS staff was unable to identify a total amount of recoupments that resulted from the activities of this unit, it is difficult to make conclusions about the value of this many staff devoted to this function.

Payment Error Rate Measurement Program (PERM)

Purpose. The Improper Payments Information Act (IPIA) of 2002 (as amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA) requires the heads of federal agencies to annually review programs they administer and identify those that may be susceptible to significant improper payments, to estimate the amount of improper payments, to submit those estimates to Congress, and to submit a report on actions the agency is taking to reduce the improper payments.

To comply with IPIA, CMS' Office of Financial Management developed the Payment Error Rate Measurement Program (PERM). It is a comprehensive, ongoing federal audit designed to estimate the proportion of Medicaid and Children's Health Insurance Program payments made in error.

Organization. Currently, CMS has hired two private contractors to implement the PERM program. One contractor provides statistical support by producing the samples to be reviewed and by calculating the error rate and the other, a review contractor, checks the accuracy of the claims-processing system and reviews documentation to determine the medical necessity of the service for which payment was claimed.

Process. CMA conducts PERM reviews of state Medicaid programs on a three-year cycle. About 17 states are reviewed each year and each state must develop a corrective action plan to reduce improper payments based on the PERM findings. Each state is also required to return the federal share of overpayments. The most recent review of Connecticut occurred in FFY 2009 (published in November 2010) and the next review is on-going now in FFY 2012. It takes about two years for the entire process to be completed for an individual state.

The PERM error rates are based on reviews of the fee-for-service (FFS), managed care, and client eligibility components of Medicaid in the fiscal year under review. It is important to note the error rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements. State payment and eligibility records are reviewed to calculate payment error rates using a random sample of claims and eligibility determinations

Figure C-1 shows the combined annual error rate for the nation. Since 2008 there has been a decline in the overall error rate from 10.5 percent in 2008 to 6.7 percent in 2011. The three-year rolling average Medicaid error rate for 2010 was 9.4 percent and 8.1 for 2011. The official 2011 Medicaid national error rate is based on the rolling average of 8.1 percent. The 2012 rate has not yet been published.

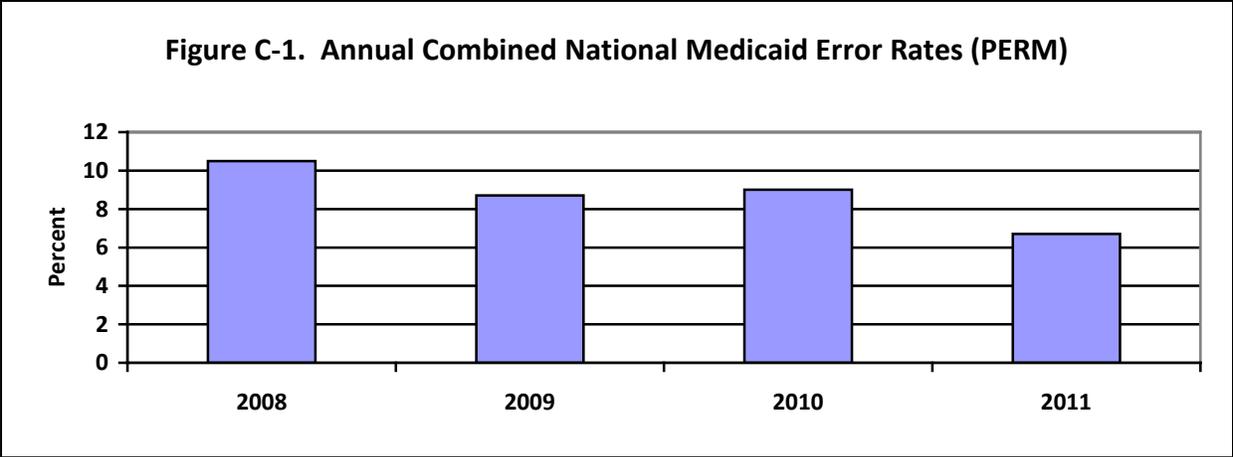
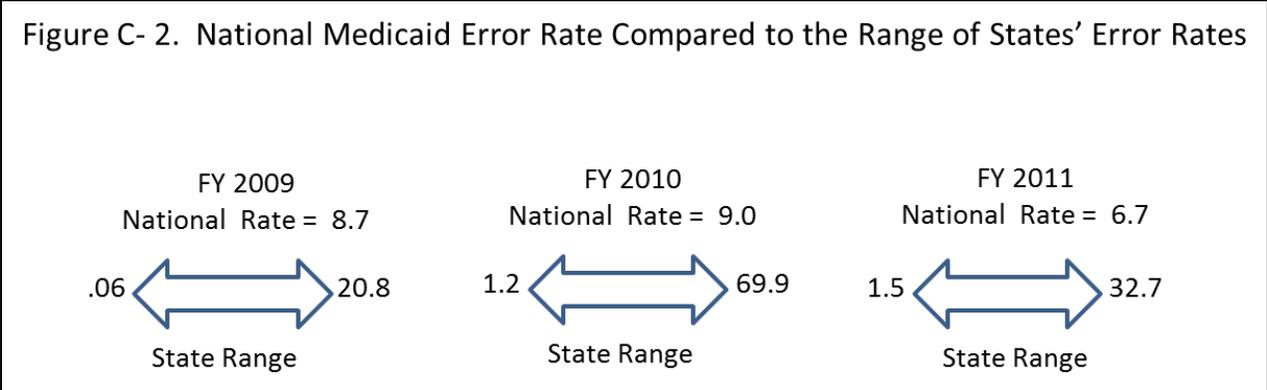


Figure C-2 illustrates the combined national Medicaid error rate compared to the range of states' error rates for 2009 through 2011. There is significant variability in error rates among the states.



Connecticut's PERM results. It should be noted that CMS cautions: “We provide each state their specific error rates and data analysis reports to develop corrective actions designed to reduce major error causes and to identify trends in errors or other factors for purposes of reducing improper payments. Due to the variation of states’ sizes, overall program variations, and different ways that each State’s rate impacts the national rate, we do not encourage comparisons based solely on PERM rates.”

In addition, CMS explains that PERM is designed to produce precise error rates at the national level, but sample sizes per state are relatively small, making the precision of state-specific error *much less reliable*. In addition, Connecticut's original rate was adjusted by CMS in August 2011 after it determined that six cases, involving state medical assistance for non-citizens, were inappropriately included in the PERM sample. This change reduced the eligibility error rate from 3.25 percent to 1.96 percent.

Table C-1 shows the results of the 2009 PERM review for Connecticut and the nation. Connecticut’s overall error rate and individual component error rates are lower than the national rate. In the case of the overall rate, Connecticut is substantially lower than the nation (2.8 percent versus 8.98 percent). In addition, Connecticut's managed care error rate was much lower

than the state fee-for-service error rate. (As of January 2012, Connecticut no longer has a managed care component for Medicaid).

For purposes of comparison, CMS developed an error rate in 2006 for Connecticut's fee-for-service component only. In 2006, the fee-for-service error rate was 8.52 percent which was significantly higher than the 2009 rate of 1.5 percent.

Table C-1. Connecticut's Error Rate is Much Lower Than the National Average		
Component	Connecticut Error Rate Estimate	National Error Rate Estimate
Overall	2.8%	8.98%
Fee-for-Service	1.5%	1.89%
Managed Care	0.1%	0.13%
Eligibility	1.5%	7.60%
Source: CMS		

Specific review areas. The PERM review consists of three distinct areas: data processing; medical necessity; and recipient eligibility. Table C-2 shows the most common errors for Connecticut for each area for the fee-for-service claim population and overall eligibility component.²⁶ The total error amount in the sample was \$28,535. No extrapolation figures were available to PRI committee staff to estimate the error cost across the entire Medicaid population.

The highest number and dollar amount of errors were found in the eligibility area. Consequently, this is the area where Connecticut is most vulnerable to improper payments according to the PERM review. Most of the eligibility errors occurred in two areas. Twenty-three cases were "undetermined" and resulted from an inability to locate the client, a lack of client cooperation with regard to providing accurate and timely information, and incorrect sampling of non-reviewable cases (as noted above).

Twenty-two cases were "not eligible." They were the result of the department's and the client's failure to verify needed information and the department's failure to properly apply information received about the client's eligibility.

The second most vulnerable area was in data processing. The single greatest dollar error in this area involved an MMIS logic edit that failed to reject a claim by a long-term care facility and the other error involved incorrectly paying pharmacy claims for which third party insurance had been identified.

Medical necessity area had the second highest number of errors but the lowest dollar amount overall. Most of these errors (five of the six) involved insufficient documentation to support claims for services billed through the Connecticut Department of Developmental Services.

²⁶ The managed care component had five payment errors for services not covered. The total dollar amount of the error was \$5.00.

C-2. Connecticut's Medicaid Payment Errors by Area								
Medical Necessity			Data Processing			Eligibility		
<i>Error Type</i>	<i>Cases</i>	<i>\$</i>	<i>Error Type</i>	<i>Cases</i>	<i>\$</i>	<i>Error Type</i>	<i>Cases</i>	<i>\$</i>
Insufficient Documentation	6	1,266	Logic Edit	1	4,028	Not Eligible or Undetermined	45	n/a
Procedure Coding Error (Underpayment)	1	249	Third Party Liability	2	1,441	Liability Understated	4	n/a
Number of Units Error	1	99				Eligible with Ineligible Services	1	n/a
TOTAL	8	\$1,614		3	\$5,469		50*	\$21,452
Source: <i>Connecticut Final Report: Data Analysis form Payment Error Rate Measurement Findings</i> , US Department of Health and Human Services, November 15, 2010								
* This number and total dollar amount contains six cases that were later removed by CMS								

Corrective actions. DSS submitted a corrective action plan to address all the identified "error elements" to the federal government on February 15, 2011. The department had a phased implementation timetable but indicated that it would implement all corrective actions by September 2012. In interviews with PRI committee staff, the department has indicated that it has completed implementation of the plan.

Office of Legislative Research

PA 07-2, June 2007 Special Session - HB 8002
Emergency Certification

§§ 18-20 — THIRD PARTY LIABILITY AND MEDICAID COVERAGE

Obligation of Insurers to Provide Information

Federal law requires Connecticut, as a condition of receiving federal Medicaid matching funds, to enact laws requiring health insurers to provide certain information to DSS to enable it to determine whether a person submitting a Medicaid claim is covered by another form of insurance.

By law, DSS must exhaust other payment sources before paying for health care services provided to Medicaid recipients, and individuals are expected to disclose when they have other coverage. The act requires health insurers to provide certain information to the DSS commissioner, when requested, regardless of whether they bear any financial risk for a Medicaid recipient's claims. As used in the act, "health insurer" includes a self-insured plan; group health plan, as defined in federal law; service benefit plan; managed care organization; health care center; pharmacy benefit manager (PBM); dental benefit manager, or other party that is by statute, contract, or agreement legally responsible for paying health care claims.

