



FY 2014 Annual Report on DMAS Program Integrity Activities



*Controlling Fraud, Waste and Abuse
in Virginia Medicaid*

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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Dear Fellow Virginians:

I am pleased to present the Virginia Medicaid Program Integrity Annual Report for State Fiscal Year 2014. Virginia Medicaid program integrity efforts are not limited to a single division in DMAS, but involve the entire agency and coordination with a variety of outside partners. The report is a compilation of the fine work of the staff of the Department of Medical Assistance Services (DMAS) and our many partners.

The Program Integrity Division (PID) is entrusted with the responsibility of ensuring that the Virginia Medicaid is equipped to combat waste and abuse and also detect fraud. Only a small percentage of Medicaid providers and recipients engage in various forms of fraud, but fraud and abuse affects everyone (the recipients of care, the taxpayers who pay for it, and the providers who provide quality care.) As such, it is important to have a Medicaid program that protects against improper payments. Each dollar lost to fraud is one less dollar available for someone in need of care.

During FY 2014, DMAS program integrity efforts identified over \$21 million in improper expenditures and prevented the payment of more than \$114 million in potential improper expenditures. In addition, PID made efforts to expand fraud identification and prosecution, making 53 referrals of potential fraud, and working with the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) to achieve fraud convictions on 31 providers. In addition to these convictions, courts ordered these providers to repay \$1.7 million to the Virginia Medicaid program. Lastly, DMAS Program Integrity and Health Care Services Divisions continue to work with DMAS' managed care partners to enhance program integrity within their organizations as well as within Virginia Medicaid.

The attached report provides information about DMAS program integrity efforts over the 2014 fiscal year to include statistical information, such as estimated savings and audit outcomes. I trust that you will find this report helpful in gaining insight into the Department's Program Integrity activities.

Sincerely,

Cindi Jones, Director
Department of Medical Assistance Services

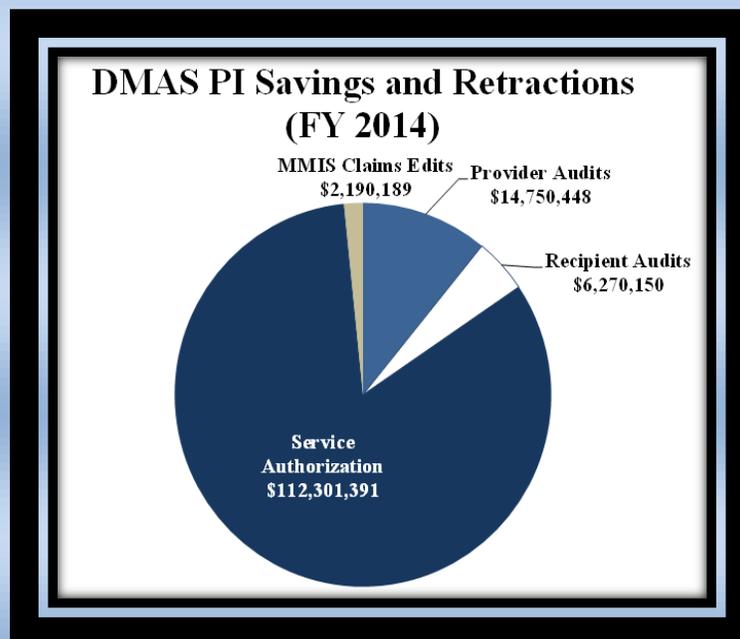
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Executive Summary

Program Integrity (PI) is the collective term given to activities conducted by the Department of Medical Assistance Services (DMAS) to ensure taxpayers' dollars are spent effectively and appropriately. The mission of the Program Integrity Division (PID) is to protect the Medicaid program from external abuse and fraudulent activities, recover inappropriate Medicaid payments, as well as support the integrity efforts of the various Medicaid programs through oversight and technical assistance. The activities of PID are supported by the PI efforts of other DMAS divisions and partner agencies to identify fraud and abuse. PID's program integrity activities are further supported by the integrity-related efforts of the Department's eight major national program integrity contracts, including a transportation broker, dental and incontinence contractor, a newly acquired behavioral health service administrator as well as the integrity programs of each of the seven managed care organizations.

