



PROGRAM INTEGRITY IN VIRGINIA MEDICAID

MEDICAID INNOVATION REFORM COMMISSION

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December 17, 2013

Summary

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- ❑ **Overview**
- ❑ Recipient Eligibility
- ❑ Provider Payments
 - ❑ Pre-payment
 - ❑ Post-payment
- ❑ Contractors – Activities and Oversight
- ❑ Provider Fraud and the MFCU
- ❑ Program Integrity Life Cycle

Fraud, Waste, and Abuse Defined

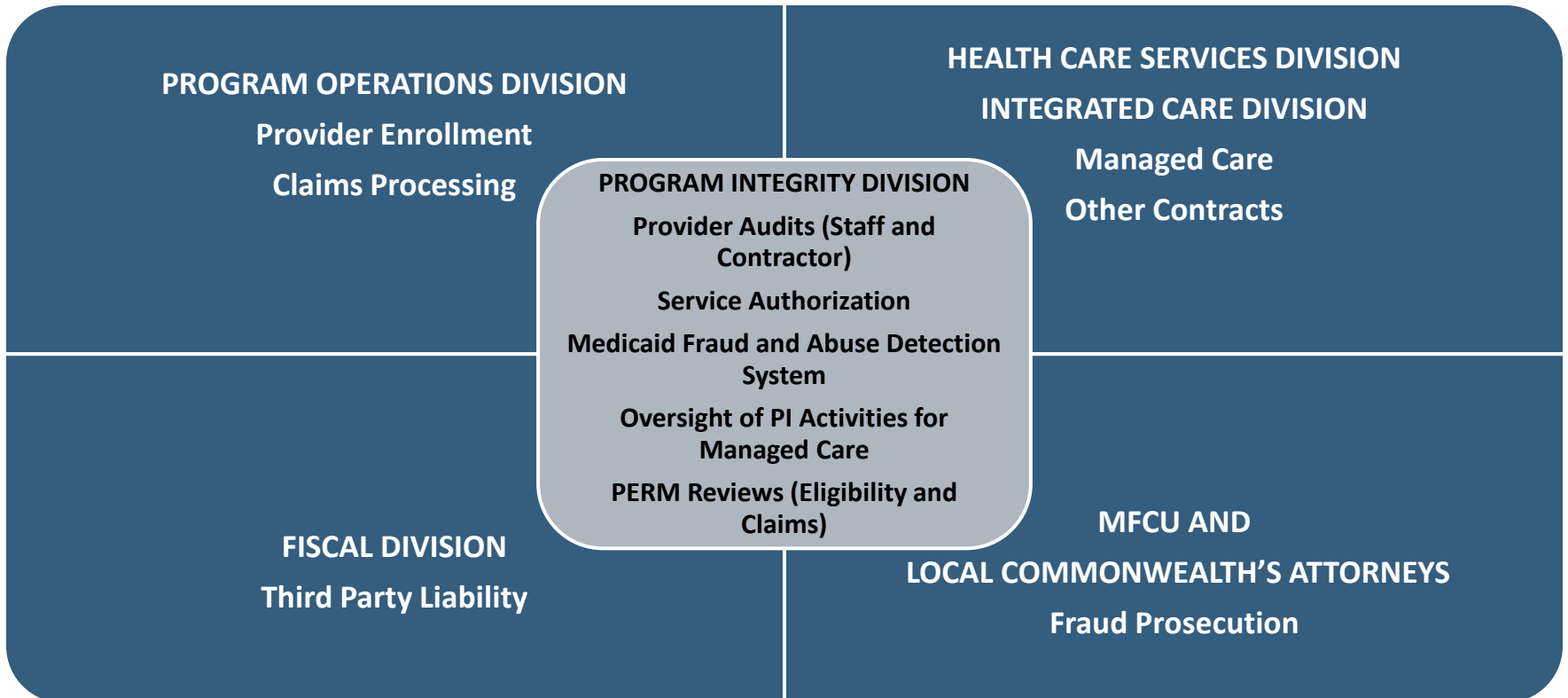
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- ❑ Improper payments may result from errors, waste, abuse, and fraud
- ❑ Errors and waste may result in unnecessary expenditures, but are not criminal activities
 - ❑ **Error:** The inadvertent product of mistakes and confusion
 - ❑ **Waste:** Inappropriate utilization of services and misuse of resources
 - ❑ **Abuse:** Action that is inconsistent with acceptable business and medical practices
 - ❑ **Fraud:** The intentional act of deception or misrepresentation
- ❑ DMAS program integrity efforts prevent and identify waste, abuse, and errors
- ❑ Potential provider fraud cases are referred to MFCU and DMAS handles potential recipient fraud cases

