COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 29, 2013

MEMORANDUM

TO: The Honorable Walter A. Stosch
Chairman, Senate Finance Committee

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones

SUBJECT: 2012 Recommendations to Strengthen the Prevention, Detection, and Prosecution of Medicaid Fraud and Abuse

The 2012 Appropriation Act, Item 307 VVV, directed the Director of the Department of Medical Assistance Services, in consultation with the Secretary of Health and Human Resources and the Director of the Medicaid Fraud Control Unit within the Office of the Attorney General, to develop a report containing recommendations to strengthen the prevention, detection, and prosecution of Medicaid fraud and abuse committed by recipients and service providers. The report shall provide estimates of the cost of implementing any new strategies to reduce and prevent Medicaid fraud and abuse as well as the potential cost savings that might be achieved. Specific consideration shall be given to enhancing the Commonwealth's ability, within federal law, of excluding or removing providers that are determined to pose a threat to the health and safety of recipients and/or to the fiscal integrity of the program. Attached is the required report which was due by December 1, 2012.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Ensuring Proper Payments Virginia Medicaid

Program Integrity Activities

DMAS Program Integrity Activities

- Recipient Auditing
- Prepayment
  - Provider Enrollment
  - Claims Processing
  - Service Authorizations
- Post payment
  - Audits – DMAS Staff & Contractors
- Fraud
- Contract Compliance Unit
- Program Integrity Initiatives
  - Recovery Audit Contract
  - Data Mining
  - Managed Care Program Integrity
  - Service Facilitator Qualifications

Recipient Auditing

- The Recipient Audit Unit (RAU) conducts investigations of recipient fraud/abuse regarding referrals received for all Medicaid groups, FAMIS and FAMIS Plus.
- In FY 2012, DMAS' RAU received 1,815 referrals and completed 1,953 investigations, with the average investigator completing about 200 investigations in a year.
  - 19 individuals were convicted of fraud in FY 2012, ordered to pay $168,041 in restitution, and banned from the Medicaid program for one year.
- A substantial number of RAU referrals are related to DSS eligibility determination errors. (312 investigations in FY 2012)

Activity	FY 2012
Investigations Processed	1,953
Overpayment Identified for Recovery	$3,085,110
Criminal Fraud Referrals	28
Fraud Referral Amount	$189,922

Recipient Auditing

- As a result of expenditure analysis on claims billed for Consumer Directed services, it was discovered that the agency's fiscal employer agent (FE/A) was paying individuals hired to provide personal care but who also were Medicaid recipients.
- As a result of these payments, these individuals may exceed the Medicaid income eligibility requirements
- This information was compiled and submitted to localities to investigate and determine if eligibility is affected.

Strengthening Provider Enrollment

- Provider enrollment program integrity efforts ensure that ineligible individuals are not enrolled as Medicaid providers
- The Patient Protection and Affordable Care Act (PPACA) requires enhanced screening of all participating Medicaid providers as well as additional screening of provider types classified as moderate or high risk providers.
  - ACA requires additional disclosure by providers of their ownership and managing partners, which DMAS will store in digital format and screen every 30 days against certain databases in order to ensure no providers or owners receive federal funds inappropriately.
  - Provider types labeled moderate- or high-risk, such as Durable Medical Equipment and Home Health, must also undergo unannounced site visits.
- These additional provider enrollment measures will help to prevent improper payments by ensuring that all enrolled providers are eligible to receive Medicaid payments.
  - Currently scheduled to be in place by late 2013

Strengthening Provider Enrollment

- HB 265 of the 2011 General Assembly session required all Home Health agencies to be licensed in order to remain enrolled as Medicaid providers
  - As a part of this licensure process, site visits were conducted on all Home Health agencies.
- Increased quality and compliance and led to the termination of 250 non-compliant agencies.
  - Medicaid beneficiaries were transferred from terminated providers to a licensed provider, ensuring continuity of care.