The act requires health insurers to provide the information in a manner and format the commissioner or his designee prescribes, that identifies, determines, or establishes third-party coverage. This includes information necessary to determine during what period a person, or his or her spouse or dependents, is or was covered by a health insurer and the nature of the coverage provided, including the insurance plan's name, address, and identifying number. The insurer must also provide this information to all third-party administrators, PBMs, dental benefit managers, or other entities with which it arranges to adjudicate health care claims.

Prior law required state-licensed insurance companies to conduct automated data matches to identify this coverage if (1) the DSS commissioner requested it and (2) compatible data elements were available. The law required the commissioner to reimburse the companies for the costs of conducting the matches. The act instead requires health insurers, as more broadly defined by the act, to do these matches at the commissioner's request or allow the commissioner or his designee to conduct them.

Insurers' Obligation to Assist DSS as Condition of Operating in State

With respect to individuals eligible for or receiving Medicaid, the act requires health insurers, as a condition of operating in Connecticut, to:

1. provide the DSS commissioner or his designee, all third-party administrators, PBMs, dental benefits managers, and other entities with which the insurer arranges to adjudicate health care claims any information the commissioner or his designee prescribes that is needed to determine whether there is available coverage and the coverage plan's name, address, and identifying number;
2. accept the state's right of recovery from the insurer and a person's assignment of benefits to the state for payment of a covered health care service for which Medicaid paid;
3. respond to any inquiry from the commissioner or his designee regarding a health care claim submitted within three years from the date the service was provided; and
4. agree not to deny a claim that the state submits solely based on its submission date, claim form, type or format, or failure to present proper documentation at the “point-of-sale” that is the basis of the claim if (a) the state or its agent submits the claim within the three-year period and (b) the state begins any legal action to enforce its rights with respect to the claim within six years of the claim submission.

Under existing law, no individual or group accident, health, accident or health, medical expense, medical service plan, self-insured plan, or self-funded plan subject to ERISA can contain provisions that have the effect of denying or limiting benefits or excluding coverage because the services are provided to someone who is eligible for or receiving Medicaid. The act applies the prohibition to the act's broadened list of health insurers' plans and extends it to include provisions that limit enrollment in private health care coverage.

DSS Subrogated to Any Right of Recovery for Medicaid Services Rendered

By law, DSS is subrogated (i. e. , entitled) to any right of recovery or indemnification that a Medicaid applicant or recipient, or his or her legally liable relative, has against an insurer for the costs of hospitalization, pharmacy, physician, and nursing services provided, up to the amount DSS spent on such services. The act extends this provision to the broadened list of health insurers and any other legally liable third party. And it adds behavioral health and long-term care services to the list of Medicaid-covered services for which DSS can recover.

Applying for or receiving Medicaid is deemed by law to be a subrogation assignment and an assignment of claims for benefits to DSS. Insurers must pay DSS directly under such an assignment. DSS can further assign its right to payment to a health care provider participating in Medicaid. Currently, providers must notify the “private” insurer of the assignment when rendering health care services. If the provider fails to do this, he or she is ineligible for DSS reimbursement. The act requires notification to a health insurer, as it more broadly defines the term, or other legally liable third party.

Requirement to Pay Claims

The act specifies that claims for recovery or indemnification that DSS or its designee submit to health insurers may not be denied solely based on the submission date, claim form, type or

format, or failure to present proper documentation at the “point-of-sale” that is the basis of the claim if (1) the state or its agent submits the claim within three years from the date of service and (2) the state begins any legal action to enforce its rights with respect to the claim within six years of the claim submission.

EFFECTIVE DATE: July 1, 2007

§ 21 — PHARMACY CLAIMS

The act prohibits any pharmacy from claiming payment from DSS under a DSS-administered medical assistance program or the Medicare Part D Supplemental Needs Fund for drugs prescribed to people who have other prescription drug insurance coverage unless the coverage has been exhausted and the person is otherwise eligible for the program or assistance from the Fund. It requires DSS to recoup from the submitting pharmacy any claims it submitted to DSS which DSS paid when other insurance coverage was available.

Under the act, DSS must investigate a pharmacy that consistently submits ineligible payment claims to determine whether the pharmacy is in violation of its medical assistance provider agreement or is committing fraud or abuse in the program. Based on its findings, the act allows DSS to take action against the pharmacy in accordance with state and federal law.

EFFECTIVE DATE: Upon passage

Fraud Prosecution

Once an improper payment is detected, a determination must be made whether fraud or abuse exists. The Department of Social Services (DSS) will conduct its own preliminary investigation of any suspected misconduct. The department will determine whether it will proceed with administrative action and/or refer the matter on to other governmental entities for further investigation and possible prosecution. The following describes the procedures used to investigate providers suspected of civil and criminal Medicaid fraud and abuse, as well as any resulting sanctions.

Investigative Procedures

Medicaid fraud is actionable under both state and federal statutes and may be prosecuted in both state and federal courts. Federal law requires a memorandum of agreement (MOU) between the single state agency for Medicaid, namely DSS and the entities involved in the prosecution of Medicaid fraud. In Connecticut, this includes the Medicaid Fraud Control Unit (MFCU) within the Office of the Chief State's Attorney (OCSA), the Office of the Attorney General (OAG), and the federal Office of the Inspector General (OIG).

The MOU sets out the various roles and responsibilities in the discovery and prosecution of violations in the Medicaid program including fraud and abuse. The MOU is intended to: (1) facilitate the referral of all suspected cases of provider fraud from DSS and (2) facilitate the routine exchange of information between DSS and the law enforcement agencies. Cooperation between these entities is essential to fostering a more efficient process of identifying and prosecuting fraud in the Medicaid program.

Referrals. As shown in Figure E-1, DSS is required to refer any suspected Medicaid fraud or abuse to the OAG, MFCU, and OIG. Each agency will review the referral for its own pertinent issues. MFCU will screen the referral for potential state criminal law issues. The OAG reviews the case to see whether a state civil action is warranted. The federal OIG will also review for potential federal criminal, civil, or OIG administrative action.

If a DSS investigation results in a payment suspension in whole or part, DSS must make a fraud referral to MFCU. The referral must be provided to MFCU in writing no later than the next business day after the suspension is enacted. The referral must conform to referral standards established by federal law.

Within 60 days of the referral, the MFCU, OIG, and OAG must determine whether further investigation is needed. They must report their decision to accept or reject the matter to DSS in writing within the 60 days. If MFCU or OIG does not believe the matter has substantial potential for criminal fraud, the case must be referred back to DSS and OAG for possible civil and/or administrative action. Similarly, the OAG must review the case to determine if civil fraud

investigation is warranted. OAG must also report its decision to accept or decline the case to DSS in writing within the 60-day period.

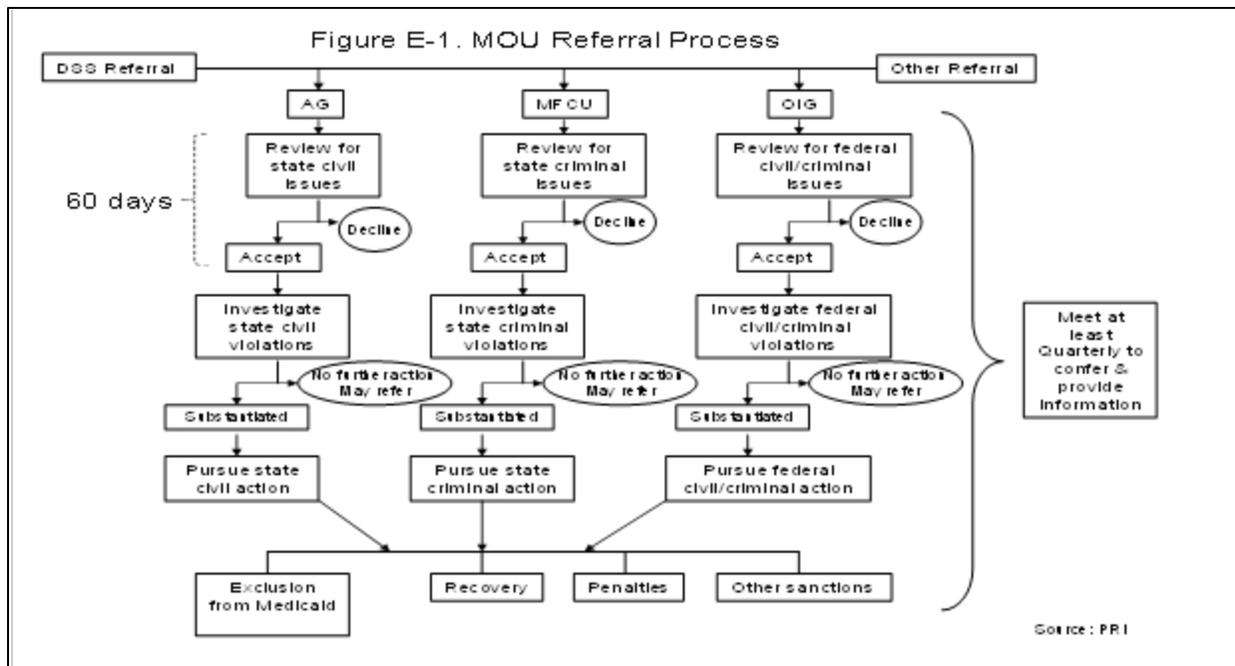
Non-DSS referrals. Each agency may also receive allegations of Medicaid violations or misconduct from non-DSS sources. Other sources of referrals may be the MFCUs in other states, other government or law enforcement agencies, whistleblowers, or members of the public. However, the MFCU may not initiate an investigation without some basis of allegation. Federal law specifically prohibits the MFCU from engaging in data mining or selecting a random target for investigation. The OAG may accept matters from any source including whistleblowers or the public. The OIG may also receive allegations or complaints from any source. Unless there is suspected conspiracy or involvement with a provider, neither the OAG, MFCU, nor OIG will investigate recipient fraud. Furthermore, federal law prohibits the MFCU to engage in routine computer screening activities that are the typical monitoring function of the Medicaid agency.

The OAG, MFCU, and OIG must inform DSS as soon as possible after a determination is made that a non-DSS referral does not warrant further inquiry but may be pursued by DSS. Any information of such non-DSS referral shall be made available to DSS to extent permissible by law. Conversely, DSS must provide information to MFCU, OIG and/or OAG for any Medicaid investigation that is initiated by a non-DSS referral.

Referrals to MFCU are screened by a panel of three – the unit director, the inspector supervisor, and the lead forensic examiner. The panel uses their own internal checklist of criteria to decide whether to accept a case. This may include weighing the potential dollar amount recoverable against the level of resources needed to complete the investigation. It may also include how much of the information/allegation can be corroborated, available evidence, and statute of limitations. Furthermore, federal regulation requires the MFCU to accept a mix of cases and ensure efforts are made to recover as much funds as possible.

Similarly, the supervisory staff of the OAG and OIG will review referrals with their own internal criteria. Each agency's decision to pursue or dismiss a matter involves similar threshold criteria of available evidence, resources, and potential outcome. In all of the agencies, one referral may lead to multiple open cases while multiple referrals may result in one opened case. Once a case is open, the unit supervisor/director at each agency will assigned the case to the appropriate staff for investigation.