During FY 2014, Program Integrity Division activities uncovered and/or prevented \$133 million in improper expenditures in the Virginia Medicaid program. In addition to efforts by PID, prepayment edits in DMAS' claims processing system saved over \$2 million by blocking or reducing reimbursement on improperly-filed claims. The chart below provides a snapshot of program integrity savings in FY 2014. A large portion of PI savings came from cost avoidance due to the service authorization process, which denies medically unnecessary service requests. While prevention is preferable, not all improper payments can be detected before payment occurs. For that reason, DMAS conducts a variety of audit activities to identify misspent funds. As a result, \$21 million in identified recoveries is attributable to audits of providers and recipients conducted by Program Integrity Division staff and contractors.

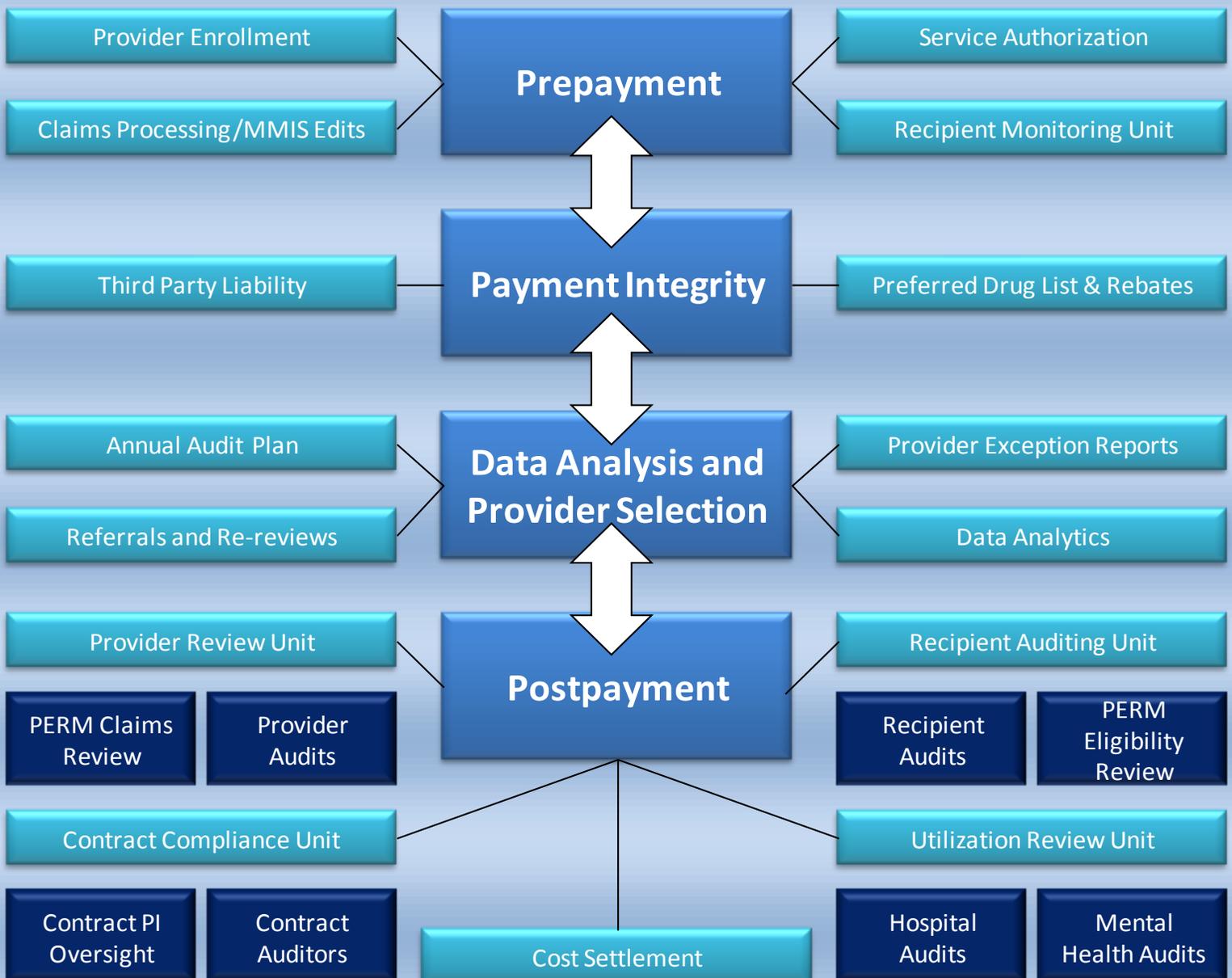


Virginia has received national recognition for its efforts in Medicaid program integrity. The director of the PI Division serves on the Center for Medicare and Medicaid Services (CMS) PI Technical Advisory Group (TAG), which is fundamental in developing and evaluating national PI efforts and which led the national PID and MCFU collaborative effort. PID staff members present for various seminars and national conferences including training sessions at the Medicaid Integrity Institute (MII), a joint program of the Department of Justice (DOJ) and the Centers for Medicare and Medicaid Services (CMS.)

Program Integrity Overview

DMAS' PI efforts are summarized in four major areas:

- **Prepayment** processes to enhance cost avoidance by preventing improper expenditures on services that are not medically necessary (Service Authorization), and providers who are not eligible to participate in Medicaid (Provider Exclusion). Prepayment programs also ensure claims are paid according to DMAS policy (Claims Processing) and control over-utilization of Medicaid services by recipients (Recipient Monitoring Unit.)
- **Payment Integrity** processes that ensure DMAS pays only its share of recipient medical expenditures (Third-Party Liability) and that DMAS receives all of its pharmacy rebates.
- **Data Analysis and Provider Selection** processes that identify potential risk areas to help inform decisions on where to target program integrity resources.
- **Post-payment** processes that identify instances of improper provider billings and improper recipient enrollment through investigation of referrals and audits of paid claims, some of which are forwarded on for criminal fraud prosecution.



Preventing Improper Payments

Preventing improper claims from being paid is always preferable to identifying improper payments after the payment has occurred. Improper payment prevention also provides an additional deterrent to providers who knowingly submit inaccurate claims. Three major components of prepayment program integrity are the Medicaid Management Information System (MMIS) claims processing system, provider network management and the service authorization process. MMIS is an automated system that ensures certain rules are met before a claim is processed for payment to a provider. For some services, providers are required to obtain service authorization (an evaluation of whether the service is medically necessary) before a claim can be paid.

