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**Department of Medical Assistance Services  
Program Integrity Efforts**

**Senate Finance Committee**

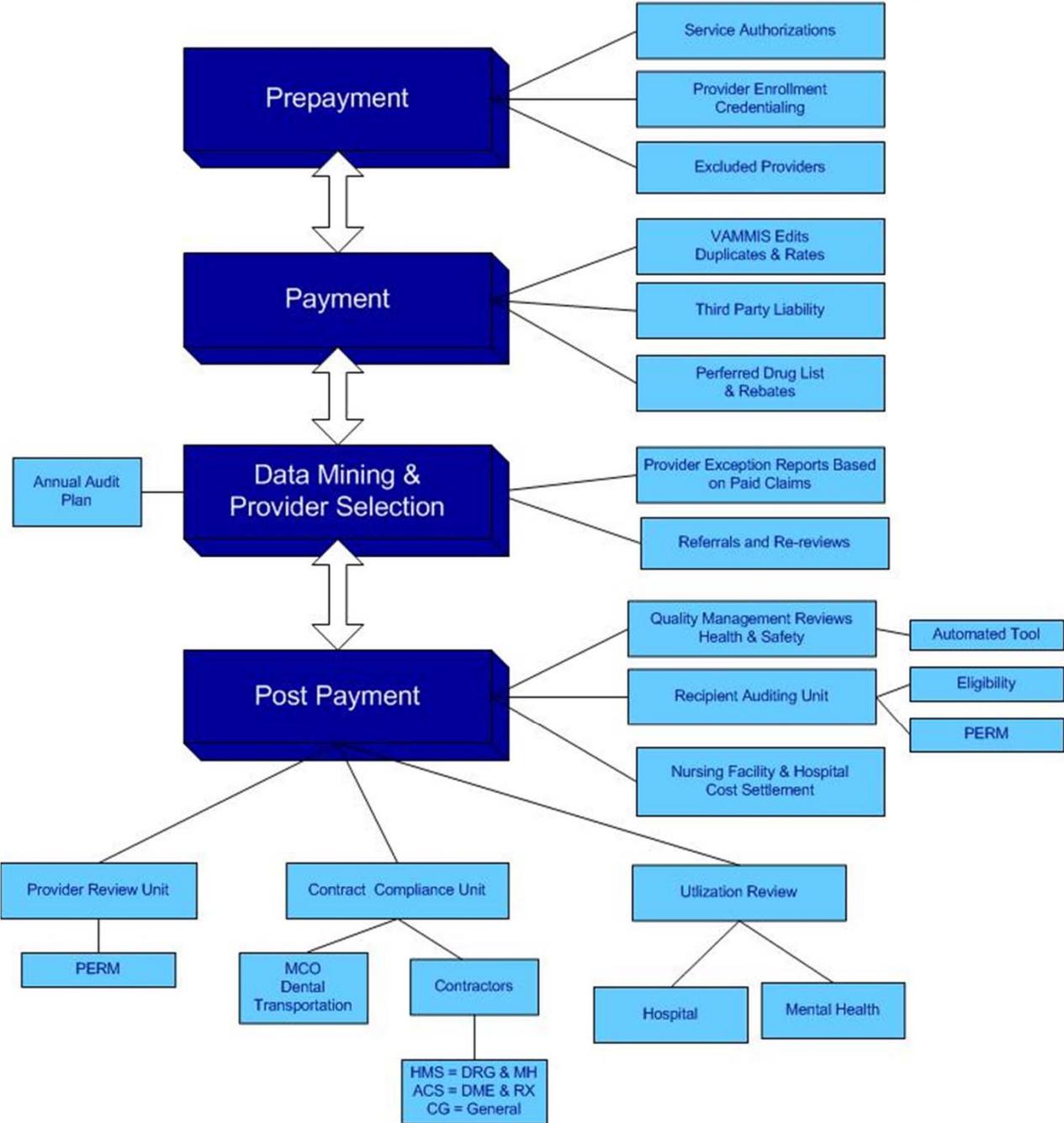
**Cynthia B. Jones  
Director**

# DMAS Program Integrity

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- ❑ **Effective Provider Audits**
  - ❑ Ensure compliance
  - ❑ Lead to policy changes
  - ❑ Improve quality of services
  - ❑ Increase referrals to Medicaid Fraud Control Unit (MFCU)
- ❑ **Program Integrity Division Innovation**
  - ❑ Data mining
  - ❑ Claims analysis
- ❑ **Proactive through the use of prepayment activity**
- ❑ **Expanding recipient eligibility reviews**
- ❑ **Working on National Team for Program Integrity**
- ❑ **Budget for PI activities (55 internal staff and 5 contractors)  
\$8.9M (total funds)**

# DMAS Program Integrity Efforts



# DMAS Program Integrity Efforts

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- ❑ **Prepayment**
  - ❑ Service Authorizations
  - ❑ Provider Enrollment
- ❑ **Recipient Auditing**
- ❑ **Data Mining**
  - ❑ Provider Selection
  - ❑ Payment Algorithms
- ❑ **Post payment**
  - ❑ Audits – DMAS Staff & Contractors
- ❑ **Referrals to Medicaid Fraud Control Unit**
- ❑ **Highlights of Program Integrity**

# Prepayment Service Authorization

- **Virginia conducts extensive prepayment review**
  - Service authorization is required on approximately 1,349 procedures through our MMIS system before any payment is made to providers.

Type of Review FY 2011	Avoided Units/Days	Program Savings
Inpatient Services	9,618	\$5,459,492.82
Outpatient Services	2,012,764	\$114,436,734.45
Waivers and Other Services	623,499	\$9,796,454.98