Program Integrity at DMAS

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- ❑ 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
- ❑ In FY 2013 alone, DMAS prevented and identified over \$247 million in improper payments

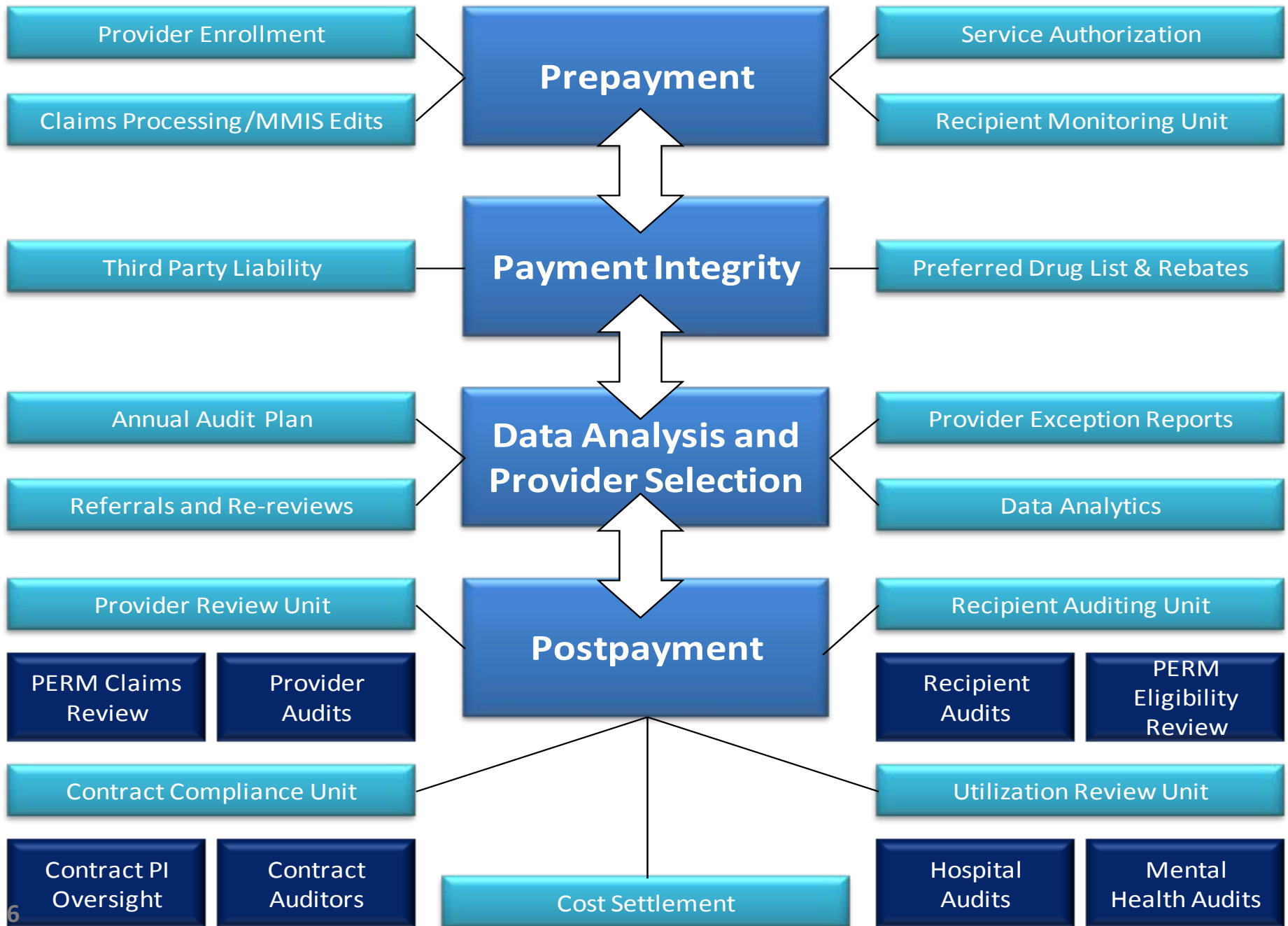


Staffing and Resources

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- ❑ Every budget cycle DMAS evaluates the need to adjust staff, vendors, resources, processes and technology to meet the evolving demands of Program Integrity