Investigations. The MOU stipulates that each agency must pursue completion of a matter as expeditiously as possible and allocate adequate resources to meet the terms of the MOU. According to MFCU, OAG, and OIG, the number of staff assigned to a case may vary depending on the nature and scope of the investigation. However, typically there is one lead staff person on each case. When necessary, other staff members may be requested to temporarily assist in cases.



The agencies generally use the DSS referral as an initial reference point for the investigation. Referral requirements are set out by federal regulation including the information to be provided by DSS to the other investigating agencies. At a minimum, the referral must include:

- Subject (name, Medicaid ID, address, provider type),
- Source/origination of complaint,
- Date reported to the State,
- Description of suspected misconduct, with specific details such as;
 - Category of service
 - Factual explanation of the allegation
 - Specific Medicaid statutes, rules, regulations and/or policies violated
 - Date(s) of conduct
- Amount paid to provider,
- All relevant communications between state and provider, and
- Staff contact information.

DSS has developed an enhanced referral package for use in fraud referrals to MFCU. Once a fraud case has been fully investigated by DSS, the department prepares referral packet consisting of large binders with clear sections containing preliminary investigation and summary, discovered evidence, interviews, and applicable billing history. The MOU agencies agree to share all information and/or documents obtained from DSS worked on jointly among the parties. The agencies must comply with all applicable state and federal law with respect to the information.

The supporting documentation for a referral is maintained with the case file at DSS but is available to the other agency staff as needed. None of the agencies can disclose to the subject or potential subject of an investigation whether the other parties are targeting or potentially targeting the subject. According to the investigating agencies, various methods of investigation

may be used such as document and file reviews, interviews, site visits, and, when necessary, undercover techniques. During the investigation, the agencies attempt to obtain voluntary compliance and cooperation from the targets but if necessary subpoenas are served. Unlike the OAG, the MFCU has no independent subpoena power but may either obtain a search warrant or request assistance from the federal partners.

As part of its investigations, MFCU or the other investigating agencies may request that DSS not suspend payments until such time as the investigation and enforcement proceedings are completed. According to MFCU, OAG, and OIG, the length of time to complete an investigation may vary from a couple of weeks to years. Periodically, the supervisory/unit head of each agency will inventory ongoing pending cases. At the close of an investigation, the results of the investigation are prepared as a report or memo that is reviewed by the unit head or supervising staff. A decision is then made whether further legal or administrative action is warranted.

Pursuant to the MOU, the parties have agreed to meet bi-monthly to discuss progress and updates on various cases as well as any other relevant issues. Each party must send designees to the meeting for the purpose of discussing potential new referrals and the status of existing referrals and pending cases. In addition to the parties to the MOU, a number of other relevant agencies may attend the bi-monthly meetings. These may include the Federal Bureau of Investigations (FBI), Department of Labor (DOL), Department of Consumer Protection (DCP), and the Department of Public Health (DPH).

Outcomes

As illustrated in Figure E-1, each agency will independently determine how it will proceed with substantiated allegations but will keep DSS and others informed of activities. In addition to recoupment or recovery of improper payments, the investigative efforts may result in criminal convictions, administrative sanctions, and/or civil monetary penalties. The case disposition differs depending on which agency is pursuing legal action. The remedies sought are not mutually exclusive. When appropriate, they are used in conjunction with each other to meet the state's needs in a particular case.

Criminal prosecution. If an investigation reveals that the allegations were substantiated, a decision must be made regarding subsequent legal action. The MFCU director has final decision authority to pursue criminal prosecution under state law. The OIG will decide whether or not to criminally prosecute under federal law. When a case is not amenable for criminal investigation or prosecution, MFCU and/or OIG must inform and refer the matter to OAG for potential civil prosecution.

In Connecticut, two state criminal laws can be used to prosecute vendor fraud in public assistance programs. In general, any public assistance vendor who defrauds the state is guilty of either vendor fraud (C.G.S. § 53a-290-296) or larceny (C.G.S. § 53a-122-125b). The primary difference between the two is that for the former a prosecutor must prove intent to commit fraud, where for the latter no such proof is required.

The vendor fraud statute gives the state explicit authority to recover any amounts paid as result of vendor fraud. To be found guilty of vendor fraud, someone must have intentionally

provided goods or services to public assistance recipients with intent to defraud and acted on his or someone else’s behalf in one of the following ways:

- presenting false claims for payment;
- accepting payment for goods or services greater than the amount due or what the law allows;
- soliciting to perform services for or sell goods to beneficiaries who do not need them, or which DSS has not authorized or;
- accepting from anyone besides the state an amount in excess of what the law allows.

The law establishes six degrees of vendor fraud, depending on the amount of money involved. (See Table below) In addition to criminal sanctions, providers convicted of fraud are automatically terminated from the Medicaid program, effective upon the conviction, unless the DSS commissioner determines a delay is necessary to protect Medicaid clients. They are likewise ineligible for state reimbursement for any goods supplied or services performed.

Degree of Vendor Fraud	Class of Crime	Amount of Money	Penalties
1 st	B Felony	Excess \$10,000	Max. 20 yrs & up to \$15,000
2 nd	C Felony	Excess of \$5,000	1 to 10 yrs. & up to \$10,000
3 rd	D Felony	Excess of \$1,000	1 to 5 yrs. & up to \$5,000
4 th	A Misdemeanor	Excess of \$500	Max. 1 yr. & up to \$2,000
5 th	B Misdemeanor	Excess of \$250	Max. 6 mos. & up to \$1,000
6 th	C Misdemeanor	\$250 or less	Max. 3 mos. & up to \$500

Medicaid providers can also be prosecuted for fraud using larceny statutes. A person is guilty if they obtain property valued at \$2,000 or more by “defrauding a public community”. For lesser amounts, no distinction is made for public community fraud. The penalties are the same as those applied in vendor fraud cases. The statute of limitation is five years for felonies and one year for violations classified as misdemeanors.

Civil action. Federal law requires that all provider fraud cases that are declined criminally be investigated and/or analyzed fully for their civil action potential. Depending on the circumstances, the state may want to pursue civil remedies in addition to or sometimes in lieu of a criminal remedy. Civil cases could be prosecuted under applicable state civil fraud statutes, specifically the Connecticut False Claims Act and/or the Connecticut Unfair Trade Practices Act (CUTPA), which are briefly described below.

The OAG must coordinate with the federal OIG and/or the United States Attorneys’ Office (USAO) if civil action is contemplated. The OIG will inform the OAG and DSS if case is

not accepted for federal criminal prosecution but has been accepted for federal civil action.²⁷ The OIG and/or MFCU will make its information available, as permitted by law, to the OAG. If the matter includes Medicare as well as Medicaid, the OIG will decide what federal administrative and/or civil action to pursue. If the OAG and/or OIG decide to pursue civil fraud action they must confer with DSS and/or MFCU to minimize adverse impact to any other proceedings. In all cases, DSS must make its employees or its contractors' employees available as expert witnesses for criminal and/or civil proceedings.

Connecticut False Claims Act. Connecticut recently enacted its own False Claims Act in 2009. Unlike the federal False Claims Act which applies broadly to any false claim submitted to the federal government, Connecticut's law applies more narrowly and only to the medical assistance programs administered by DSS including Medicaid. Since 2005, the federal government provided incentive for states to enact their own false claims laws: specifically, the retention of ten percent of the federal Medicaid share of any funds recouped in a Medicaid fraud action.

The law prohibits any person from knowingly presenting (or causing to be presented) a false or fraudulent claim for payment or approval under the medical assistance programs administered by DSS, or knowingly making (or causing to be made) a false statement in order to get such a claim approved, or knowingly concealing, avoiding or decreasing any obligation to pay or transmit money or property to the state. The prohibition extends to a conspiracy, that is, an unlawful agreement between two or more persons, to defraud the state. The law requires "knowing" conduct. "Knowing" conduct may be found where a person or entity consciously avoids learning relevant facts (deliberate ignorance) or acts in reckless disregard for relevant facts.

Another feature of the false claims act is that it provides for qui tam suits, that is, suits brought by private individuals (known as relators) in the name of the government charging fraud on the part of people who improperly receive or use government funds. Relators share in the damages recovered as a result of the lawsuit.

The false claims act allows for penalties ranging from \$5,000 up to \$10,000 per violation. It also authorizes recovery of up to three times the damages sustained by the state as a result of the false claim. The false claim act also has time limits for bringing claims. Generally, claims cannot be brought more than six years after the date the violation occurs or more than three years after the date when a state official knew or should have reasonably known about the violation but in no event more than ten years after the date that the violation occurs.

Connecticut Unfair Trade Practices Act (CUTPA). Prior to the enactment of the False Claims Act, the OAG relied primarily on the Connecticut Unfair Trade Practices Act (CUTPA) for its fraud cases. Under the CUTPA provisions, businesses are prohibited from engaging in unfair and deceptive acts or practices. The Department of Consumer Protection (DCP)

²⁷ The federal government may pursue a Medicaid fraud case for imposition of multiple damages and penalties under the federal civil False Claims Act. Alternatively, if authorized by the federal DOJ, the OIG may seek assessments and penalties under the Civil Monetary Penalties Law. The OIG is authorized to seek different amounts of civil monetary penalties and assessments based on the type of violation at issue.

commissioner may promulgate regulations defining what constitutes an unfair trade practice. CUTPA provisions allow the DCP commissioner to issue subpoenas, administer oaths, and conduct hearings. In addition, the commissioner or his representatives may:

- enter and investigate any establishment at reasonable times;
- check invoices and records;
- have access to and copy documents; and
- undertake other investigatory actions.

If CUTPA violations are suspected, the commissioner may conduct a hearing after providing notice of the charges. Testimony must be taken under oath. The commissioner has the power to issue subpoenas to compel the appearance of witnesses or the production of documents.

If the commissioner concludes a CUTPA violation has occurred, written findings of fact and a cease and desist order must be issued. Restitution may also be ordered if the case involves less than \$5,000. Other options include accepting voluntary statements of compliance or to ask the Attorney General seek judicial enforcement of his orders. The commissioner's order may be appealed to the Superior Court in accordance with the Uniform Administrative Procedure Act. CUTPA allows for recovery of actual damages and, within the court's discretion, punitive damages as well as attorney's fees may be awarded. The court may also order injunctive or other reasonable relief. The CUTPA statute of limitations is three years.

Sanctions

Individuals and/or health care entities committing Medicaid fraud are subject to a number of possible sanctions under federal and state law. As described earlier, DSS may pursue administrative action against providers who have violated the Medicaid program rules. In addition, various licensing boards may be involved in sanctioning providers.

DSS administrative action. If DSS intends to pursue administrative action with respect to case that has or will be referred to the other agencies or is being investigated by the other parties, DSS must consult with the other agencies to coordinate any actions. Details of any planned DSS administrative action must be provided to other parties including any information that may be germane to other actions. These can include settlements, sanctions, and overpayment recoveries. DSS must allow for a 30-day window to other parties allowing them to review the matter. However, DSS may determine that immediate action is necessary to protect the Medicaid program and/or its recipients. In those cases, DSS must provide prior written notice to the other parties and the reasons for immediate action.