Claims Processing

- DMAS' Medicaid Management Information System (MMIS) is an automated claims processing and review system.
  - Currently, there are over 1,550 edits in the Virginia MMIS, which reject things like duplicate claims or claims for services or service levels that are not authorized under Medicaid policy.
- Enables DMAS to accurately and consistently reimburse claims based on clinical appropriateness and medical payment policies.
- One particular edit "pends" emergency room claims which are reviewed and reimbursed at the lower non-emergency rate when the admitting diagnosis is not readily identified as an emergency.
  - The savings from this process for FY 2011 was $14,690,903

Claims Processing

- As a part of claims processing, DMAS also utilizes two products that consist of packages of regularly-updated edits which prevent improper payment
  - Correct Coding Initiative edits were developed by CMS to prevent inappropriate payment of services that do not match the diagnosis or are not billed in accordance with industry standards (i.e. unbundling.)
  - Claim Check is a commercial software product that is used to compare current claims with historical claims to determine whether there is a billing conflict.
- These edits cost-avoided over $6.5 million in FY 2011 and FY 2012
- DMAS will be implementing the CMS-mandated prepayment National Correct Coding Initiatives for Medicaid programs during June 2013

Service Authorizations

- Prior authorization of medical necessity is required on approximately 1,349 procedures including:
  - Acute Medical/Surgical Hospital admissions,
  - Inpatient/Outpatient Rehab,
  - Home Health,
  - Durable Medical Equipment (DME),
  - Residential Treatment Facilities
  - Waiver enrollments,
  - Substance Abuse Services,
  - and Community Mental Health Rehabilitative Services (CMHRS).
- DMAS claims processing system will not issue payment for these services without an authorization code.

Service Authorizations

- DMAS employs a contractor to evaluate the medical necessity of a service based on information submitted by the servicing provider.
  - Denial determinations are made by physician staff
- Providers may request authorization via telephone or HIPAA compliant web portal.
  - Portal has front end edits to include member information, provider information, and procedure codes that require service authorization.
- DMAS employs a separate contractor to review some dental services, and the Department of Behavioral Health and Disability Services authorizes services provided under the Intellectual Disability and Day Support Waivers.

Service Authorizations

- Service Authorization specifies approval or denial for service, number of units, and time frame, and program savings are realized through denial of medically unnecessary services

Type of Review	Denied Units/Days	Program Savings
Inpatient Services	10,222	$5,289,375
Outpatient Services	2,840,123	$176,378,299
Waivers and Other Services	824,331	$12,986,506
Totals	**3,674,676**	**$194,654,150**

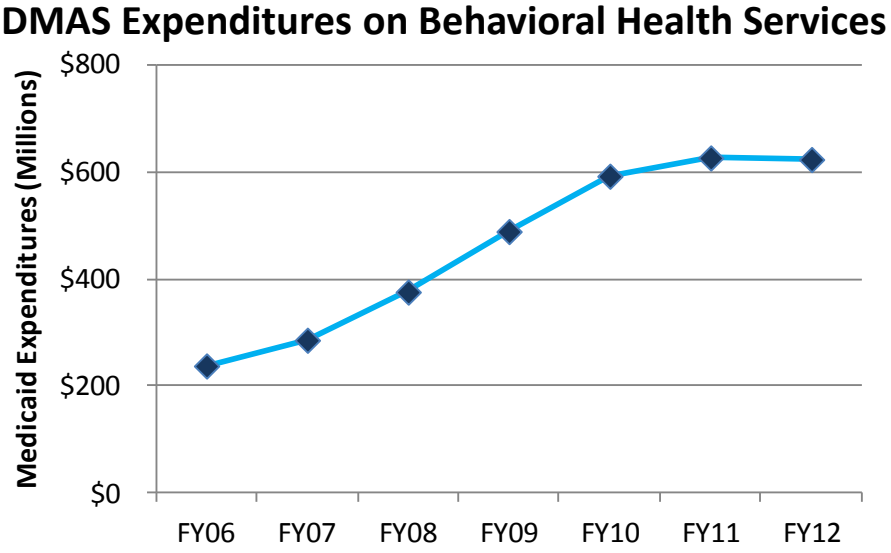
- In addition to savings from service denials, Service Authorization creates a deterrent effect resulting in fewer claims being filed
  - Documentation required deters fraudulent claims
  - Providers who are denied authorization stop submitting requests that they know will not be approved

Service Authorizations

- DMAS has brought a variety of new services under the Service Authorization contract, centralizing the determination of medical necessity.
- DMAS also made regulatory changes that limited the duration of services covered by a single authorization to ensure that medical necessity is evaluated at regular intervals.
- Documentation requirements of the service authorization process facilitate fraud prosecutions.
  - Allows investigators to compare service authorization justification documents to the medical record to identify discrepancies.