<b>Totals</b>	<b>2,645,881</b>	<b>\$129,692,682.24</b>

# Prepayment System Edits

## □ Claim Check

- This is a commercial software product that is used to compare current claims with historical claims to determine whether there is a billing conflict.

## □ MMIS edits

- Currently there are over 1,550 edits in the MMIS that must be passed before claims are adjudicated for payment .
- Correct Coding Initiatives (CCI) were developed by CMS to prevent inappropriate payment of services that should not be billed together.

<b>Combined Savings for Claim Check &amp; CCI</b>	
FY10	\$2,665,881.81
FY11	\$3,661,459.69
Totals	\$6,327,341.50

# Provider Enrollment Efforts

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- ❑ Received approximately 14,000 provider enrollment applications in 2011.
- ❑ Conduct license validations of all enrolled providers.
- ❑ Validation that all providers, owners and managing employees have not been excluded from participating in federal and state healthcare programs via the OIG's List of Excluded Individuals and Entities (LEIE).
- ❑ Collaborate with the Division of Program Integrity regarding provider convictions and fraud related activities.
- ❑ Upload all terminated providers to the national Children's Health Insurance Program State Information Sharing database (MCSIS).

# Recipient Auditing

- ❑ Investigation of recipient fraud/abuse regarding referrals received for all Medicaid groups, FAMIS and FAMIS Plus.
- ❑ A significant number of RAU referrals are related to DSS eligibility determination errors.

Activity	FY 2011
Investigations Processed	2,144
Recovery Identified	\$3,994,399.44
Criminal Fraud Referrals	28
Criminal Fraud Convictions	26