Exclusions. In addition to monetary recoveries and penalties, the investigating agency may seek to impose exclusion from Medicaid and other federal health care programs. Federal law authorizes the exclusion of individuals and entities from participating in all federal health care programs for a number of reasons. There is mandatory exclusion for individual and entities convicted Medicaid or Medicare fraud as well as criminal convictions of a variety of program related offenses. There is also permissive exclusion which allows for discretion to exclude individuals and entities on a number of grounds. Exclusions are automatic after a program-

related criminal conviction. DSS also has the authority to exclude individuals who commit healthcare fraud and abuse even in the absence of a criminal conviction. During FY10-11, two cases resulted in exclusion.

Exclusion from the Medicaid program is one of the strongest sanctions available to the state. Federal law prohibits payment for any items or services furnished or prescribed by an excluded individual or entity for any federal program including Medicare. Participation in the Medicaid and Medicare program can be a substantial and critical source of revenue for providers. Furthermore, excluded individuals and entities cannot be employed by or enter into contracts with any other participating Medicaid health care entities to provide services to any federal program beneficiaries. All Medicaid providers must ensure that new hires or current employees are not on the federal excluded list. Failure to do so may result in liability for monetary penalties. Therefore, the practical effect of exclusion is to preclude employment of an excluded individual in any capacity by a health care provider that receives reimbursement, indirectly or directly, from any federal health care program.

Licensing sanctions. When a provider is sanctioned by DSS and the federal government it often triggers further sanctions from other regulating entities such as licensing boards. The investigating agencies work together with the Department of Public Health (DPH) and the Department of Consumer Protection (DCP) to address any necessary action regarding misconduct or violations of the Medicaid program.

Global Cases and Settlements

Connecticut also participates in multi-state fraud investigations and case settlements. These cases represent a cooperative effort with the United States Department of Justice (DOJ), federal Office of Inspector General (OIG) and various states represented by the National Association of Medicaid Fraud Control Units (NAMFCU). NAMFCU facilitates the coordinated multi-state efforts in numerous global settlements of Medicaid fraud cases.

Process. The DOJ or a United States Attorney's Office or other law enforcement source may contact NAMFCU to coordinate the assistance of the individual MFCUs to obtain relevant information and compile a list of states affected by the suspected wrongdoing. The NAMFCU president appoints a NAMFCU investigative team made up of two or three representatives.

Together with the federal government, each NAMFCU settlement team negotiates for the best possible settlement for its member states and when appropriate, will seek penalties as well as damages. NAMFCU protocols dictate all state recoveries are allocated based upon a state's actual damages. The participating states usually supply state-specific data, however, sometimes information is supplied by the federal government.

Any settlement may consider several crucial factors including: the provider's ongoing economic viability, the effect on shareholders, potential employment impact on specific communities and the effect that exclusion from Medicaid, Medicare and other state and federal health care payment programs will have upon a Medicaid beneficiaries' access to adequate and convenient medical care. Settlements may include additional terms such as incarceration of

employees or officers, corporate reorganization and compliance or corporate integrity agreements.

Lead roles. The MOU also delineates roles and responsibilities when dealing with multistate settlements. The agencies are required to share with each other any requests for Medicaid fraud and/or abuse information from any other federal agency, authority of another state, or organization of multiple government agencies.

If any agency becomes aware of multi-state settlement being undertaken they must notify the other parties. Connecticut’s interest will be coordinated by the party who initiated the settlement as described below.

MFCU has primary responsibility if settlement is exclusively criminal in nature and have final approval of settlement. If settlement is exclusively civil in nature then OAG will have primary responsibility for state’s interest and final settlement. The matter is be handled jointly by both MFCU and OAG if involved both criminal and civil issues ensuring that the state’s best interests are served. If civil issues predominate, then OAG may take lead role. If criminal issues predominate, the MFCU may take lead role. Both MFCU and OAG must keep DSS informed in timely fashion of all significant actions of multistate matters to allow DSS input as to the state’s and program and recipient’s best interest. OIG may coordinate with other federal entities to assert the federal government’s interests in multistate settlements.

Staffing. Table E-1 provides staffing comparisons for the Health Care Fraud Unit within the OAG and the MFCU within the Office of the Chief State’s Attorney as of July 2012. As the table shows, the OAG unit had a professional staff of twelve with three administrative staff while the MFCU employs nine professional staff with one administrative person. The OAG unit is primarily staffed by attorneys while the MFCU staff consists mainly of investigators. In addition to its’ own staff, each unit may, on occasion, employ medical or health care experts or specialists for specific cases.

Table E-1. Staffing Levels for OAG and MFCU (as of July 2012)		
STAFFING	OAG	MFCU
Attorney	9	2
Fraud Inspectors	-	4
Forensic Fraud Examiner	2	2
Legal Investigator	1	-
Administrative staff	3	1
TOTAL	15	9
Source: OAG and MFCU		

It should be noted that the OAG has recently made organizational and staffing changes to its unit. The Health Care Fraud Unit has been merged into the Antitrust Department within the OAG. Two of the health care advocacy attorneys of the Health Care Fraud Unit now report to a different division. MFCU also anticipates filling four additional staff positions.

Furthermore, each entity has responsibilities beyond investigating and prosecuting Medicaid fraud. In addition to Medicaid fraud matters, the MFCU staff is responsible for investigating cases of Medicaid patient abuse and neglect as well as complaints of misappropriation of patient's funds in Medicaid facilities. MFCU does not investigate recipient fraud, unless there is a conspiracy with a provider. The OAG staff within the Health Care Fraud Unit also work cases that involve alleged fraud in other state health care programs such as ConnPace.

Source of MFCU referrals. While MFCU receive referrals from DSS, the agency responsible for auditing and reviewing Medicaid provider claims, it may get referrals from other different sources. Referrals may be received from MFCUs in other states as well as other law enforcement or government agencies. Pursuant to federal regulation, the MFCU may not engage in the routine computer screening activities that are the typical monitoring function of the Medicaid agency such as data mining.

The PRI committee requested the state MFCU provide information regarding the number and source of referrals since FY 2009. The results are presented in Table E-2. Since FY 2009, there have been a total of 197 MFCU referrals from a variety of sources. The largest number of referrals was received in FY 2009 and has since decreased in number.

Source of Referral*	FY 09	FY 10	FY 11	FY 12	TOTAL (%)
DSS	9	6	5	7	27 (14%)
Private Citizen	6	8	11	10	35 (18%)
HHS-OIG	3	3	3	-	9 (5%)
Law Enforcement	-	1	3	2	6 (3%)
Licensing Board	8	16	8	2	34 (17%)
Provider	5	3	3	1	12 (6%)
Other	7	-	1	3	11 (6%)
Medicaid Agency Other (non-Global)	15	27	15	6	63 (32%)
TOTAL	53	64	49	31	197 (100%)
Source: MFCU					
*Categories are designated by MFCU. This does not include referrals of Global cases.					

The table shows the largest source of MFCU referrals (32%) is from the category Medicaid Agency Other. According to MFCU, 60 of the 63 total referrals in this category are from the Attorney General.²⁸ The second (18%) and third (17%) largest sources of MFCU referrals are private citizens and licensing boards, respectively. DSS is the fourth major referral

²⁸ The remaining three referrals are from different state MFCUs (2) and another unit within DSS (1).

source with 14 percent of the total referrals made since FY 2009. Referrals have also been submitted by providers, the federal HHS-OIG, and others.

The only category to increase since FY 2009 is the referrals from private citizens. Conversely, the number of referrals from providers has decreased. Referrals from the federal agency HHS-OIG has remained stable since FY 2009 while there has been some fluctuations the number of referrals from licensing boards and the OAG (seen in the category Medicaid Agency Other).

The DSS referrals remained somewhat steady with a small number of referrals in the last few years. Although DSS is the single state agency charged with auditing and reviewing Medicaid claims, DSS has not been a significant source of referrals to MFCU.

Pending/open cases. MFCU is required to report the length of time cases continue to be open or pending at the end of the federal reporting period. Table E-3 shows the total number of open cases has grown since April 2008 with a slightly decrease in the most recent reporting period. The biggest change is seen in the number of cases after seven to twelve months. The open cases are aging significantly with twice as many cases over two years old in the most recent reporting period (18) compared to the nine cases reported the year before. According to MFCU's annual report, six of the cases are more than three years old.

MFCU states the open or pending cases are due to either: staff actively working on the case, the matter awaits further court action; or will proceed as the active workload allows. Four of the pending cases are contingent on a defendant's participation in a pretrial diversionary program of up to two years. Prosecution can be dismissed or reinstated depending on the defendant's failure or success. As such, MFCU labels the cases pending.

Length of Time Pending/Open	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011-March 2012
0-6 months old	11	18	17	13
7-12 months old	12	19	18	5
13-24 months old	3	19	18	21
24 months and over	19	5	9	18
TOTAL	45	61	62	57

Source: MFCU Annual Reports

Other reported measures. In addition to the data request, the program review committee examined different statutorily required OAG reports. These include: the OAG annual report, the Connecticut False Claims Act report; and the Health Care Fraud Program Report Cards submitted to the Appropriations committee. A summary of performance measures provided from these sources is presented below.

The number of claims, referrals, and complaints related to Medicaid fraud that were received by the Health Care Fraud unit within the OAG for the past three fiscal years is shown in

Table E-4. As the table shows, the number of matters received has fluctuated with a steady number of matters that remain open.

Table E-4. Medicaid Fraud Matters Received by OAG (FY10-12)			
	FY 2010	FY 2011	FY 2012
Number of claims, referrals and complaints received	65	82	44
Number of matters still open	22	23	26
Source: OAG			

The OAG provided the committee with the outcomes for Medicaid fraud matters it received since FY 2010. Table E-5 shows that in the three last fiscal years two Medicaid fraud matters ended in exclusion, five resulted in payment suspension, and five matters involved administrative or injunctive relief.

Table E-5. Outcomes of Medicaid Fraud Matters Overseen by OAG (FY10-12)			
	FY2010	FY2011	FY2012
Number of matters resulting in:			
• Exclusion	0	2	0
• Payment suspension	0	2	3
• Other administrative or injunctive relief	1	4	0
Source: OAG			

As noted earlier, the state false claims act allows the OAG to bring its own civil health care fraud cases as well as qui tam cases filed by private relators. The information presented in Table E-6 is derived from the most recent OAG reports on state false claims activity.