Behavioral Health Program Integrity

- DMAS Expenditures on Behavioral Health Services increased substantially between FY 2006 and FY 2009, more than doubling from $237 M to $489 M.



- The vast majority of this increase (70%) came from two service types, Intensive In-Home (IIH) and Therapeutic Day Treatment (TDT)

Behavioral Health Program Integrity

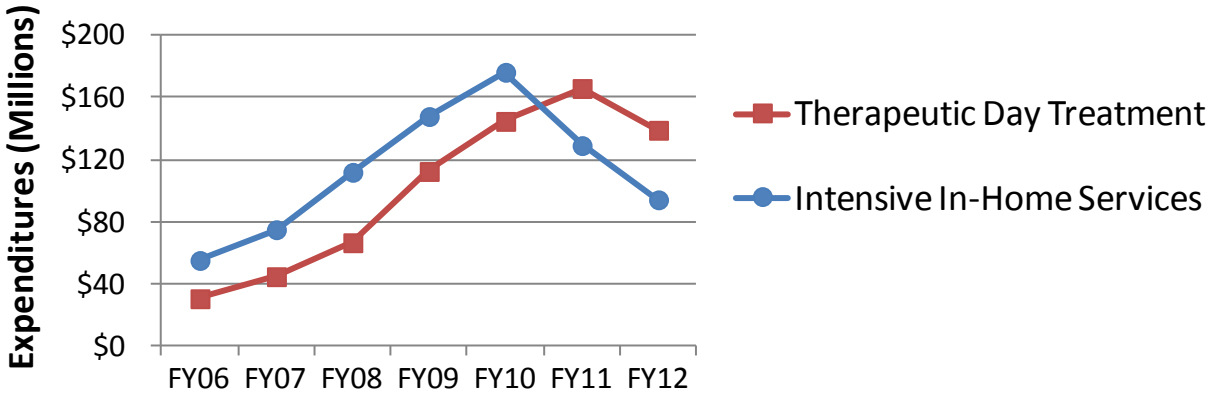
- In order to ensure that regulations stay up-to-date with the changing nature of mental health services, DMAS established the Office of Behavioral Health.
- DMAS has promulgated new regulations to tighten the requirements for a variety of behavioral health services which will ensure these services are utilized appropriately
  - Clear guidelines are essential to ensure audit findings are upheld and strengthen fraud prosecution cases
- DMAS has also supplemented its staff audits of behavioral health providers with additional audits conducted by a contractor
  - This contract was expanded from 88 audits in FY 2011 to 125 audits in FY 2012

Behavioral Health Program Integrity

- In response to this increase in expenditures, during FY 2009 and FY 2010, DMAS subjected both IIH and TDT to greater scrutiny by the Service Authorization(SA) contractor, adding TDT to the contract in August 2009.
- Pursuant to the 2011 Acts of Assembly, DMAS began the Virginia Independent Clinical Assessment Program (VICAP) which required an independent clinical assessment (ICA) be completed by a Community Services Board prior to receiving IIH or TDT services.
  - In July and August of 2011, CSBs began conducting independent clinical assessments (ICAs) for new service requests and re-authorizations
- The Service Authorization contractor now reviews information from the ICA and the service provider when making a determination of whether to authorize the service as medically necessary.

Behavioral Health Program Integrity

- The "deterrent effect" of the combination of Service Authorization and the VICAP program is illustrated by expenditures IIH and TDT services, which fell drastically after subjected to authorization.
  - IIH expenditures fell $82.1M (47%) from $176.5M in FY 2010
  - TDT expenditures fell $26.9 M (16%) from $166.1M in FY 2011



Post-Payment Efforts

- During last two fiscal years, close to 1,700 providers have been reviewed through a combination of staff and four contracts with national auditing firms.
- In addition to audit efforts, per Item 307 YYY of the 2012 Appropriations Act, DMAS convened a workgroup of representatives of providers of Home and Community Based Care Services to evaluate the effectiveness and appropriateness of the audit methodology.