MMIS Claims Processing Edits

DMAS always has subjected claims to rigorous prepayment scrutiny through its automated claims processing and review system called the Medicaid Management Information System (MMIS). This system contains edits that reject duplicate claims and claims for services or service levels that are not authorized under Medicaid policy. In June 2013, DMAS implemented the CMS-mandated National Correct Coding Initiatives (NCCI) edits to improve the prepayment claims review process. These prepayment edits prevented \$2,190,189 in improper payments in FY 2014.

Provider Network Management

Provider enrollment processes ensure the integrity of the provider network by reviewing the credentials of individuals applying to enroll as Virginia Medicaid providers. In addition, enrolled providers are routinely reviewed, and unqualified or barred providers are terminated from the program. In the first quarter of 2014, DMAS became the first state agency in the region to implement enhanced provider screening requirements under the Affordable Care Act (ACA.) Effective March 31, 2014, DMAS implemented significant changes in the way we screen providers, DMAS now regularly screens both service providers and business owners against a variety of federal databases of banned and/or suspect providers. DMAS also conducts on-site screenings on all high-risk providers prior to enrollment or recertification. These additional provider enrollment measures help to prevent improper payments by providing more complete and up-to-date information on providers, and by assigning greater scrutiny to the enrollment of riskier providers.

Providers are Screened against a Variety of Databases

- **Medicaid and CHIP State Information Sharing (MCSIS)** – Single source for collecting and sharing Medicare and Medicaid and CHIP provider termination data; used to identify providers excluded from other state Medicaid programs.
- **Excluded Parties List System (EPLS)** – Identifies Federal debarments and suspensions
- **List of Excluded Individuals & Entities (LEIE)** – Federal Program list of Exclusions
- **Social Security Administration- Death Master File (SSA-DMF)** – Federal database of certified deaths and death dates
- **National Plan & Provider Enumeration System(NPPES)** – Identifies deactivated and mismatched provider identification numbers
- **VA Department of Health Professions (DHP)** – Provides verification of provider licensing status
- **Provider Enrollment, Chain & Ownership System (PECOS)** – Identifies providers already screened for Medicare enrollment; allows DMAS to leverage Medicare screening

Service Authorization

DMAS requires providers to obtain prior authorization of the medical necessity of certain services (referred to as service authorization) before a claim can be paid through MMIS. DMAS contracts with Keystone Peer Review Organization (KePRO,) which allows providers to submit requests by phone or via the internet.

