



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 spilt 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 Basic tools for management oversight are limited, outdated, or lacking.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.