



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's Office of Quality Assurance (OQA).

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 staff has conducted numerous interviews with different state and federal agencies in addition to state contractors and provider groups. Staff is working with several entities to collect, reconcile, and aggregate data among the various sources.

How an Improper Medicaid Payment Can be Avoided by DSS

Pre-payment activities by DSS are intended to prevent improper Medicaid payments, and include:

- *Provider enrollment/re-enrollment.* Providers are screened for enrollment and re-enrollment in the Medicaid program per federal law to ensure only qualified providers receive Medicaid reimbursement.
- *Provider education.* The enrollment contractor is required to: offer provider education about the complexities of Medicaid billing policies, procedures, and appropriate coding of claims; and operate a provider relations center.
- *Claims rejection.* Each claim is submitted to a series of automated system checks that rejects claims that contain incomplete, inaccurate, or conflicting information.

How a Medicaid Claim Can be Reviewed After Payment is Made

Post-payment review processes examine the accuracy of payments that have already been made to providers. Claims can be reviewed after payment through:

- *Audits.* Four different entities conduct Medicaid provider audits for, by, or in consultation with DSS. In FY 12, most audits were conducted by DSS (86) and a LTC cost report auditor (78). Combined they identified about \$19 million in overpayments.
- *Error estimates.* CMS found in 2009 that Connecticut had an overall error rate of 2.8 percent, which was much lower than the national average of 8.98 percent.
- *Investigations.* Most fraud and/or abuse investigations initiated by DSS are the result of complaints received through its fraud hotline and e-mails alleging provider misconduct. In FY 10, DSS received 124 complaints, conducted 122 preliminary reviews, of which 12 led to a full review. Seven cases were referred to MFCU.
- *Third-party liability.* Because Medicaid is the payer of last resort, DSS uses two contractors to collect payments made in error for clients who have commercial health insurance and Medicare. In FY 12, they collected about \$44 million.

What Happens When Medicaid Fraud is Suspected

DSS must make a fraud referral to MFCU, OAG, and OIG. Each agency will review the referral and investigate for its own pertinent issues.

- The number of DSS referrals has remained stable for the past three fiscal years.
- Sanctions may include criminal convictions, arrests, program exclusions, payment suspensions, and administrative or injunctive relief.
- In FY 11, \$50.1 million was recovered with the state share of \$29.1 million. The majority of recoveries are made via global settlements which have typically involved large pharmaceutical settlements.

Next Steps

PRI staff will continue to compile and analyze data regarding the number of audits and investigations of improper payments, the amount of funds recovered, and identify coordination efforts between DSS and other state and federal agencies.

List of Acronyms

CMS	Centers for Medicare and Medicaid
DSS	Department of Social Services
HMS	Health Management Systems
HP	Hewlett-Packard
LTC	Long-term care
MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
NAMFCU	National Association of Medicaid Fraud Control Units
OAG	Office of the Attorney General
OIG	Office of the Inspector General
OQA	Office of Quality Assurance

Pre-Payment Review: How an Improper Medicaid Payment Can be Avoided by DSS

Provider Enrollment/Re-enrollment	Provider Education	Medicaid Management Information System (MMIS)
<p>Performed by DSS and Contractor</p> <ul style="list-style-type: none"> • Online Application <ul style="list-style-type: none"> • Required for Medicaid reimbursement • Based on provider type • Required disclosures • Vetted by HP (contractor) • Final check by DSS • 37,700 providers in FY 12 <ul style="list-style-type: none"> • 5,427 new applications/2,578 re-enrollments processed <ul style="list-style-type: none"> • 156 denied <ul style="list-style-type: none"> • 26 appealed • 17 overturned 	<p>Provided by DSS and Contractor</p> <ul style="list-style-type: none"> • HP offers online education for new providers and on-site refresher courses (scheduled Sept. and Oct. 2012) • DSS sends out bulletins for policy changes related to billing and MMIS changes • OQA offers one-on-one education following provider audits to prevent future improper payments • Some provider associations may target specific issues or billing areas 	<p>Designed and Maintained by Contractor</p> <ul style="list-style-type: none"> • Over 33 million claims submitted FY 11 • Claims processing - almost 900 system checks of submitted claims: <ul style="list-style-type: none"> • missing information • duplicate claims • benefit levels reached • medically unlikely claims • conflicts between two or more procedure codes • HP operates provider relations program/help line for claims-related questions • MMIS generates management reports for use by DSS