KePRO medical staff review the information submitted by providers and determine if the service is medically necessary under DMAS policy. Service authorization avoided costs of over \$112 million in FY 2014.

Type of Review	FY 2014 Denied Units/Days	FY 2014 Program Savings
Inpatient	5,793	\$5,823,360
Outpatient	1,039,459	\$100,106,773
Waivers/Other Services	801,269	\$12,194,618
Total	1,840,728	\$112,301,391

Total units denied and resulting savings decreased in FY 2014 from FY 2013. This was the result of behavioral health services being moved to a service administrator with responsibility for performing these service authorization reviews. The Behavioral Health Services Administrator performed 72,042 service authorization reviews from January 2014 to June 2014 on behavioral health services alone.

Monitoring Recipient Pharmaceutical Utilization

Improper usage of pharmaceuticals by recipients presents both program integrity and quality of care issues in the Medicaid programs. In particular, misuse and overuse of narcotic painkillers represent a major challenge. In order to mitigate and control this issue, DMAS has enacted several measures to monitor and manage recipients to ensure proper utilization of these drugs. Within the DMAS fee-for-service program, the DMAS Recipient Monitoring Unit analyzes and evaluates recipients to determine if they meet the criteria to be enrolled in a pharmaceutical management program. This program can involve assigning a recipient to a single prescribing physician and/or a single pharmacy to allow coordinated oversight of pharmaceutical usage. In FY 2014, pharmaceutical management enrollment averaged about 153 members.

In addition to this program, DMAS' managed care partners have implemented similar processes to manage and control pharmacy usage for members enrolled in their programs. In FY 2014, MCO pharmaceutical management enrollment averaged 1,197 members. In order to encourage a coordinated effort to address pharmacy misutilization, DMAS established a workgroup where DMAS and the MCOs can identify emerging issues and discuss possible approaches to address these issues. In FY 2014, DMAS engaged a contractor to analyze prescribing patterns to identify potentially problematic providers. The workgroup will look to expand on this analysis in FY 2015 and identify approaches to mitigate the risk posed by these providers.

Respite Success

During FY 2011, in response to budgetary concerns, the General Assembly required a reduction in the number of respite case hours allowed. Accordingly, DMAS made significant changes to the MMIS and the respite care Service Authorization process. In the course of enacting the required changes, DMAS was able to enhance the efficiency of the annual renewal process by evenly distributing renewals throughout the fiscal year. Additional changes also included allowing providers the opportunity to align the annual review dates for personal care services and respite care services, in order to streamline these reporting requirements. No changes were made to the audit plan with respect to respite care services.

Recipient Eligibility Investigations

DMAS conducts a wide variety of activities to ensure the accuracy and integrity of the Virginia Medicaid recipient enrollment process. Audits are conducted to identify recipients who do not meet eligibility requirements, as well as to uncover improper payments made on behalf of ineligible recipients. DMAS also collaborates with the Virginia Department of Social Services, the State police, and a new eligibility contractor to address recipient fraud and abuse, as well as enrollment accuracy.

The Recipient Audit Unit (RAU) is responsible for the investigation of allegations of acts of fraud or abuse committed by recipients of the Medicaid, Family Access to Medical Insurance Security (FAMIS), and State & Local Hospital (SLH) programs. The investigations may result in the identification of misspent funds, administrative recoveries from recipients, or criminal prosecution. The unit also investigates drug diversion and performs joint investigations with various law enforcement entities (the Virginia State Police, the FBI, etc.), as well as the Social Security Administration, and other federal/state agencies.

Typical Recipient Eligibility Issues

- deceit in application
- illegal use/sharing of a Medicaid card
- uncompensated transfer of property
- excess resources or income
- fraudulent household composition.
- failure to report changes in income, resources, household composition or other eligibility-impacting factors

In FY 2014, the RAU received 2,344 referrals from various sources, such as citizens, providers, and local Departments of Social Services. RAU investigated 2,635 referrals over that time period and uncovered a total of \$6,270,150 in improper payments. Of that, \$3,319,383 was submitted for administrative recovery. In order to supplement the excellent investigative work conducted by RAU staff, DMAS engaged a contractor in FY 2014 to conduct 400 investigations of Medicaid recipients. These investigations identified a total of \$1,557,035 in improper payments, of which \$1,187,348 was submitted for administrative recovery.