Post-Payment Efforts

	FY2011 total audits	FY2011 Overpayment	FY2012 total audits	FY2012 Overpayment
DMAS - Provider Review Unit	176	$1,827,415	156	$1,071,533
DMAS - Mental Health	52	$3,948,332	55	$2,962,497
DMAS - Hospital	96	$8,149,662	95	$1,393,622
Xerox Pharmacy & DME	79	$2,082,161	80	$1,688,343
Health Management Systems DRG	90	$3,173,822	87	$5,867,252*
Health Management Systems Mental Health	88	$1,679,743	125	$3,724,883
PHBV Partners LLP General Auditing Services	209	$8,392,790	309	$8,645,195
Total	790	$29,253,924	907	$25,353,325

*includes preliminary overpayments for 7 of the 87 audits

Fraud

- PI refers providers to the Medicaid Fraud Control Unit (MFCU), Department of Health Professions and other state licensing agencies if a review indicates fraud or abuse.
- MFCU determines if the case warrants further investigation and gathers evidence to establish the existence of provider fraud.
- MFCU works in collaboration with PRU staff during the investigation as subject matter experts and owners of the original audit.
- DMAS then cancels the enrollment of convicted providers as of their date of conviction.
- DMAS staff also provide assistance other cases, including civil qui tam cases.

Fraud

- DMAS referred 82 cases of provider fraud to the MFCU in FY 2012.
- MFCU obtained convictions of 21 Medicaid providers as well as restitution in the amount of $40,260,843 ordered to be returned to Medicaid.
- PID and MFCU staff coordinate regularly through monthly meetings to discuss referrals, investigations and status of ongoing cases.
- This coordination is seen as a national best practice and PID is leading a CMS technical advisory group on MFCU/State Medicaid Agency interaction.

Notable Fraud Convictions

- A personal care provider was sentenced to 51 months in prison and ordered to return nearly $1 million in fraudulent billings to Virginia Medicaid.
- A marketing company owner was sentenced to 37 months in prison and ordered to pay $545,000 to Virginia Medicaid for conspiring to receive Medicaid kickbacks for inappropriately recruiting children to an intensive in-home (IIH) therapy service provider.
- The program director of an IIH service provider was sentenced to 24 months in prison and ordered to pay $325,980 in restitution to Virginia Medicaid for submitting false service authorization documentation and billing for medically-unnecessary services.

Contract Compliance Unit

- DMAS created the Contract and Compliance Unit (CCU) to consolidate oversight of provider audit contractors, service contractors and managed care plans' program integrity efforts.
- The unit is working to ensure consistent expectations of contract auditors including HMS, Xerox and PHBV.
- In addition, CCU is working to ensure that contracts throughout DMAS include adequate program integrity including oversight of:
  - DMAS Managed Care Organizations (MCOs)
  - Transportation broker
  - Fiscal employee agent
  - Dental services contractor

Program Integrity Initiatives

- Recovery Audit Contract
- Data Mining
- Program Integrity in Managed Care
- Service Facilitator Qualifications