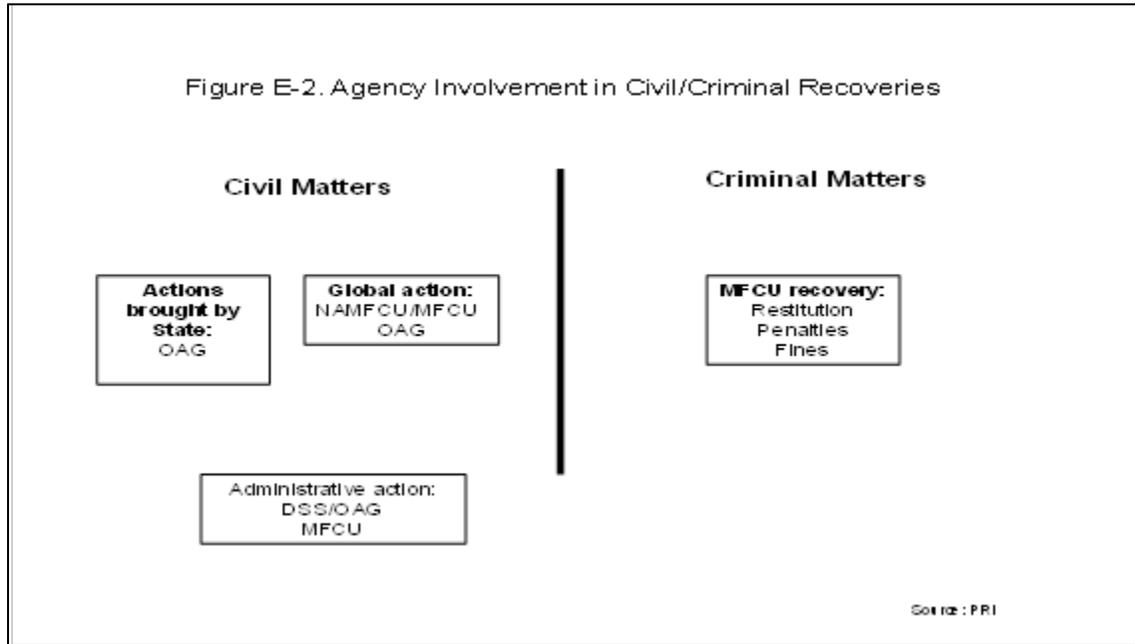
Table E-6. Summary of False Claims Act Cases (2009-2011)			
	2009	2010	2011
Pending Cases Beginning of Period	0	4	103
New Cases initiated During Period	9	84	77
Cases Closed During Period	6	11	30
Pending Cases at the End of Period	3	77	150
Source: OAG			

There has been a substantial increase in the number of cases initiated since the passage of the act in 2009. As of July 2012, the OAG reports a total of 235 claims have been filed under the False Claims Act. Fifty-three claims have been closed while 182 remain pending. These cases have been brought by private parties under the qui tam provisions of the false claims act. According to the OAG, many of these matters involve large pharmaceutical companies and are still under seal.²⁹ The OAG anticipates some of these cases may result in settlements providing revenue to the state. Others will be closed, following investigation, as lacking merit.

²⁹ Matters brought by private parties must be filed under seal and cannot be served on the alleged violator for at least 60 days, during which time the OAG must decide whether to join the case and prosecute the alleged violation.

Fraud Recovery Reports

Figure E-2 illustrates the recovery scheme for Medicaid fraud matters in Connecticut. The involvement of the OAG and MFCU in the recovery process depends on the type of matter. MFCU is responsible for state criminal recoveries including restitution, penalties and fines. For civil matters, the level of involvement of each entity depends on who brings the action.



Civil actions sought through global cases, as discussed earlier, involve the federal OIG and the NAMFCU with the cooperation of the MFCU and the participation of the OAG. Recoveries from civil actions that are brought solely by Connecticut are the jurisdiction of the OAG with acknowledgement from MFCU. Any administrative Medicaid recoupment collected by voluntary agreement is handled by DSS with the advice and counsel of the OAG and acknowledgment of MFCU.

Recoveries	FFY 2007	FFY 2008	FFY 2009	FFY 2010	FFY 2011
Criminal	n/a	n/a	n/a	\$ 1,118,665	\$258,176
Civil	n/a	n/a	n/a	\$ 15,644,279	\$45,997,855
Total	\$3,635,691	\$4,016,030	\$37,531,237	\$16,762,945	\$46,256,031

Source: OIG

MFCU recovery reports. Of the sources of data readily available to the program review committee, the MFCU reports to the federal OIG appears to provide the most comprehensive fraud recovery information. Table E-7 lists the total Connecticut recoveries as reported to the federal OIG since FY 2007. Information sorted by civil and criminal recoveries was only

available for FFYs 2010 and 2011. Recoveries are defined as the amount of money that defendants are required to pay as a result of a settlement, judgment, or pre-filing settlement in criminal and civil cases and may not reflect actual collections.

As the table shows, the amount of monies recovered can vary vastly from year to year. Connecticut has made substantially more recoveries from civil matters than criminal. This is in part due to the recoveries made via global settlements which have typically involved large pharmaceutical settlements. Further analysis of Connecticut fraud recoveries compared to other states is provided in Appendix G.

OAG recovery reports. The OAG also reports on the recoveries made on behalf of the state as part of its annual report on Connecticut False Claims Act activity. Table E-8 presents this data as reported for the last three calendar years.

Table E-8. Recoveries of Medicaid Settlements as Reported by OAG (CYs 2009-2011)				
Type	CY 2009	CY 2010	CY 2011	TOTAL
Medicaid State Share	\$5,697,506	\$7,747,824	\$4,050,275	\$17,495,605
Medicaid Federal Share	\$5,385,201	\$8,193,515	\$3,897,205	\$17,475,921
State Program Recovery DSS	\$242,000	\$2,015,218	\$990,135	\$3,247,353
TOTAL	\$11,324,707	\$17,956,557	\$8,937,615	\$38,218,879
Source: OAG Annual False Claims Reports				

According to OAG reports, the state share of Medicaid recoveries related to civil matters totaled approximately \$17.4 million between 2009 and 2011. (The Medicaid federal share was about same amount.) The OAG also recovered over \$3 million since 2009 for other health care programs administered by the state such as ConnPace. Overall, Connecticut has recovered settlements totaling more than \$38 million between 2009 and 2011.

Table E-9. Connecticut Civil Recoveries for Health Care Fraud		
Year	State Share of Amount Recovered	Total CT Medicaid
FY 10-11	\$29.1 million*	\$50.1 million
FY 09-10	\$34.3 million**	\$47.5 million
FY 08-09	\$11.4 million	\$16.8 million
FY 07-08	\$5.4 million	\$10.2 million
FY 06-07	\$6.0 million	\$8.6 million
FY 05-06	\$4.0 million	\$7.0 million
FY 04-05	\$3.4 million	\$6.7 million
Source: OAG		
* McKesson case (state share \$15 million)		
** EliLilly case (state share \$25.1 million)		

The OAG has also published recovery amounts from health care fraud settlements and judgments in its 2012 Healthcare Fraud Program Report Card to the legislature's Appropriations committee. According to the OAG, the Health Care Fraud Unit has recovered almost \$150 million over a number of years. The majority of the recoveries were based on federal and multi-state litigation and settlements. For these cases, the state and federal government share in the recovery.

As noted earlier, Connecticut enacted its False Claims Act in 2009. Prior to that, Connecticut relied primarily on the Connecticut Unfair Trade Practices Act (CUTPA). Table E-9 provides the amount of recoveries as reported by the OAG from global settlements and the state share of civil recoveries since FY 04. In particular, the most recent fiscal years include single large recovery cases. The 2012 Program Report Card issued by the OAG indicates that if those outliers are removed, the current trend is revenue remaining stable in the range of \$10 million annually. Although there is no way to predict the future frequency and magnitude of fraud-related recoveries, the OAG expects the newly enacted state False Claims Act to produce increasing revenue.

Case Review of 32 DSS Referrals

To examine the effectiveness of the state's system to combat Medicaid fraud, the program review committee intended to examine the case flow of suspected fraud matters from initial detection, investigation, and final disposition including recovery and sanctions. To do this, committee identified 32 DSS referrals of suspected fraud from FY 2009 to July 2012. While committee encountered several challenges in conducting its case file review. The results of the review are presented in this section.³⁰

Case review challenges. The purpose of the file review was to evaluate case flow efficiency and effectiveness of the overall system. In particular, PRI committee was to determine timeliness of case management within and between the agencies involved and identify whether any issues exist as cases are either passed on to each agency or when a case requires joint handling by more than one agency.

There were several limitations on the information readily available to committee. While each agency has its own internal electronic case management/tracking database, the level, type, and format of information contained in the databases varied considerably. There was no simple method to link and compare the information without requesting each agency to further supplement the electronic data or retrieve additional information from the actual case file.³¹

Case Review Profile

Program review committee examined 32 DSS referrals of suspected Medicaid fraud submitted to MFCU, OAG, and the federal OIG. The referral to the federal OIG is statutorily required, however, the PRI case file review focused solely on the state agency involvement but where OIG information was easily attainable it was used. The 32 referrals were made between 2009 and 2012. Using the data that program review committee could obtain, the referrals were examined for a number of items including type of provider involved, origin of referral, timeliness, current status/outcomes, and recoveries.

Referrals by provider type. Table F-1 shows the number of referrals each year by provider type. While there have been referrals on different provider types, personal care assistants (PCAs) were the most frequent referrals to MFCU, followed by dental providers.

³⁰ MFCU identified one additional DSS referral (#33); however, there was no available time to reconcile the information among the other agencies. Therefore, the committee staff review was based on 32 referrals.

³¹ Access to case files was stymied by unresolved confidentiality concerns, physical location of older archived cases, and staff time and resources available to review cases.

Provider Type	FY 09	FY 10	FY 11	FY 12	Total
Behavioral Health Clinician	1	1	-	1	3
Community Clinic	-	-	-	1	1
DDS Performing Provider	-	-	2	1	3
DDS Rehab Therapist	-	-	-	1	1
Dentist or Dental Group	-	1	4	4	9
Home Health Agency	-	1	-	-	1
Medical Equipment Supplier	-	1	1	-	2
Personal Care Assistant	7	2	-	-	9
Personal Care Wavier Recipient	1	-	-	-	1
Physician Group	-	-	1	-	1
Missing	-	1	-	-	1
Total	9	7	8	8	32

Source: DSS Referral Database

Referral origin. Table F-2 shows the origin of the 32 cases. The most frequent source results from complaints about a provider, followed by ad hoc reports generated by the DSS using the data warehouse. As indicated in body of this report, of the three data mining approaches (SURS/Profiler, Fraud, Abuse and Overpayment System, and ad hoc queries) used by the unit, the ad hoc reports are the most useful.

Origin	Number Received	Percent of Total
Provider	1	3%
Ad Hoc Report	7	22%
Audit	3	9%
Complaints	11	34%
DDS	6	19%
Other DSS unit	1	3%
Targeted Query	3	9%
Total	32	99% (not 100 - rounding)

Source: DSS Referral Database

Nature of allegations. Program review committee examined the nature of allegations presented in the 32 DSS referrals. Table F-3 summarizes the results. It is important to note that there may be more than one allegation of misconduct associated with a single referral. The most common allegation (47%) dealt with billing of claims. This included billing for services never rendered, duplicate billing, excessive billing, inconsistent claims, upcoding, or billing for unnecessary services. Problems with documentation were the second most common allegation (32%). Allegations in this area ranged from conflicting or forged time sheets, falsified documents, or no documentation to support claims. The third most common allegations (14%) dealt with providers who were unlicensed, excluded, or misrepresented their credentials when providing service. There were also allegations related to quality of care or financially exploiting patients.