In addition, 31 individuals with \$259,242 in overpayments were forwarded on for criminal prosecution. During FY 2014, 32 individuals were convicted of fraudulently obtaining benefits and ordered to pay \$283,544 in restitution. These recipients also are banned from the Medicaid program for one year (the maximum time allowed under federal law), and can be subject to jail time as well.

Identifying Out-of-State Recipients through Federal PARIS Matches

Public Assistance Reporting Information System (PARIS) is a computer matching system administered by the federal government that provides States with information about individuals who are enrolled in multiple State Medicaid programs. Beginning in July of 2013, the DMAS RAU established a unit dedicated to investigating these cases to determine if the individuals were improperly enrolled in Virginia Medicaid. In FY 2014, this unit investigated 642 of these cases and identified overpayments totaling \$372,423. Because many Virginia Medicaid recipients are enrolled in managed care organizations, a monthly capitation rate is paid on their behalf whether they use any Medicaid services or not. It is important to identify and disenroll these individuals as early as possible in order to ensure these monthly payments are halted.

Provider Audits

The Program Integrity Division (PID) and its contractors focus extensively on providers, particularly audits of paid claims to Medicaid providers. These audits generally examine a selection of claims filed during prior fiscal years to ensure that the claims were filed in accordance with DMAS and Medicaid policy. In most cases, these audits involve examining medical records to ensure that the record exists, supports the claim as billed, and is completed in accordance with DMAS policies. In addition, some audits may examine the credentials of the servicing provider to ensure they are qualified to provide the service that was billed. Contractors play an integral role in provider auditing, supplementing staff audits and providing knowledge and expertise in identifying audit targets and conducting reviews. In FY 2013, DMAS issued RFPs and awarded new contracts for three of its four audit contracts. **As shown in the table below, during FY 2014 provider audit activities, DMAS and its contractors identified over \$14.7 million in overpayments to Medicaid providers.**

	FY 2014 Total Audits	FY 2014 Overpayments
DMAS - Provider Review Unit	54	\$2,205,267
DMAS - Mental Health	49	\$824,314
DMAS - Hospital	76	\$1,264,712
PID Audit Total	179	\$4,294,293
Xerox - Pharmacy & DME (6 mo.)	40	\$640,325
Xerox - ClaimCheck Project	93	\$206,266
Health Management Systems - Hospital DRG	90	\$5,551,574
Health Management Systems - Mental Health	70	\$1,434,322
Myers & Stauffer - Physicians & Waiver Services (6 mo.)	161	\$2,623,668
Contractor Audit Total	454	\$10,456,155
Total, PID and Contractor Audits	633	\$14,750,448

Identifying Additional Recoveries

Recovery Audit Contractor

Since early FY 2013, DMAS has utilized a Recovery Audit Contractor (RAC) to audit payments to Medicaid providers. RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they identify and collect from providers. The cost to the State is minimal for this program, as the RAC's contingency fees come out of recovered overpayments, and the Federal Government covers 50 percent of any administrative costs. As of the end of the SFY 2014, DMAS has received \$221,386.57 in payments from providers based on audits conducted under the RAC contract. In addition, DMAS has allowed \$349,176.65 in provider adjustments for rebilling of erroneous claims, for a total of more than \$570,000 in savings and recoveries.

Medicaid Fraud and Abuse Detection System

Fraud and abuse in Medicaid cost states billions of dollars every year, diverting funds that could otherwise be used for legitimate health care services. While states have traditionally relied upon the “pay and chase” model, paying Medicaid claims and then trying to recover improper payments, the



focus is increasingly on preventing and detecting fraudulent activities early on. DMAS is committed to the continuous improvement of its PI tools to contain costs, reduce inaccurate or unauthorized claims and reimbursement, and better detect fraud and abuse. As a result, in July 2013, DMAS awarded the Medicaid Fraud and Abuse Detection (MFAD) system contract to Health Management Systems (HMS). The MFAD will enhance efforts to further identify potential fraud, waste, and abuse (FWA) target areas. The system has created a series of tests that identify possible FWA behavior based on known patterns, issues, scenarios, and statistical models used to identify anomalies, outliers and trends. During the second year of the contract, the system customized a set of edits that identified approximately \$1.5M in potential recoveries for DMAS.