- ❑ Program Integrity currently has
 - ❑ 48 FTEs
 - ❑ 15 Wage
 - ❑ 7 Contractors



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Recipient Eligibility Reviews

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- ❑ DMAS investigates allegations of fraudulent provider activity or abuse committed by recipients in Medicaid and Family Access to Medical Insurance Security (FAMIS)
 - ❑ Investigations may result in the identification of misspent funds, administrative recoveries from recipients, disenrollment, or criminal prosecution
- ❑ From FY 2010 to FY 2013, DMAS investigated **7,948 referrals** and uncovered a total of **\$12.2 million** in overpayments
- ❑ **106 individuals were convicted of fraudulently obtaining benefits** and banned from the Medicaid program for one year (the maximum penalty under federal law,) and can be subject to jail time and restitution as well

Recipient Eligibility Reviews

- ❑ CMS conducts the National Payment Error Rate Measurement (PERM) review to determine how a state measures up on a national level in the area of eligibility accuracy
- ❑ DMAS engaged a contractor to work closely with the Virginia Department of Social Services and made a substantial improvement over the prior PERM review
- ❑ During FY 2013 CMS PERM eligibility review, Virginia had a **payment error rate of 0.47 percent** based on the accuracy of Medicaid eligibility determinations
- ❑ Virginia's error rate is lower than the reported national average

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Provider Enrollment

- ❑ Provider enrollment ensures the integrity of the provider network including reviewing credentials as well as terminating providers and cancelling provider agreements
- ❑ In the first quarter of 2014, DMAS will become the first state agency in the region to implement enhanced provider screening requirements under the Affordable Care Act (ACA)
 - ❑ All providers must undergo additional automated screening
 - ❑ 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 providing more complete and up-to-date information on providers as well as greater scrutiny on the enrollment of riskier providers

Service Authorizations

- ❑ DMAS contracts with Keystone Peer Review Organization (KePRO,) that reviews the information submitted by providers to determine if the service is medically necessary under DMAS policy and is required on approximately 1,349 procedures including:
 - ❑ Acute Medical/Surgical Hospital Admissions
 - ❑ Inpatient/Outpatient Rehab
 - ❑ Home Health
 - ❑ Durable Medical Equipment (DME)
 - ❑ EPSDT Services for Children
 - ❑ Home and Community-Based Waiver Enrollments
 - ❑ Substance Abuse Services
 - ❑ Organ Transplants
- ❑ DMAS claims processing system will not issue payment for these services without an authorization code

Service Authorizations

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- ❑ Service authorization avoided costs of over **\$630 million** from FY 2010 to FY 2013

Type of Review	Denied Units/Days FY 2010-FY 2013	Program Savings FY 2010-FY 2013
Inpatient Services	49,646	\$38,803,128
Outpatient Services	8,638,679	\$553,013,825
Waivers and Other Services	2,439,574	\$38,220,816
Totals	11,127,899	\$630,037,737

- ❑ 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

Claims Processing

- ❑ DMAS' Medicaid Management Information System (MMIS) is an automated claims processing and review system
- ❑ MMIS' 1,550 unique edits enables DMAS to accurately and consistently reimburse claims based on clinical appropriateness and medical payment policies
- ❑ As a part of claims processing, DMAS also utilizes two products that consist of packages of edits that prevent improper payment
- ❑ National Correct Coding Initiative edits, which were developed by CMS to prevent inappropriate payment, were implemented in June 2013 and saved **\$174,600** in that month alone
- ❑ 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

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Post-Payment Provider Reviews

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- ❑ **Post-payment** processes identify instances of improper provider billings through data and risk analysis, investigation of referrals and reviews of paid claims
 - ❑ Staff and Contractor's Reviews – 800 provider reviews annually
 - ❑ PI Contractors: HMS Inc, Meyers Stauffer, Xerox/ACS
 - ❑ Third Party Liability Recovery
 - ❑ MFCU Criminal Fraud Referrals and Civil (Qui Tam) cases
 - ❑ Oversight of MCO and other Contractor PI activities