Table F-3. Nature of Allegations for 32 DSS Referrals	
Type of Allegation	Number of Referrals (%)
Billing	27 (47%)
Problems with Documentation	18 (32%)
Quality of care	2 (4%)
Financially Exploiting Patient	2 (4%)
Excluded/Unlicensed Provider	8 (14%)
Source: OAG	

MFCU outcomes. Of the 32 referrals, there are nine cases still active at MFCU. Six cases resulted in court action with three ending in arrest and conviction. The charges in the cases include: larceny in the 1st degree, insurance fraud, identity theft, and forgery. Five of the six court cases had criminal restitution ordered ranging between \$8,527 and \$210,000. The total amount of restitution ordered for the five cases was \$402,551. To date, \$324,748 has been collected. Seventeen of the 32 DSS referrals were closed by MFCU with no arrest or further action. Fourteen of the 17 referrals were referred back to DSS by MFCU.

Returned referrals. Of the 14 referrals returned by MFCU since FY 2009, half involved personal care assistants and two involved dentists. The remaining returned referrals involved behavioral health clinicians, a rehab therapist assistant, psychiatric group and a medical physician group. The DSS referral database indicates the most common reasons reported for the cases being returned was because MFCU did not find substantial evidence to support a criminal complaint or it was too difficult to prove the provider possessed criminal intent. In addition, one referral exceeded the statute of limitations for criminal prosecution and one was returned because DSS had already recouped the improper payment.

OAG outcomes. Cases rejected for criminal prosecution by MFCU may be pursued for civil action by the OAG. Sixteen of the 32 referrals remain open at the OAG. No further civil action was taken in eleven cases because of the small likely judgment amount. The OAG recommended DSS conduct a more focused audit in one case. In another case, the referral was incorporated into a global settlement. State false claims cases were initiated in three instances.

Administrative sanctions and other action. DSS has the option to pursue administrative sanctions such as payment suspension or recoupment for the cases returned by MFCU. Table F-4 lists the additional action, if any, taken in the 14 returned referrals. In six cases, DSS did not proceed with further action. Most of those cases were in FY 2009 and all involved PCAs where a determination was made that the PCA was not informed of certain program requirements.³² The OAG followed up with civil prosecution in two of the 14 cases. DSS sought recoupment in three cases while in three other cases another state agency got involved. In five cases, the OAG provided legal counsel or assistance.

³² As a result, DSS made changes to the PCA program.

Additional Action on Returned Referrals	2009	2010	2011	2012	TOTAL
None	5	1	-	-	6
DSS recoupment	-	2*	1*	-	3
OAG pursued civil matter	-	1	1	-	2
Further action by another state agency (DDS)	-	2*	-	1	3
TOTAL	5	6	2	1	14
* OAG provided legal counsel or assistance.					
Source: DSS Referral Database					

Timeliness. The memorandum of understanding (MOU) between DSS and the three law enforcement entities (MFCU, OAG, and OIG) requires that notice be provided to all three groups giving them 60 days in which to determine whether or not they will accept a matter. Table F-5 provides the time analysis performed on the 32 referrals.

Time Between DSS Notice to Accept Date	MFCU	OAG	OIG
Less than 30 days	13	28	11
One month	0	-	7
Two months	7	2	4
Three months	8	-	-
More than 3 months	4	1	2
Accept Date Missing	-	1	8
Source: PRI analysis			

As the table shows, the vast majority of referrals are accepted within the 60-day period. Almost all of the DSS referrals were accepted by OAG in less than a month. Approximately a third of the cases are accepted within a month of referral by MFCU. Eight referrals accepted by MFCU were just a few days beyond the 60-day timeframe and four referrals were accepted after more than three months. The OAG accepted one case after three months while the OIG had two matters for longer than three months. There were no OIG accept dates recorded for eight matters.

Program review committee also examined the length of time from when the agency accepted the case and finally closed it. The results of the closed cases are presented in Table F-6. MFCU had 11 cases that took less than 12 months but a majority of its cases lasted longer than a year with three cases closing more than two years later. The OAG closed most of its cases after

two years with only three cases closed in less time. On average, the OAG cases were active approximately three years. Seven cases referred to the OIG were closed within 12 months; while another seven lasted over a year with two cases closed after more than two years.

Table F-6. Time Between Agency Accept Date to Close Date			
Time B/w Accept Date to Close Date	MFCU (N=22)	OAG (N=15)	OIG (N=14)
Less than 12 months	11	2	7
12 to 23 months	8	1	5
24 months and over	3	12	2
AVERAGE	11	37	11
Source: PRI Analysis			

Committee research did not find any specific best practice information related to fraud and abuse investigation timeliness. Performance standards established by federal OIG, which were updated in June 2012, indicate only that fraud investigations should be completed in an appropriate timeframe based on the complexity of the cases.

Appendix G

MFCU State Comparisons

This discussion focuses on the activities of Connecticut's Medicaid Fraud Control Unit (MFCU) within the Office of the Chief State's Attorney (OCSA). In particular, it examines the number of fraud matters investigated, convictions, amounts recovered and compares it to MFCUs in other states. Overall, Connecticut's MFCU compares favorably with other MFCUs responsible for similar sized Medicaid budgets.

Comparison States

For comparison purposes, the program review committee selected five states closest to Connecticut's Medicaid budget funding. These states were chosen because their similarly sized Medicaid budget represents similar level of exposure to fraud. Table G-1 provides each state's annual Medicaid budgets for FY 2011. As the table shows, Connecticut's Medicaid budget falls in the middle of the range. With the exception of Louisiana, the selected states receive between \$1 million and \$2 million dollars in federal funding. In addition, the number of staff, as reported in FY 2011, ranges from eight to 51.

It is important to note that unlike the majority of other states, Connecticut's authority over civil and criminal matters is separated into the Office of the Attorney General and Office of the Chief State's Attorney respectively. As such, Connecticut's MFCU does not have prosecuting authority over civil matters, which are handled by OAG staff.

Table G-1. State Comparison of Medicaid Expenditures and Federal Grant for MFCUs

State	FY 2011 Medicaid Expenditure	FY 2011 MFCU Grant	FY 2011 MFCU Staff
AL	\$5,014,342,056	\$1,005,505	8
SC	\$5,086,419,319	\$1,313,573	16
KY	\$5,853,031,358	\$2,530,903	27
CT	\$5,999,527,969	\$1,175,450	8*
WA	\$6,146,426,452	\$2,617,429	22
LA	\$6,588,249,693	\$4,752,048	51

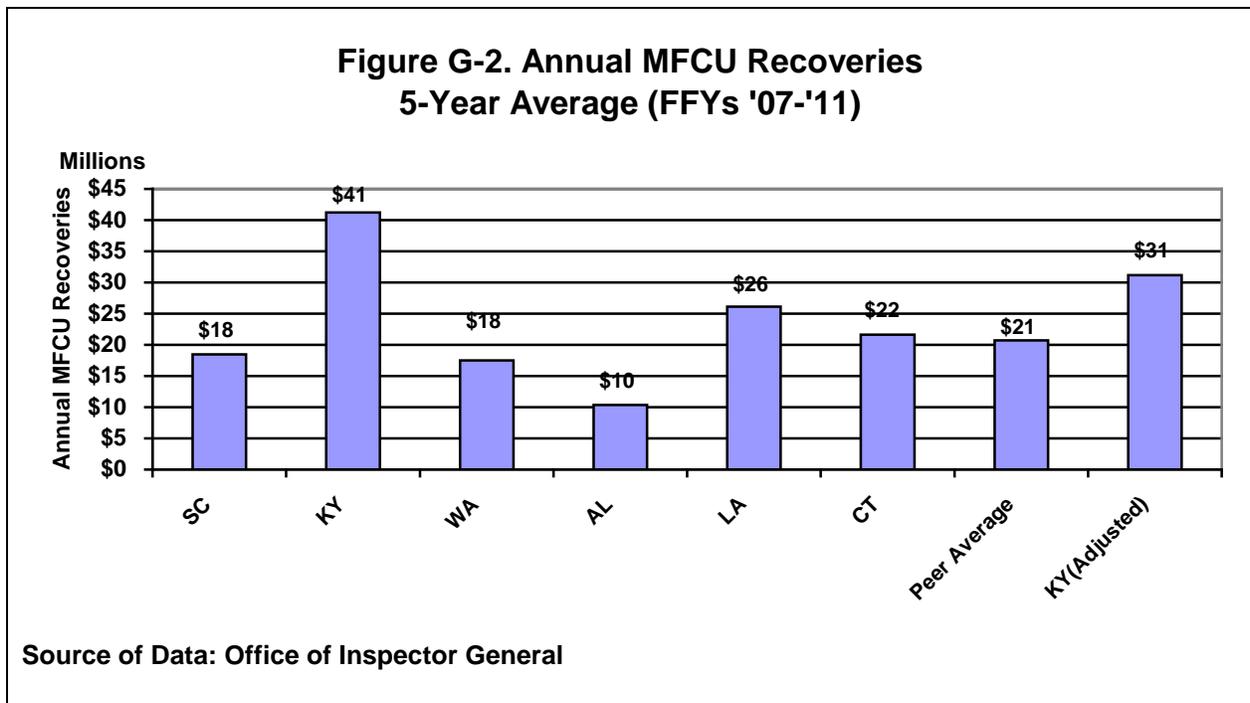
Source of Data: Office of Inspector General

The program review committee was able to collect certain information for a five-year period (federal fiscal years 2007-2011) for each of the comparison states but some of the more detailed information was only available for FFYs 2010 and 2011. Due to the limited availability of other states' data, PRI committee had to conduct analysis on different periods of time. For example, data was available regarding total reported recoveries for each state going back to 2007; however, a breakdown of criminal versus civil recoveries is only available for the last two fiscal years.

Fraud Recoveries

Compared to its peers, Connecticut's total recoveries of fraudulent payments are slightly higher than average. The Connecticut civil recoveries are mainly the result of successful litigation against the pharmaceutical industry. Monies coming from criminal fraud cases which usually involve local providers seem comparatively less substantial.

Figure G-2 illustrates the five-year average of annual recoveries by Connecticut's MFCU and the selected comparative states. As the figure shows, the peer average for the five-year period is \$21 million. Connecticut's average recovery for the same period is slightly higher at \$22 million. It should be noted that Kentucky had an extraordinary recovery one year of \$81 million which accounts for its significantly higher average. Even by removing the outlier year (shown in the adjusted bar at the far right of the graph), Kentucky's average recoveries are still higher than its peer group.



The program review committee acknowledges each state may experience different types of fraud matters which may impact the amount of recovery. In addition, resolution of cases and timing of recoveries do not occur on predictable annual cycles. Nevertheless, the PRI committee believes that examining recoveries over a five-year period may provide a reasonable comparison period.³³

³³ In 2012, the Utah Office of Legislative Auditor General conducted a similar analysis of Utah's MFCU and comparable states.

More detailed data was available for two recent fiscal years allowing the program review committee to examine the level of civil and criminal recoveries. Table G-2 presents the data results for the selected comparison states.