The MFAD system also identified 149 targeted leads from anomaly routines and validated correct claims processing for multiple DMAS programs.

Prosecuting Fraud

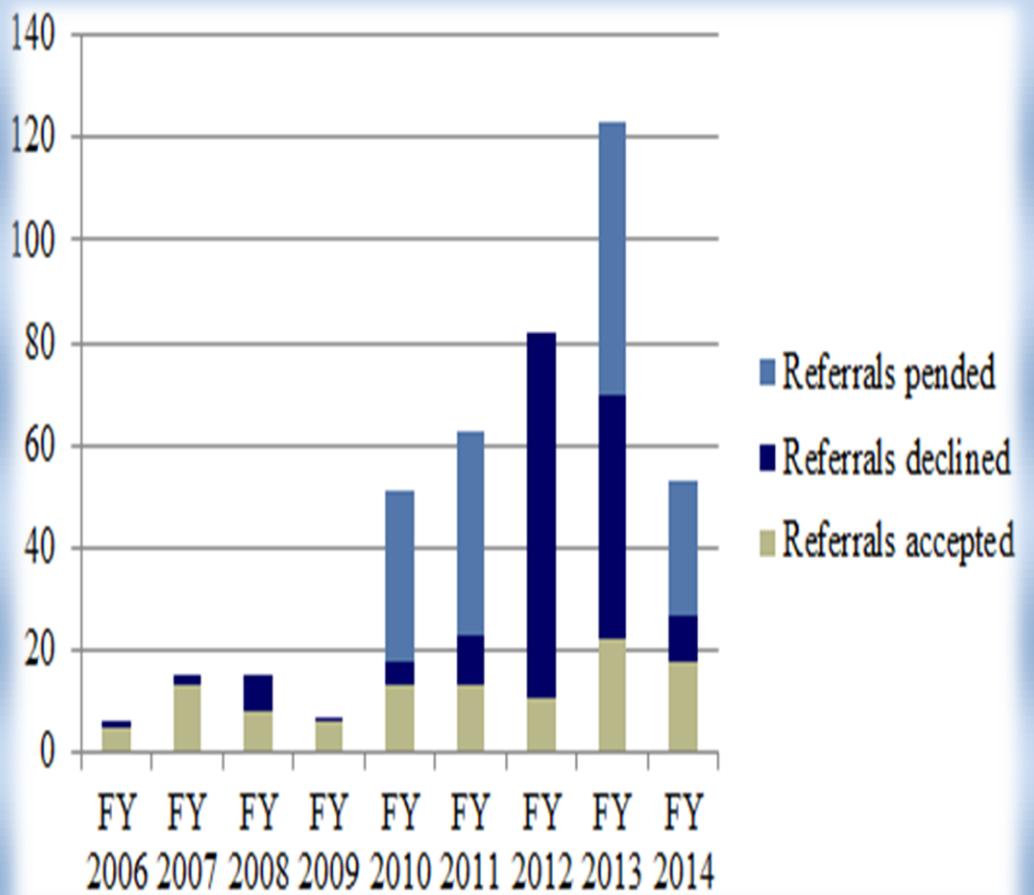
In addition to identifying improper payments for collection, audits conducted by DMAS and its contractors may uncover evidence of potential fraud. Medicaid fraud is a criminal act that occurs when a Medicaid provider or recipient intentionally misrepresents themselves in order to receive an unauthorized benefit. Pursuant to federal law, Virginia’s Medicaid Fraud Control Unit (MFCU) was established as a division of the Office of the Attorney General in 1982, and works closely with DMAS to investigate and prosecute suspected cases of Medicaid provider fraud. In addition to establishing restitution for past fraudulent activities, fraud convictions play an important role in program integrity more broadly, as convicted providers are banned from Medicaid participation for life.

DMAS refers potential cases of fraud to the MFCU, provides program knowledge to aid in investigations, and testifies in cases. DMAS has an exceptional working relationship with the MFCU that continues to improve through constant communication and collaboration, including monthly meetings between staff of the two agencies, and the MFCU’s participation in quarterly program integrity collaborative meetings with DMAS and its managed care partners. In FY 2014, MFCU obtained convictions of 31 health care providers. **Those cases**

resulted in a total of \$1,705,029 in court-ordered fines, penalties, and restitution to the Virginia Medicaid program.