# Post-payment Program Integrity Efforts

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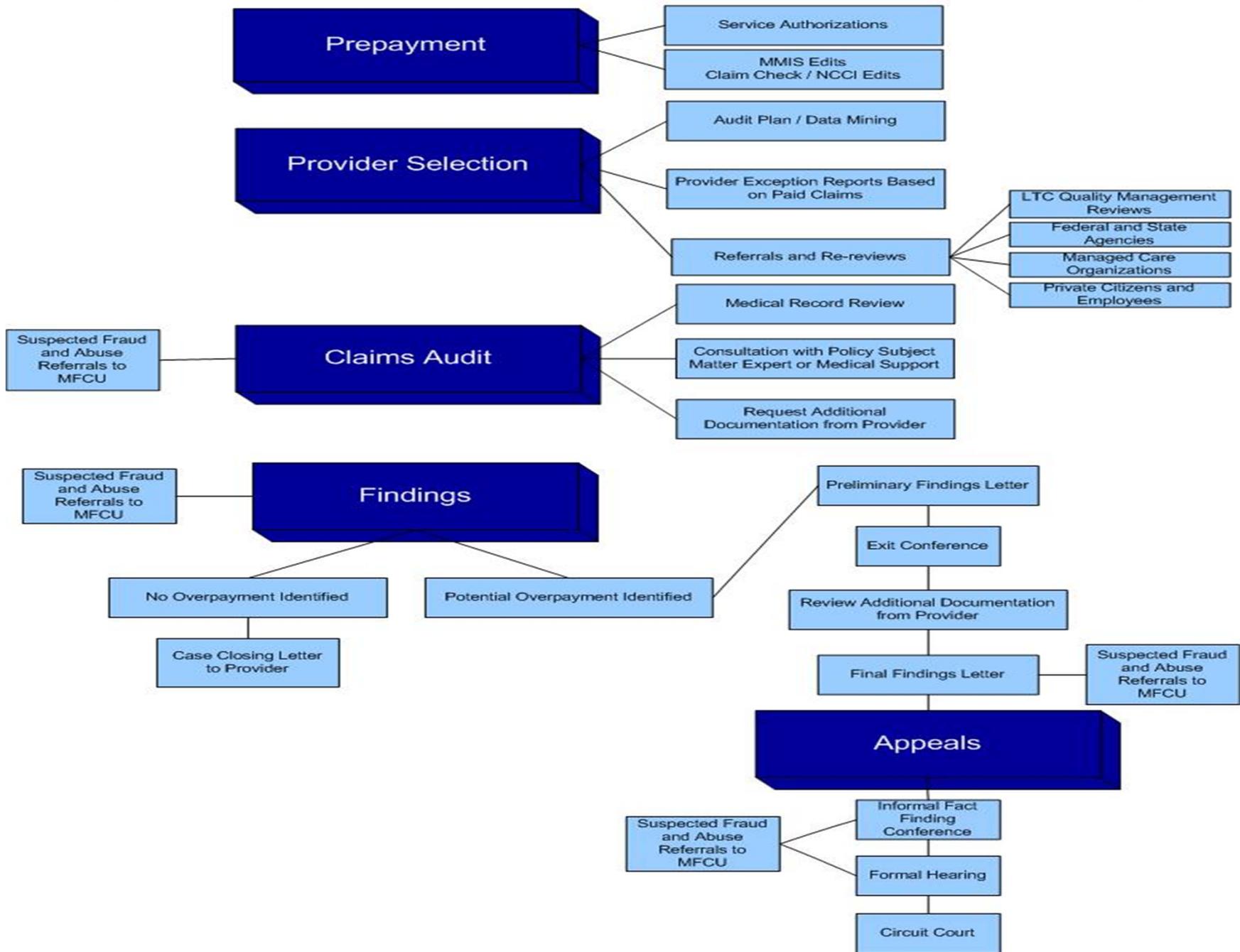
## □ Audits

- During last two fiscal years, over 1,500 providers audits have been reviewed through a combination of 16 full-time staff and (currently) four national auditing firms under contract.
- Every review must be conducted utilizing the policies contained in the DMAS provider manuals as well as the regulations Virginia Administrative Code (12 V.A.C.) that are in effect during the period of service being reviewed.

## □ Data Mining

- DMAS utilizes claims-based data mining software package, to determine which providers are exceeding the billing norms for their peer groups.
- DMAS maintains an internal control testing library called the Business Process Review System (BPRS) comprised of approximately 200 concurrent tests of the internal control of the 142 business processes comprising the Agency.
- DMAS posted a data mining RFP on January 18, 2012. Implementation is slated for late summer. This project will enhance efforts to identify potential target areas for auditing.