Table G-2. State Comparison of Civil and Criminal Recoveries (FY 2010-2011)

STATE	Civil Recoveries (MILLIONS)		Criminal Recoveries		Total Recoveries (MILLIONS)	
	FY 2010	FY 2011	FY 2010	FY 2011	FY 2010	FY 2011
AL	\$12.9	\$23.3	\$24,352	\$1.1 million	\$12.9	\$24.4
SC	\$26.5	\$18.4	\$3.7 million	\$1.1 million	\$30.3	\$19.6
KY	\$66	\$81.3	\$249,449	\$48,173	\$66.2	\$81.4
CT	\$15.6	\$45.9	\$1.1 million	\$258,176	\$16.7	\$46.2
WA	\$26.3	\$18.9	\$83,787	\$548,579	\$26.4	\$19.4
LA	\$52.6	\$20.5	\$4.9 million	\$5.7 million	\$57.6	\$26.3

Source of Data: OIG

Connecticut's total recoveries were the second lowest in FY10 and second highest in FY11. As the data demonstrates, the amount of civil and criminal recoveries may vary significantly from year to year. In general, civil recoveries for all the selected states have totaled in the millions while criminal recoveries are much more inconsistent. Connecticut had the second lowest civil recoveries in FY10 but then was second highest in FY11. Conversely, Connecticut's criminal recoveries were third highest in FY10 and second lowest in FY11. Connecticut's fluctuation in the amount recovered appears to be typical of the comparative states.

Fraud Investigations. Table G-3 summarizes two years of MFCU fraud activity for Connecticut and the selected comparison states as reported to the federal Office of Inspector General. As a purely numerical indicator, Connecticut has the second lowest number of fraud investigations reported; however, it is impossible to account for the level of complexity of cases presented without more information. Given the reported staffing levels, the number of Connecticut fraud investigations seems reasonable and comparable to most of the other states.

Table G-3. State Comparison of Fraud Investigations (FY 2010 and FY 2011)

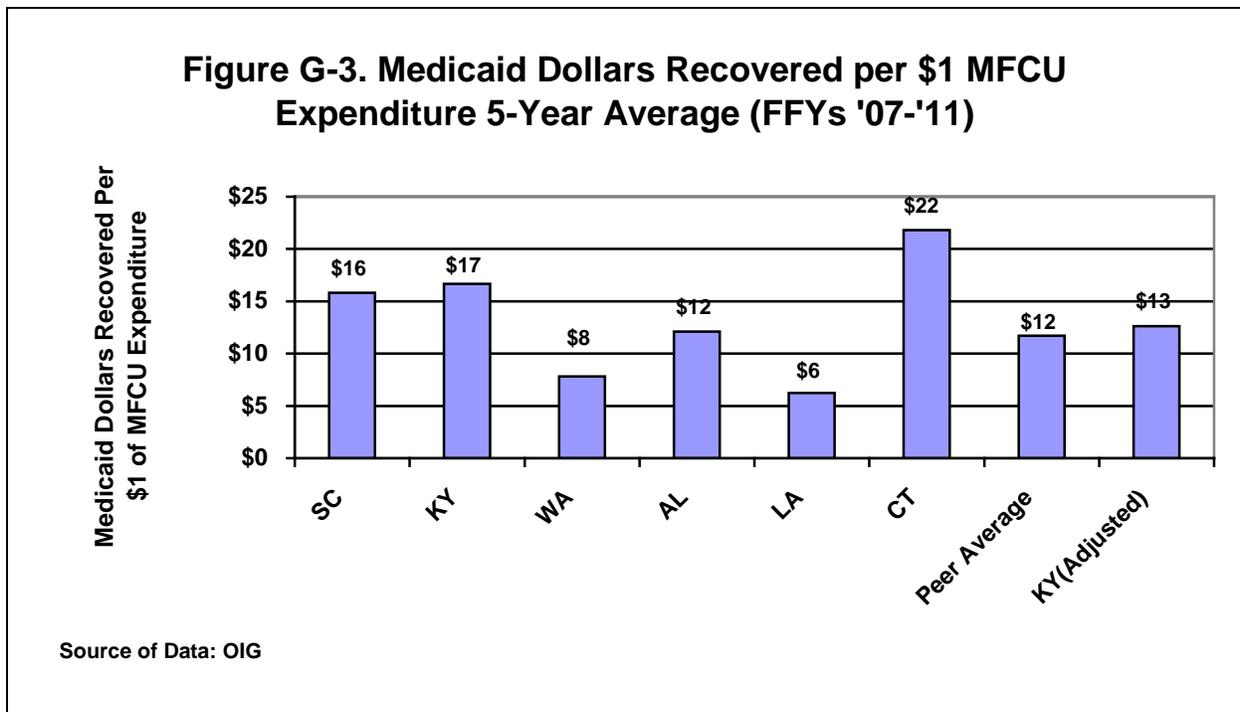
MFCU	STAFF LEVEL	2 YR TOTAL Fraud Investigations	Number of Fraud Investigations Per Staff	2 YR TOTAL Indicted/Charged w/ Fraud	2 YR TOTAL Convicted of Fraud
CT	8	106	13	18	15
SC	16	263	16	18	16
KY	27	212	8	7	5
WA	22	516	23	15	15
AL	8	24	3	4	5
LA	51	564	11	235	87

Source of Data: OIG

Return on Investment (ROI)

Connecticut has the highest return per dollar spent on state MFCUs, relative to the selected comparison states. Using the methodology of the Utah study, return was measured as each MFCU's average annual recoveries divided by each unit's average annual expenditures.³⁴ PRI committee used the five-year, federal fiscal year 2007-2011 period for this comparison as well.

As Figure G-3 illustrates, Connecticut's ROI (\$22) is significantly higher than the peer average (\$12). Even when adjusting for Kentucky's substantial total recoveries in 2010 (shown in last bar), Connecticut is considerably higher. Connecticut MFCU's smaller staff size together with slightly higher than average recoveries appears to drive Connecticut's greater return per dollar invested.



It bears noting again that unlike other states where MFCUs have jurisdiction over both criminal and civil matters, Connecticut MFCU does not have prosecuting authority over civil matters which are under the jurisdiction of the OAG. As described throughout this report, the OAG staff participates in civil recoveries and global settlements. It is likely that Connecticut's ROI would be lower if the OAG's involvement and resources are taken into consideration. Given the staffing and budgetary structure of the OAG's Health Care Fraud Unit, the OAG staff resources and expenditures could not be accounted for in the ROI analysis. Interviews with DSS staff also suggest they may get involved in data preparation for global matters.

³⁴ Performance Audit of the Medicaid Fraud Control Unit (August 2012), Utah Office of Legislative Auditor General, page 6

Appendix H:

Agency Response



RODERICK L. BREMBY
Commissioner

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February 7, 2013

Ms. Carrie Vibert, Director
Legislative Program Review and Investigations Committee
State Capitol, Room 506
Hartford, CT 06106

Dear Ms. Vibert,

Thank you for the opportunity to comment on the Legislative Program Review and Investigations Committee's report entitled *Medicaid: Improper Payments*. We welcome this review of our program integrity efforts as we believe that any third party review is beneficial to the Department of Social Services (DSS) and our partners.

We feel the report, to a large extent, identifies the strengths and weaknesses of our existing capabilities in the DSS Office of Quality Assurance (OQA). The report presents five goals that the recommendations are intended to achieve:

- Better support providers' ability to avoid improper payments.
- Improve DSS tools to avoid and detect improper payments.
- Strengthen DSS management and oversight.
- Explore opportunities to increase recovery of improper payments.
- Improve interagency collaboration and communication.

These goals are completely in line with the goals of the OQA and in fact, we believe that the goals as presented reflect the many months of discussions and interviews with DSS OQA staff, who shared and expressed these very same goals throughout the process.

For instance, the department has increased our efforts to improve communication with providers, as we recognize the benefits to all when the provider community is better educated and informed about department processes and protocols. Furthermore, the department is actively taking steps to improve our fraud detection systems and is currently exploring options for updated technologies including predictive analytics and data mining.

Because we understand the need for strong management and oversight we are drafting procedures and regulations and improving our case tracking systems. In addition, our audit sampling methodologies are currently under review to determine whether new methodologies should be adopted.

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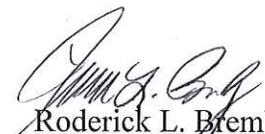
Ms. Carrie Vibert, Director
February 7, 2013
Page 2

We are continuously exploring means to increase recoveries and in fact, in the 2012 legislative session, DSS proposed and the legislature passed a bill that enhanced our ability to pursue third-party claims and we have just contracted an expansion of our vendor's review of third-party denials. Finally, we welcome all efforts to improve interagency collaboration as a way to strengthen all of our efforts, and hope that our partners share this goal.

In the document attached, we address each of the committee's recommendations that pertain to DSS.

We thank you for your comprehensive review and thoughtful recommendations on this important and timely topic. It was a pleasure to work with your professional and accommodating staff and we look forward to our continued work together toward our common goals.

Sincerely,



Roderick L. Bremby
Commissioner

Committee Recommendations

Section II: Prepayment

1. Based on the state Medicaid plan submitted to the Centers for Medicare and Medicaid Services, the Office of Quality Assurance within the Department of Social Services should identify each provider screening and enrollment requirement and identify how it will be met. In addition, the department should evaluate if the staff resources needed to meet the new requirements are adequate.

The department is in the process of implementing measures to comply with the enrollment requirements of the Affordable Care Act. A work plan has been submitted to the Centers for Medicare and Medicaid Services (CMS) and we are moving forward with the plan. We are awaiting specific guidance from CMS with regard to the requirement to fingerprint high risk providers.

2. At the time providers must re-enroll in the Medicaid program, an optional survey should be included in the on-line application packet. The survey should solicit provider input on the various activities performed by the current vendor on behalf of the Department of Social Services so that the vendor can improve its operations and be more responsive to providers' needs. In addition, the results of the survey should be shared with the Office of Quality Assurance so it can also assess HP performance.

The current contract with HP requires that they conduct provider surveys on an annual basis. The department will evaluate the findings of the survey and determine if enhancements are necessary.

DSS should compile audit findings into a single database and identify the top ten most common audit findings by provider type. This information should be distributed to provider associations so that they may educate their members and also posted on the DSS website under a provider education tab.

These recommendations require the dedication of resources in several areas of the department. We will evaluate this recommendation further to determine if resources are available. We wish to note that the Department has periodically provided the most common audit findings to provider associations upon their request. In addition, we have participated in several seminars with large provider associations to discuss this specific issue.

3. DSS should also include on its website for providers links to other government and national organizations that are concerned with Medicaid program integrity and offer educational materials on this topic to provider's knowledge.

The department will evaluate the feasibility of implementing this recommendation.

4. The Department of Social Services: 1) develop a method to determine the effectiveness of the current claims processing system in identifying improper payments and avoiding unnecessary costs; 2) assess current claims routines used to capture improper payments and ensure they are updated; and 3) assess if and how the use of prepayment analytics and reviews could strengthen prevention efforts. This assessment should contain a return on investment determination that compares the additional resources necessary to perform these activities, and the extent to which enhanced federal participation (90 percent reimbursement) would be available to reduce state costs.