In addition, each of these health care providers was barred for life from participating in the Medicaid program. In addition to working on criminal fraud cases, DMAS also aids MFCU civil prosecutions by reviewing records and testifying in national qui tam cases against pharmaceutical manufacturers.

This chart represents DMAS referrals to MFCU over the last 9 fiscal years. In FY 2014, DMAS made



53 fraud referrals, 18 of which were accepted by MFCU to be opened as full-scale fraud investigations. A substantial number of referrals from FY 2014 (26) are still pending, as MFCU has yet to vet those referrals.

Program Integrity in Managed Care

The majority of Medicaid recipients are covered by managed care organizations (MCOs) that receive a contracted monthly rate for each enrolled member, and each MCO is responsible for paying providers directly for the medical services incurred by its members. The MCOs are required to have policies and procedures in

place to prevent, detect and investigate allegations of fraud, waste and abuse. **In FY 2013, MCO program integrity activities avoided or recovered more than \$1.1 billion, including \$1 billion in prevented payments for things such as non-covered services, ineligible recipients, and improper claims.**

DMAS continues to hold quarterly Managed Care Program Integrity Collaborative meetings where program integrity staffs from the MCOs and DMAS share information about PI issues they identified. In addition, MFCU representatives attend these meetings and provide updates on the status of their fraud investigations.

During FY 2014, DMAS brought a wide variety of new services and types of members under a

managed-care system. One effort involved covering members who are eligible for both Medicaid and Medicare (“Dual Eligibles”) through managed care instead of fee-for-service. Another major effort was the development of a managed care structure to pay for outpatient behavioral health services, which were historically “carved-out” of the services provided by MCOs and paid for directly by DMAS. During the first year of these contracts, staff from PID’s Contract Compliance Unit provided guidance on contract oversight and reporting to ensure adequate program integrity activities were conducted. Utilizing “lessons learned” from oversight of the Medallion II program, other managed care expansion areas have been able to quickly ramp up their oversight programs by leveraging already-existing templates and oversight processes.

Program Integrity Compliance Audit

Each year, DMAS conducts an audit of each MCO’s compliance with the program integrity requirements under the MCO contract called the Program Integrity Compliance Audit (PICA.) The 2014 PICA review focused on the annual monitoring and audit plans that outline the planned program integrity activities of each MCO. DMAS reviewed the plans submitted by each of the MCOs to ensure that they provided a complete overview of all efforts to prevent, detect and recover improper payments, and to ensure that those efforts represented a coordinated approach to PI.



Conclusion

The combined program integrity efforts of DMAS identified and/or prevented \$133 million in improper expenditures in the Virginia Medicaid program in FY 2014. The vast majority of these dollars (\$114 million) were savings from prepayment activities such as service authorization and MMIS claims processing edits, which stop improper payments before they are made. DMAS anticipates the prevention of even greater amounts of unnecessary expenditures in the future through enhanced provider screening and the implementation of prepayment analytics through its fraud and abuse detection system. Audits of providers and recipients uncovered another \$21 million in improper payments during FY 2014. Contract auditors play a large role in the DMAS PI process and DMAS continually evaluates these contracts to identify opportunities for enhancement through the development of new focus areas and deliverables. DMAS also has engaged a Recovery Audit Contactor (RAC) which is currently auditing provider claims and being reimbursed on a contingency-fee basis for dollars recovered. This contract has identified or prevented over \$570,000 on its own.

DMAS has fostered a collaborative approach with its program integrity partners through monthly meetings with the Medicaid Fraud Control Unit as well as the quarterly Managed Care Program Integrity Collaborative. The collaborative has become a national model and has already helped to create an open and cooperative approach to PI in Virginia Medicaid across all payers. DMAS has worked vigilantly to stamp out fraud, resulting in criminal convictions of 32 Medicaid recipients and 31 Medicaid providers and over \$2 million in court-ordered fines, penalties, and restitution to the Virginia Medicaid program in FY 2014.

As we move forward, DMAS will continue to find ways to further ensure the integrity of the Medicaid program, and will remain vigilant in preventing and identifying fraud, waste and abuse.