Post-Payment Provider Reviews

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- ❑ The Department and its PI contractors focus extensively on reviews of paid claims to Medicaid providers to identify error, waste and abuse
- ❑ Errors include: missing medical records, claims or provider qualifications not compliant with DMAS policies, records that do not support the claim as billed
- ❑ From FY 2010-FY 2013, DMAS and its contractors conducted **3,197 reviews** and identified over **\$112 million** in overpayments to Medicaid

Post-Payment Provider Reviews

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- ❑ Payment Error Rate Measurement
- ❑ CMS also conducts a PERM review of claims payment accuracy
- ❑ During FY 2013, CMS conducted its most recent PERM review of paid claims for FFY 2012 which reviewed a total of **1,347 claims** for data processing and medical record errors
- ❑ **\$781,391** in claims payments were reviewed and a only **\$6,330** or **.08%** was found to have been paid in error



Data Analysis to Identify Improper Payments - New Contracts

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- ❑ In July 2012, DMAS engaged a contractor to develop a Medicaid Fraud and Abuse Detection (MFAD) system that will enhance efforts to further identify potential fraud, waste, and abuse
- ❑ Contractor created a series of tests that identify possible FWA behavior based on known patterns, issues, and scenarios as well as using statistical models to identify anomalies, outliers and trends
- ❑ During the first year of the contract, the system identified approximately **\$44M** in potential recoveries for DMAS
- ❑ The Affordable Care Act required states to utilize Recovery Audit Contractors (RACs) to audit payments to Medicaid providers
- ❑ Since September of 2012, Virginia's RAC evaluated and analyzed DMAS historic data on processed claims and has moved forward on DMAS-approved audit proposals and identified over **\$21 million** of improper payments

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Managed Care Program Integrity

- ❑ MCOs have Program Integrity Units that focus on prevention and recovery through network management, service authorizations, and reviews
- ❑ In FY 2013, MCO program integrity activities avoided or recovered more than **\$417 million**
- ❑ In 2012, DMAS strengthened the MCO PI contract language and now performs an annual compliance review of each MCO's program integrity activity
- ❑ The managed care contract for FY 2014 included PI provisions that would allow DMAS staff to also conduct audits of managed care providers

Program Integrity and Service Contractors

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- ❑ Since FY 2011, DMAS has held quarterly Managed Care PI Collaborative meetings with PI staff from the MCOs, DMAS and MFCU
- ❑ The collaborative has been identified as a national best practice
- ❑ As a result of these collaborative and contracting effort, program integrity requirements and oversight are being included for every major service contractor
- ❑ DMAS ensures their program integrity processes and protocols are compliant by conducting annual desk-top assessments as a quality assurance measure on an annual basis