# DMAS Program Integrity Case Process



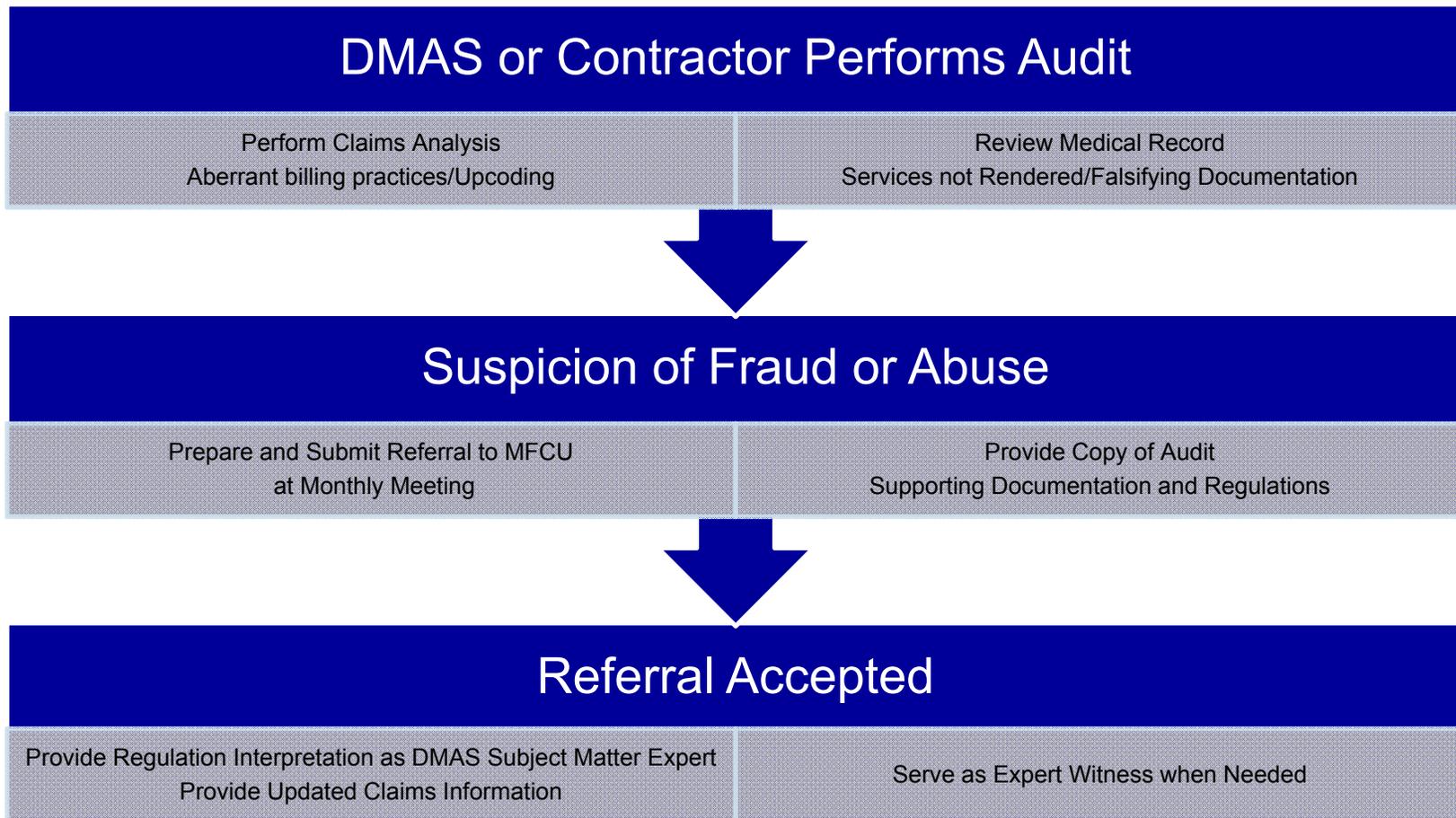
# Provider Types Reviewed

Provider Type	DMAS	Contract	Provider Type	DMAS	Contract	Provider Type	DMAS	Contract
Adult Day Health Care	√		Intensive Inhome	√	√	Outpatient Rehab Facilities		√
Ambulatory Surgical Center	√		Intensive Rehab Facilities		√	Personal Care	√	√
Assisted Living	√		Lab	√	√	Pharmacy	√	√
Audiologist	√		LCSW	√		Physicians	√	√
Case Management Waiver	√		Licensed Psychologist	√		Podiatrist	√	
Clinical Psychologist	√		LPC	√		Private Duty Nursing	√	√
Diagnostic Related Group		√	Mental Health Support		√	Rehab Agency	√	
Durable Medical Equipment		√	MH Hospital	√		Renal Unit	√	
Emergency Room physicians	√	√	MH Rehab and RTC	√	√	Respite Care	√	√
Environmental Modification & Assistive Technology	√	√	MHMR	√		RTC level A - B - C	√	√
Family Care Giver Training	√		MR waiver services	√	√	Skilled Nursing Home	√	
Home Health	√	√	Nurse Mid Wife	√		Therapeutic Day Treatment	√	√
Hospice	√	√	Nurse Practitioner	√		Transportation	√	
Hospital	√		Optometrist	√		Treatment Foster Care	√	√
			Outpatient Psychotherapy/SA	√	√			

# Identified Overpayments

	<i>FY2010 total audits</i>	<i>FY2010 Overpayment</i>	<i>FY2011 total audits</i>	<i>FY2011 Overpayment</i>
<b>DMAS - Provider Review Unit</b>	185	\$620,222	176	\$1,827,415
<b>DMAS - Mental Health</b>	63	\$4,448,462	52	\$3,948,332
<b>DMAS - Hospital</b>	50	\$1,824,397	96	\$8,149,662
<b>Affiliated Computer Services Pharmacy &amp; DME</b>	79	\$1,645,502	79	\$2,082,161
<b>Health Management Systems DRG</b>	89	\$3,260,609	90	\$3,173,822
<b>Health Management Systems Mental Health</b>	70	\$10,504,452	88	\$1,679,743
<b>Clifton Gunderson/PHBV Partners LLP Physicians &amp; Waiver Services</b>	241	\$10,770,029	209	\$8,392,790
<b>Total</b>	<b>777</b>	<b>\$33,073,673</b>	<b>790</b>	<b>\$29,253,924</b>