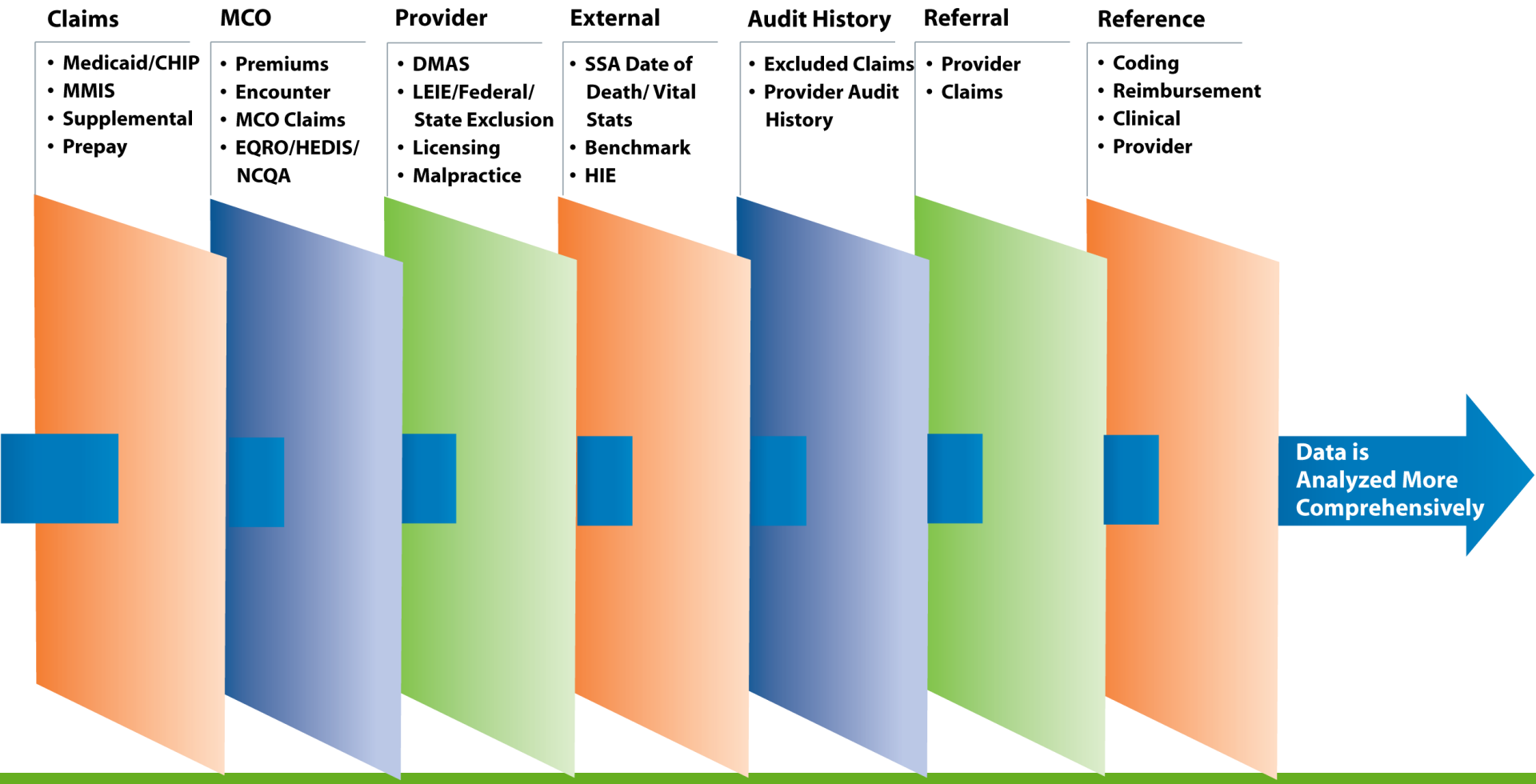
Recovery Audit Contract

- Pursuant to recent Budget language, DMAS has engaged HMS as its Recovery Audit Contractor (RAC) and is in the process of identifying the audit activities the RAC will undertake.
- The RAC will be unique in that the contractor will be paid a contingency fee based on overpayments identified through their audits.