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Medicaid Provider Fraud

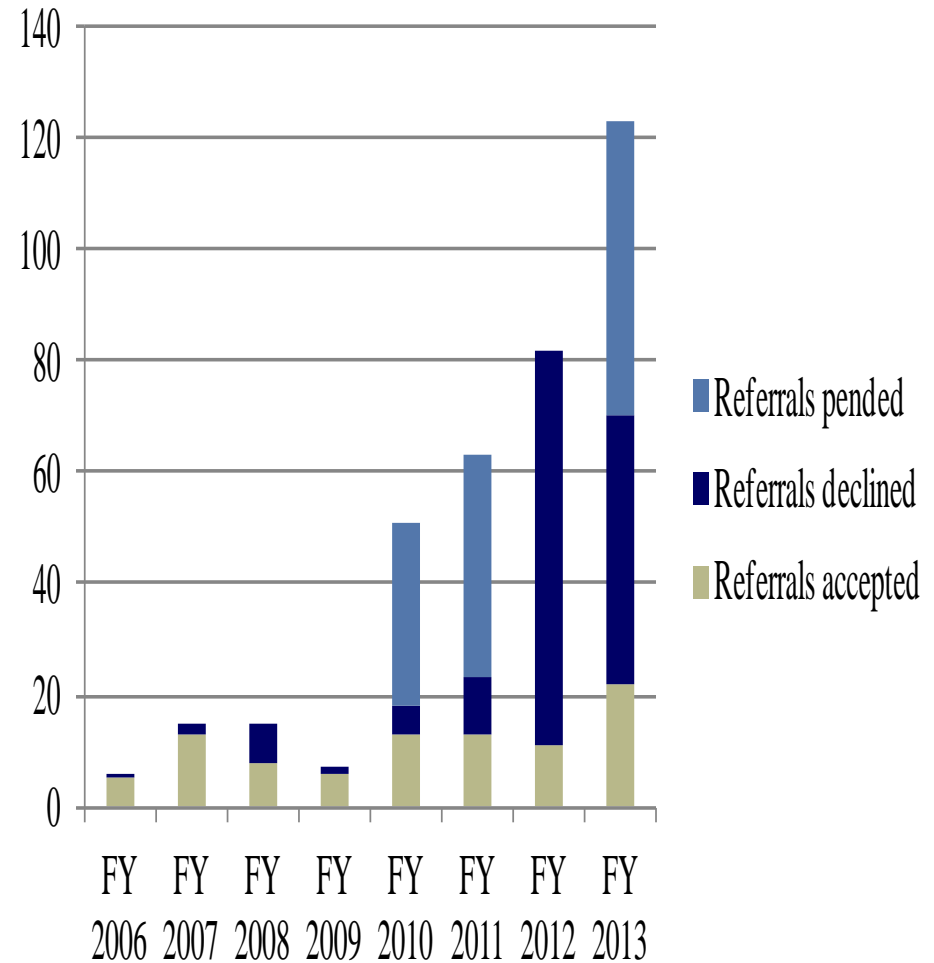
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- ❑ Fraud cases are handled by Medicaid Control Fraud Unit (MFCU)
- ❑ DMAS works closely with the MFCU and coordinates on case development during monthly and quarterly meetings
- ❑ Civil - Qui Tam cases
 - ❑ DMAS staff review records and testifies on national pharmacy cases that make up some of the largest MFCU recoveries
- ❑ Criminal cases
 - ❑ DMAS staff
 - refer of potential cases of fraud uncovered through DMAS PI activities;
 - provide program knowledge to aid in investigations; and
 - testify on cases

Medicaid Provider Fraud

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- ❑ DMAS referrals to MFCU increased substantially beginning in FY 2010 due to increase in staff and contractor activity
- ❑ In FY 2013, DMAS made **123 referrals** of suspected fraud to the MFCU
 - ❑ MFCU accepted 19 of these referrals, a substantial increase from prior years
 - ❑ In addition, MFCU accepted an additional seven cases from those that were pended in FY 2011 and FY 2012