The department's InterChange system is its certified system to process Medicaid payments. There are multiple "edits" built into this system that prevent inappropriate claims from being paid. The audit and claims analysis functions performed by the Office of Quality Assurance (OQA) have identified system edits that were not performing as intended. This ongoing and evolving process constitutes the recommended "method" to determine the effectiveness of the claims processing system. In addition, the department continually reviews and updates the logic in InterChange.

The reference to prepayment analytics is captured in the Department's response to recommendation #13.

Section III: Post-Payment

5. The Department of Social Services completed the development of policies and procedures that include all aspects of the program integrity program within the next 18 months.

The department does not agree that all aspects of the program integrity functions need to be supported by additional written policies and procedures. For example, the extensive Third Party Liability (TPL) recovery functions are explicitly documented in the contract with HMS, our TPL vendor. However, the department does acknowledge the need for improved documentation of certain procedures and we are currently in the process of finalizing a manual to address those procedures we have identified. We anticipate this to be complete within the next six months.

6. The Department of Social Services design and implement a uniform, automated case management and information system that captures essential case information and results in the production of valid and reliable data.

The recommendation for a uniform case management system does not recognize that the multiple program integrity functions are individually unique and because of this a "one size fits all" case management system is not feasible. The department agrees that current case management reporting tools need to be

improved and the necessary steps to implement improved case management systems are underway.

7. The Department of Social Service should develop and track performance measures to ensure the work of the OQA is performed according to statutory timeframes, ensures that staff is optimally deployed and productive, contains all the required fields required by federal regulation, tracks estimated and actual recoupments received, and indicates when a case is closed once all the dollars are recouped.

The department assumes that the statutory reference is C.G.S. §17b-99. The department currently complies with all aspects of this statute but agrees that an enhanced case management system will improve the ability to monitor continued compliance. Evaluation and monitoring of staff performance is always a key performance requirement of management. The department does not understand the reference to “required fields required by federal regulation” and therefore does not offer comment. OQA is not responsible for the collection of identified overpayments. This is a very important segregation of responsibilities to ensure proper internal controls on the collection of funds. As such, in regards to the OQA, a case is deemed to be closed when the audit process is finalized.

8. The Department of Social Services develop a more formal risk-based audit planning process that identifies, measures, and prioritizes risks posed by different provider types and providers to establish which will be reviewed on an annual basis.

This approach should include a variety of factors that define the potential risk providers may pose and should include but not be limited to the size of the provider-type, the total monetary reimbursements for that provider type, average value per claim, extent of specialization, level of claims processing sophistication, history of fraud, experience of management, and any other elements that are related to the risk of improper payments being submitted.

As referenced above, the department has historically utilized risk-based audit planning. The combination of claims analysis, industry knowledge and provider history all play a role in the selection of a provider for review or audit. The recommendations reflect current practices.

9. The Department of Social Services should develop an audit guide book with accompanying protocols to assist providers in complying with Medicaid program requirements and prevent improper payments.

The guide book should provide more detail than the requirements in regulation and include, but not be limited to, the department's expectations of providers during an audit, how an audit will be conducted, how the sampling and extrapolation processes are implemented, the expected timeframes for DSS to complete each phase of the audit, the exit conference process, and how the appeal process works.

The protocols should contain information by provider type that describes DSS' application of articulated Medicaid agency policy and assist the Medicaid provider community in determining if they are in compliance with Medicaid requirements under federal and state statutory and regulatory law. The protocols should be phased in over a five-year period.

The department is in the process of finalizing the audit regulation that is required by C.G.S. §17b-99. We anticipate that the regulation will provide a comprehensive overview of the audit process. The vast majority of the published information that the department relies on to evaluate compliance during the audit process is currently available to all providers on the HP website www.ctdssmap.com. The resources that will be required to develop the recommended guidebooks would be better applied to the identification of Medicaid overpayments.

10. The Department of Social Services should have its overall sampling and extrapolation methodologies reviewed by a statistician to ensure that statistically valid methods are used to draw samples and for projecting overpayments.

While the department is confident in the statistical methods we currently use in the audit process, which have been determined to be sound by a statistician at CMS, we recognize the importance of third-party review. As such, our sampling methodologies are currently under review.

11. The department of Social Services should evaluate the potential to expand its audit program. It should estimate the potential for improper payments through a risk-based analysis. This assessment should contain a return-on-investment determination that compares the additional resources (both in-house and private contractor) necessary to perform these activities to its potential benefits.

The department has recently expanded its audit program to include the services of a Recovery Audit Contractor (RAC) as required by the Affordable Care Act. The proper coordination of these additional audit activities continues to be evaluated and adjusted. However, initial results indicate that this will be a successful expansion of the audit function. Regarding risk-based analysis, it has been previously stated that risk-based analysis is used in the audit selection process and this also applies to the selection of the RAC audit targets.

12. The Department of Social Services should explore software in use in other states to identify those states with the best data mining results and determine the reasons why their data mining functions yields better results. Based on this information, DSS should issue an RFP to either purchase state-of-the-art data mining software or contract out this function to an entity that specializes in this area. The goal should be better targeting of providers engaging in potentially abusive and/or fraudulent

practices and therefore, identify more improper Medicaid payments for recovery. If the department contracts for this function and potentially fraudulent or abusive practices are discovered by the contractor, the Office of Quality Assurance should conduct an investigation to determine if the provider should be referred to the Medicaid Fraud Control Unit.

The department is extremely interested in developing a state-of-the-art fraud, waste and abuse detection system. The potential to incorporate predictive analytics to prevent the payment of an improper claim is not only an attractive feature of available systems, but a much needed feature to help reduce the payment of improper claims. We are currently exploring several technological options in this area.

Section IV: Third Party Liability

13. The Third Party Liability Unit within the Office of Quality Assurance undertake a review of the reasons for TPL denials to determine if program or system changes could be implemented that would allow for a greater percentage of denied claims to be re-submitted by HMS to the responsible third party and therefore, increase Medicaid recoveries.

The department and our vendor, HMS, have performed a review of TPL denials and as a result, a contract amendment has been proposed to increase the recovery of denied claims.

The Third Party Liability Unit within the Office of Quality Assurance should complete an analysis of the recovery of Medicaid dollars through third-party liability to determine if procedures used for recovery maximize collection efforts. If deficiencies are found in those procedures, the office should develop strategies to address any gaps.

The department agrees with this recommendation.

HMS should report to DSS, on a monthly basis, the status of the number and dollar amount of claims: selected for recovery; billed; paid; denied; resubmitted; and outstanding. Such reported statistics could be analyzed by the unit for the purposes of establishing benchmarks to compare HMS performance overall and from year-to-year.

The department acknowledges that this data and information is currently available. Appropriate steps will be taken to analyze the available data in an effort to enhance recoveries.

Based on the information provided by HMS, DSS should continuously analyze the success of the Third Party Liability Program by examining all claims billed in one

year and the amount collected in that year and future years to determine the actual collection rate.

The department agrees with this recommendation

15. The Third Party Liability Unit within the Office of Quality Assurance should identify and evaluate the outcomes of CMA efforts based on the number and dollar amount of Medicare claims appealed and the number and amount recovered for those claims. If the office determines that the total amount recovered through the Medicare appeal process exceeds the Department of Social Services cost of the contract, it should consider expanding the number of claims it allows the contractor to appeal. Furthermore, when the contract is rebid in 2017, the department should consider reimbursing the contractor on a contingency fee basis rather than a per-case fee.

The department plans on performing a thorough evaluation of the CMA contract which will include the actual return on investment. It is anticipated that the review will result in a change to the scope of services.

Section V: Interagency Collaboration

16. The OAG staff should be included in any cross-training sessions on Medicaid fraud offered by DSS or MFCU.

The department has a close working relationship with the OAG and does not understand the basis for this recommendation. As the department can speak only on its own behalf, cross-training offered by the MFCU cannot be addressed.

17. MFCU should provide written notice to DSS explaining the specific reasons for declining or not prosecuting a Medicaid referral.

The department would welcome enhanced notification by the MFCU.

18. DSS should comply with the provisions of C.G.S. §17b-99(c) to notify the proper professional society and licensing agency of any program violations. The Department of Public Health shall directly notify the Office of Quality Assurance within DSS of enforcement actions against providers.

The department agrees with this recommendation and will ensure future compliance.

19. A final accounting of identified, ordered, collected and outstanding recoveries should be part of the joint annual report.

The department will address this recommendation in its response to the next item.

20. Beginning January 1, 2014 and annually thereafter, a joint report shall be prepared by the Department of Social Services, as the lead Medicaid agency, in consultation with

the Office of the Attorney General, and the Medicaid Fraud Control Unit, documenting the effectiveness of the state's efforts to control Medicaid fraud, abuse, or errors and to recover Medicaid overpayments during the previous fiscal year. At a minimum, the report shall contain the following on:

DSS Audits-

- Number of audits completed by provider type
- Amount of overpayments identified due to audits
- Amount of avoided costs identified due to audits
- Amount of overpayments recovered due to audits
- Number of audits resulting in referral to MFCU

DSS Investigations-

- Number of complaints received, source and reason
- Number of investigations completed by source (e.g., complaints, data mining, etc.), provider type, and outcomes (e.g., closed - no recoupment, closed- recoupment, open, referred to law enforcement, other)
- Amount of overpayments identified due to investigations
- Amount of overpayments collected due to investigations
- Number of investigations resulting in a referral to MFCU
- Number of investigations resulting in payment suspension by provider type
- Number of investigations resulting in provider exclusion by provider type

Third Party Liability-

- Total claims selected for billing by commercial health insurance and Medicare
- Total amount billed for those claims
- Total claims reimbursement
- Total amount collected
- Total amount cost avoided in the future because DDS client file updated with third party insurance information

MFCU and OAG fraud investigations-

- Number of cases opened and investigated each year
- Source or origin of the cases opened
- Summary of the types of allegations by provider type

- Breakdown of reasons for not accepting referrals
- Number and disposition of the cases closed each year
- Length of time between cases opened and closed
- Recovery from MFCU criminal investigations
- Recoveries from settlements or judgments
- Civil monetary penalties

Recovery amounts from-

- Data mining activities
- CMS Medicaid Integrity Contractor
- Recovery Audit Contractor
- Other recovery contractors

The report shall also document new initiatives taken to prevent overpayments and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment.

Each agency must develop detailed unit-specific performance standards, benchmarks and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year. The report shall be submitted to General Assembly as well as the Human Services committee and Appropriations committee.

As a general premise, the department agrees that annual reporting of program's efforts will benefit the various parties associated with or impacted by the program integrity efforts. However, enhancing the ability to accurately report program integrity activity efforts must first be taken before this measure should be implemented.

The department does not agree that an annual report is an appropriate medium to make policy recommendations. State agencies have processes for policy development and typically policy recommendations would not be made in an annual report.

21. DSS, OAG, and MFCU shall establish routine monitoring and evaluation processes to ensure the Medicaid partners receive regular and relevant information regarding the impact of their efforts.

The department believes that all of the information that it maintains relative to cases involving the OAG and/or the MCFU is readily available to each of our partners.