Data Mining

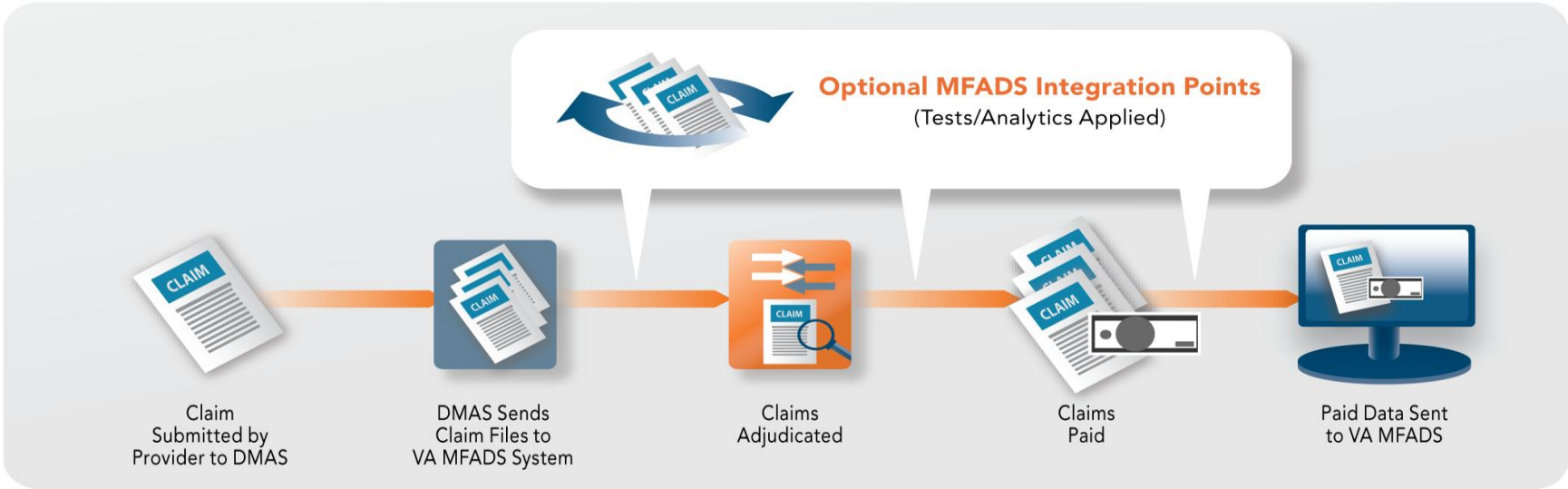
- Medicaid Fraud and Abuse Detection (MFAD) system project will enhance efforts to further identify potential fraud waste and abuse (FWA) target areas.
  - Project will create a series of tests that identify possible FWA behavior based on known patterns, issues, and scenarios
  - System will provide ongoing statistical models of normal PHI for each claim type, and use the statistical models to identify anomalies, outliers, and trends
  - Reporting will allow DMAS to better understand FWA issues, providers, trends across the program, across multiple program years

MFAD Integrates Multiple Data Sources



MFAD Facilitates Multiple Integration Points

- The MFADs flexible configuration allows for multiple integration points within the claim cycle. Tests can be applied pre-payment, pre-adjudication, post-adjudication and/or retrospectively.
- This allows the system to prevent non-compliance and inaccurate claims from being paid, while allowing the system to track payment behavior for further analysis.



Program Integrity in Managed Care

- The CCU is also working with DMAS Managed Care Organizations (MCOs) to enhance program integrity in their programs by facilitating sharing of information on potential fraud and abuse through efforts like the quarterly Program Integrity Collaborative meeting
- DMAS is helping to monitor the movement of individuals enrolled in MCO pharmacy utilization management programs and notify plans when clients move from one plan to another.
- New program integrity language was included in the most recent MCO contract that required more complete and consistent reporting on program integrity activities.

MCO Program Integrity Collaborative

- DMAS holds a quarterly meeting of program integrity staff from each of the MCOs to discuss emerging issues as well as opportunities for collaboration.
- At meetings, DMAS and MCO representatives present trends and schemes they are currently investigating, as well as the names of individual providers who appear to be committing fraud, waste and abuse.

MCO Program Integrity Compliance Audit (PICA)

- In February of 2012, staff from the Program Integrity Division and Health Care Services Division undertook a comprehensive audit of each MCOs compliance with the program integrity requirements under the MCO contract

- During the PICA audit, MCOs were generally found to be compliant, though some deficiencies were identified.
  - Worked with the plans on corrective actions

- The PICA audit tool is being modified to assess similar PI requirements in other contracts such as PPL, Dental and Transportation.

Service Facilitator Qualifications

- Pursuant to Item 307 XXX of the 2012 Appropriations Act, DMAS has taken efforts to strengthen qualifications and responsibilities of Consumer Directed Service Facilitators (CDSFs.)
  - Individuals choosing consumer-directed services must receive support from a CDSF.
  - CDSFs are responsible for supporting waiver individuals or their family/caregiver by ensuring the development and monitoring of the service plan, training on the management of the individual's provider/employee and completing ongoing reviews, as required.
- New standards for CDSF qualifications and care will provide consistency to the quality of the consumer directed program in line with other community-based services to ensure the health, safety and welfare of Medicaid home- and community-based waiver enrollees.

Conclusion

- Current DMAS program integrity activities identify and prevent substantial fraud, waste and abuse in the Virginia Medicaid system.
- DMAS is committed to the continuous improvement of its' tools to contain costs, reduce inaccurate or unauthorized reimbursement, and better detect fraud, waste and abuse.