Medicaid Provider Fraud

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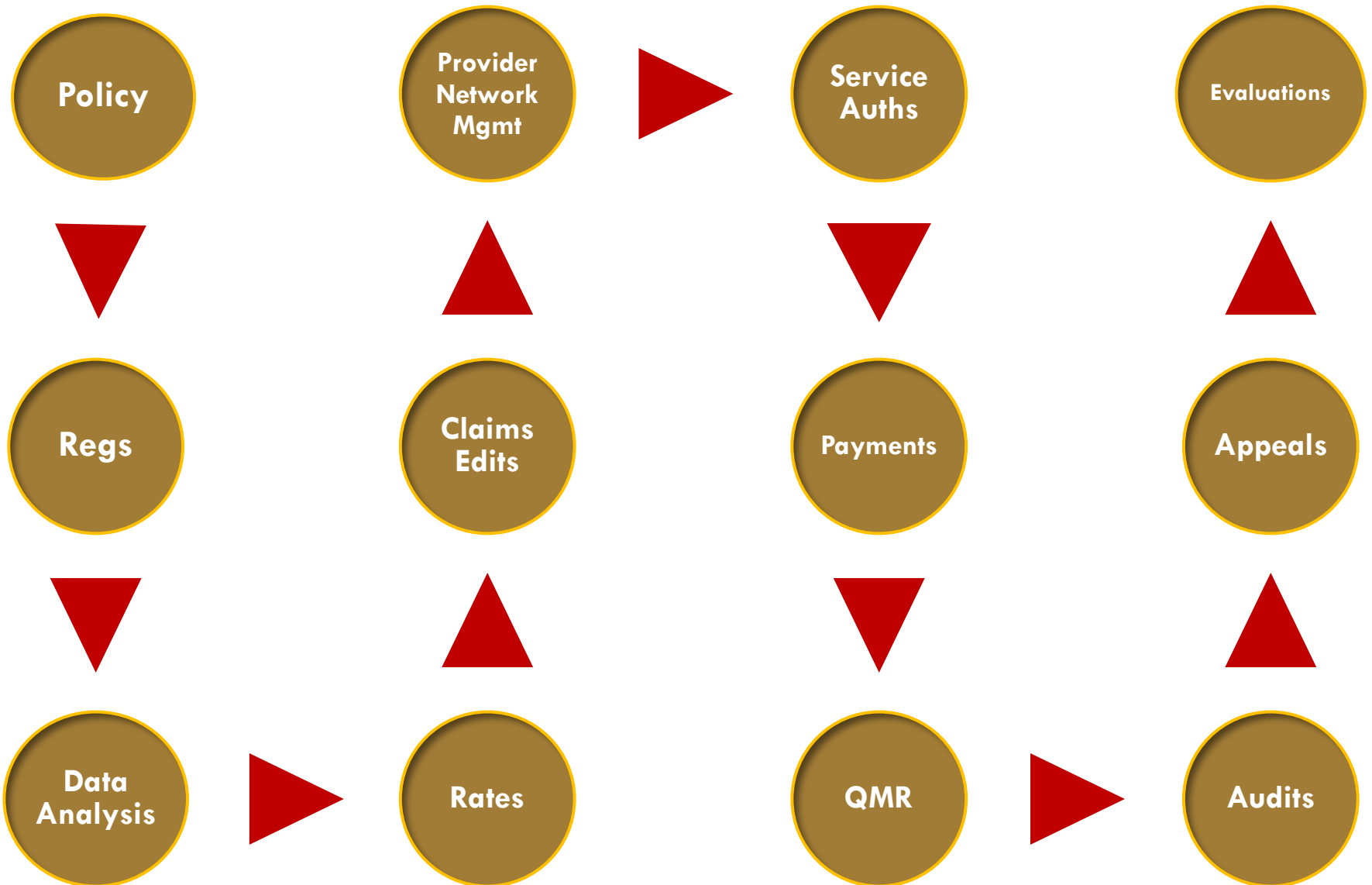
- ❑ DMAS and MCFU joint activities include:
 - ❑ Pursuit of fraud cases and civil cases
 - ❑ DMAS leads the PI/MFCU national technical advisory group
 - ❑ PI Collaborative
 - ❑ 2013 new Memorandum of Understanding
- ❑ DMAS and MFCU have been cited as a National Best Practices
 - ❑ Open Communications between PI and MFCU
 - ❑ Cross training between the two entities
 - ❑ Auditing with fraud prosecution in mind
 - ❑ Information sharing

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DMAS Program Integrity Life Cycle



Example of A Program Integrity Life Cycle: Preventing Improper Behavioral Health Expenditures

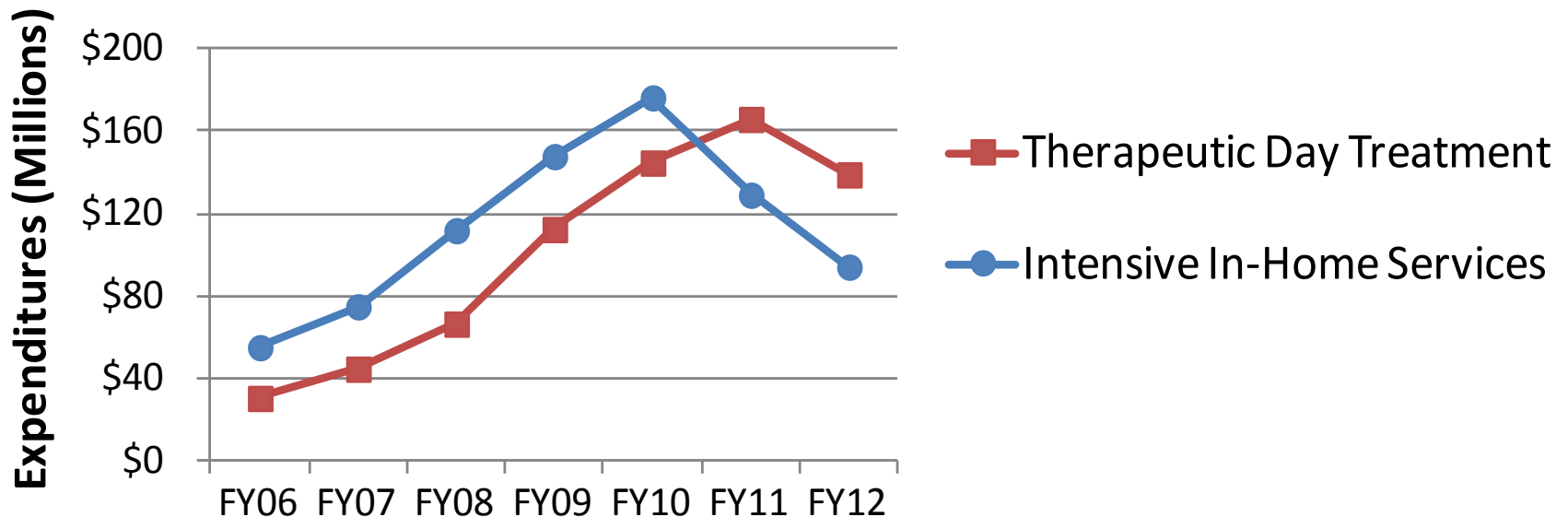
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- ❑ DMAS expenditures on Community Behavioral Health Services (CBHS) increased substantially and DMAS began targeted reviews
- ❑ The vast majority of this increase came from three service types: Intensive In-Home (IIH), Therapeutic Day Treatment (TDT) and Mental Health Support Services (MHSS)
- ❑ Agency Actions Taken:
 - ❑ Development of new Office of Behavioral Health
 - ❑ Policy and Regulatory Changes
 - ❑ Data Analysis
 - ❑ Service Authorization
 - ❑ Rate Changes
 - ❑ Reviews and hired a contractor with BH specialty
 - ❑ Case Referrals to MFCU