# Fraud Referral Process



# Examples of Providers Convicted of Medicaid Fraud

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## Referred to MFCU in February 2009

DMAS Personal Care review identified:

- Forged staff training certificates
- Services were billed but not rendered
- Submitted false nursing assessments to obtain service authorization
- Falsified documentation to state recipients were getting required nursing visits when they were not.
- Amount of billing (over \$980,000 2007-2010)
- **Sentence: \$323,000 in restitution, \$10,000 fine and 3 years probation.**

## Referred to MFCU in March 2010

DMAS Mental Health review identified:

- Unqualified staff
- Duplicate assessments
- Duplicate notes
- Extensive utilization of hours
- Amount of billing (over \$9.5 million from 2006 – 2009)
- Amount of overpayment – 35 recipients, \$731,955 overpayment
- **Sentence: \$601,580 in restitution and a total term of fifty-five months' imprisonment.**

# Summary of Cases of Suspected Fraud or Abuse

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- ❑ In Virginia, suspected cases of fraud are referred to our Medicaid Fraud Control Unit (MFCU) established at the Office of the Attorney General.
  - ❑ 114 cases referred from DMAS over the past two years.
  - ❑ 21 DMAS referrals accepted and opened as investigations.
  - ❑ 80 referrals were placed on hold by MFCU for future investigations.
  - ❑ 13 referrals declined for various reasons:
    - ❑ Evidence in the referral did not establish that a Medicaid Crime was committed.
    - ❑ The amount of loss due to fraud does not equal the minimum level needed to prosecute.
    - ❑ Violation is beyond the statute of limitations.
    - ❑ Referred to another agency for their review or administrative action.