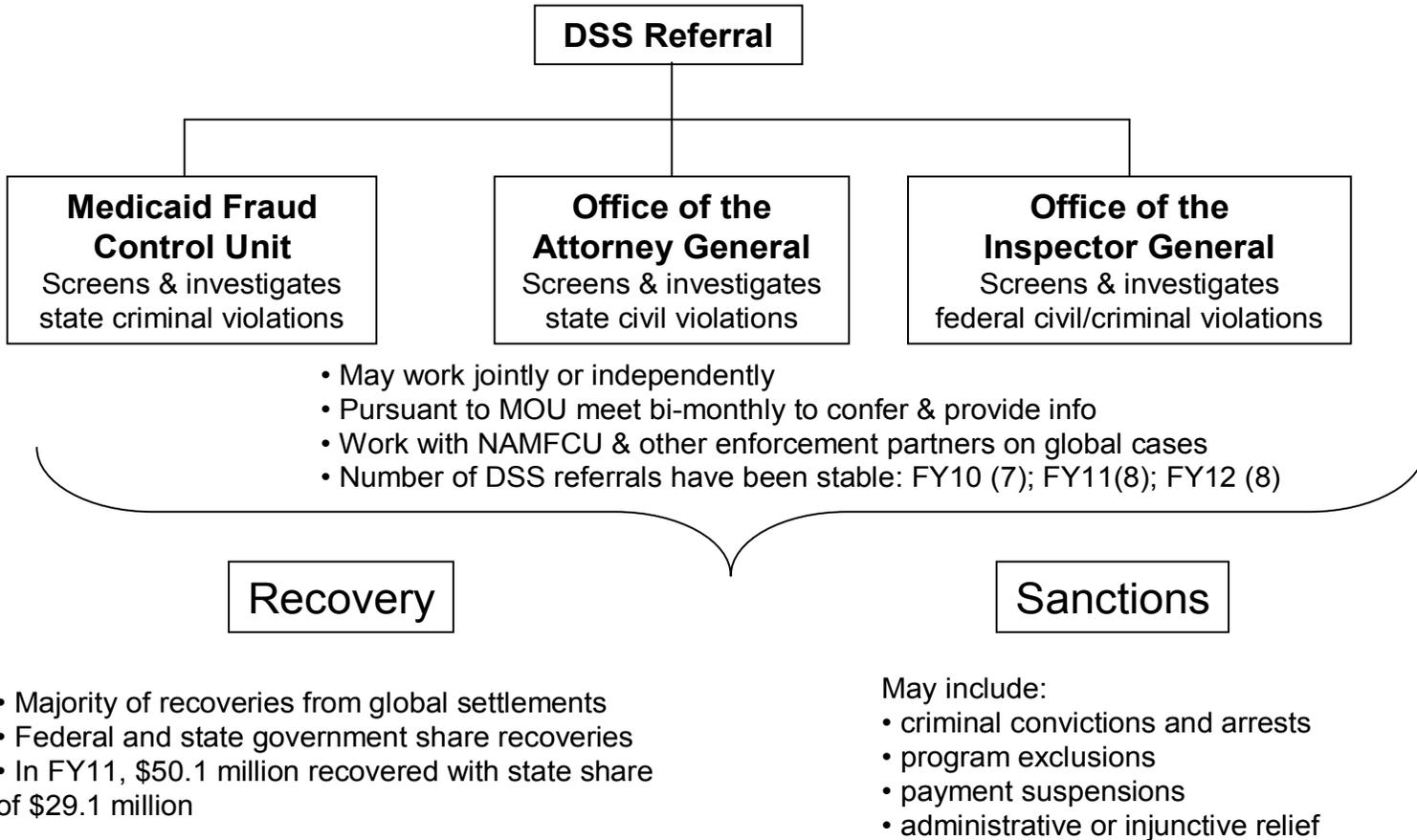
Source of Data: DSS

Post-Payment Review: How a Medicaid Claim Can be Reviewed After Payment is Made

Audits	Payment Error Rate Measurement Review	DSS Special Investigations Unit (created in FY 10)	Third Party Liability Collection
<p>Four entities perform audits</p> <ol style="list-style-type: none"> 1. DSS <ul style="list-style-type: none"> •86 audits •\$13.5 million FY 12 2. Cost Report Auditor <ul style="list-style-type: none"> •DSS contractor •LTC cost report audit •78 audits •\$5.8 million FY12 3. Recovery Audit Contractor <ul style="list-style-type: none"> •New federal requirement •DSS contractor - HMS •Contingency basis 4. Medicaid Integrity Contractor <ul style="list-style-type: none"> •2006 Federal requirement •CMS contractor •20 audits, 8 no findings •Draft findings only •Not successful nationally 	<p>CMS requirement</p> <ul style="list-style-type: none"> •Measure of error rate • Connecticut's 2009 rate <ul style="list-style-type: none"> •2.8 % Overall •1.5 % Fee for service •0.1% Managed care •1.5 % Eligibility •National error rate 8.98% •DSS reimburses CMS for errors 	<p><i>Data Mining:</i> software that identifies unusual claim patterns that warrant further investigation</p> <p><i>Audits:</i> When fraud is suspected</p> <p><i>Complaints:</i> •Fraud Hotline(187) •E-mail •Providers •DSS/Contractors •Other</p> <p><i>Other Agency Referral to or Consultation with DSS</i></p>	<p>Two contractors collect payments from other liable health insurers</p> <ol style="list-style-type: none"> 1. HMS <ul style="list-style-type: none"> •DSS Contractor •Matches with 400+ insurance companies •\$41 Million in FY12 2. Center for Medicare Advocacy <ul style="list-style-type: none"> •DSS Contractor •Focus on Medicare appeals for nursing homes, home health, and chronic disease hospitals •\$3 million FY 2011

Source of Data: DSS

What Happens When Medicaid Fraud is Suspected?



Source of Data: MFCU, OAG, DSS, OIG