# Initiatives Included in the Governor's Introduced Budget

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- ❑ Establishes an on-going eligibility review program to meet federal requirements and to improve eligibility determination for the Medicaid and FAMIS programs in the Commonwealth. The department will contract with a vendor to conduct the federally mandated Payment Error Rate Measurement (PERM) eligibility review and to establish a permanent quality assurance eligibility program.
- ❑ Authorizes the agency to make necessary changes to comply with a new federal health care reform mandate for screening of Medicaid and FAMIS providers. These changes will require the agency to make significant systems changes, revisions to the provider enrollment contract for increased services, a new contractor to accommodate site visits, and one position to monitor contractor activities and manage the criminal background checks and fingerprinting requirements.
- ❑ Provides four audit positions to increase the detection of fraud and abuse by recipients in the Medicaid program. These positions will investigate referrals of fraudulent activity and abuses conducted by individuals that results in improper enrollment in the Medicaid or FAMIS programs.
- ❑ Provides funding for four Quality Management Review (QMR) positions for the Medicaid home and community-based waivers. The state is required under federal rules to monitor and report on quality assurance measures through QMRs.

# Highlights of Virginia's Program Integrity Efforts

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- ❑ Most recent PERM payment error calculation established a payment error rate of *less than 1%* (0.7%), considerably below the national average.
  - ❑ Indicates that pre-payment activities employed by Virginia Medicaid have been extremely successful in avoiding “improper” payment.
- ❑ Post-payment identification of over \$40M in improper payments indicates that 99% of what is missed on prepayment review (based on the PERM error rate) is identified in post-payment review.
- ❑ The Program Integrity Division Director has national auditing experience and was selected to serve on the National Program Integrity Technical Advisory Group.
- ❑ DMAS and MFCU have a very collaborative working relationship which has been identified as a best practice.

# Highlights of Virginia's Program Integrity Efforts

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- ❑ DMAS is in the process of issuing several RFP's to enhance audit activities:
  - ❑ Data mining RFP will enhance efforts to further identify potential target areas for auditing. This will expand the existing library of over 300 concurrent Program integrity tests to include the data mining and analytic testing of claims, both pre and post payment.
  - ❑ Recovery Audit Contractor RFP will be awarded in 2012 to enhance audit activities. The contractor will perform auditing services and maximize efficiency and cost effectiveness by identifying underpayments and overpayments for services that result from inappropriate billing by providers
  - ❑ DMAS has expanded the number of contractor audits for service providers that had significant findings in prior audits.

# Highlights of Virginia's Program Integrity Efforts

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- ❑ DMAS has established a Data Mining Unit to work with the contractor awarded the data mining RFP. This will enhance efforts of identifying improper payments through the use of algorithms and data analysis.
- ❑ DMAS created the Contract and Compliance Unit to consolidate oversight of provider audit contractors, service contractors and managed care plans' program integrity efforts.
- ❑ DMAS Program Integrity Division will increase the analysis of audit and appeals findings and create Corrective Action Plans (CAP) as a means of enhancing feedback to policy staff (subject matter experts) regarding recommended policy changes to improve provider compliance.

# Highlights of Virginia's Program Integrity Efforts

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- ❑ Per Item 297 AAAA of the 2011 Appropriations Act DMAS is consulting with representatives of providers of Home and Community Based Care Services to evaluate the effectiveness and appropriateness of the audit methodology.
- ❑ The new ACA Provider Screening Regulations will significantly increase the number of provider site visits, criminal background checks and eligibility to participate in federal programs validations required during the enrollment and re-enrollment processes.
- ❑ Virginia is one of 5 states working closely with CMS to pilot national solutions which will allow states the ability to consistently and successfully comply with the ACA Provider Screening Regulations .