Preventing Improper Behavioral Health Expenditures

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- ❑ One step was to develop an assessment/service authorization process
- ❑ The “sentinel effect” of the combination of the assessment program and Service Authorization is illustrated in the following graph as
 - ❑ IiH expenditures decreased **\$82.1M (47%)** from \$176.5M in FY 2010
 - ❑ TDT expenditures decreased **\$26.9 M (16%)** from \$166.1M in FY 2011



Preventing Improper Behavioral Health Expenditures

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- ❑ New regulations were implemented in December 2013 that clarified the scope of Mental Health Skill Building Services and tightened the criteria
- ❑ On December 1, 2013, DMAS implemented a contract with Magellan Health Services for a Behavioral Health Services Administrator
- ❑ Magellan is conducting service authorizations, provider enrollment, network management and claims payment for all Fee For Service (FFS) behavioral health services offered to Medicaid and FAMIS enrollees
- ❑ Magellan will work with DMAS on programs, policies and program integrity efforts to increase efficiencies

PI Pearls

What does Virginia Medicaid do to fight fraud, waste, and abuse?

- The Department and MFCU work together to prevent and prosecute providers who abuse, waste, or fraudulently affect the system
- Program integrity is a multi-division function that is embedded in the pre-payment, post-payment systems, and contractors with the Department
- MCFU investigates and prosecutes fraud

Virginia's Medicaid program contains large amounts of fraud, waste, and abuse by providers

- Virginia's most recent federal National Payment error rate is low .007%
- DMAS PI efforts on data analysis, pre-payment and post-payment review activities, as well as program and delivery changes ensures there are no full scale large provider fraud schemes in Virginia as there were in Florida

All program integrity activities focus on fraud

- Improper payments may result from a variety of circumstances including errors (services provided without sufficient documentation), waste (services that may not be medically necessary), abuse, and fraud
- Errors and waste may result in unnecessary expenditures, but are not criminal activities like fraud

Program integrity success should be defined by identified improper payments

- Good program integrity processes should provide feedback loops to prevent identified overpayments through front-end edits and service authorization

Prepayment and automated reviews require little or no staff resources

- Data analytics only provide leads and staff or contractor resources are still required to establish improper payments
- In addition, DMAS staff work with contractors to develop these systems
- DMAS takes efforts to ensure that new vendor proposals are not duplicative of existing contracts

PI Pearls

Medicaid lacks competitive incentives for controlling medical costs and improper expenditures

- DMAS enters into capitated, risk-based contracts with its managed care partners, who are each paid based on the same set of actuarially-based rates
- MCOs control costs through negotiated contracts with providers, ensuring appropriate cost-effective medical care, and preventing and identifying fraud, waste, and abuse

All improper activities should be prosecuted as fraud

- Fraud convictions require demonstration that an individual “knowingly and willfully” engaged in activities to obtain funds improperly
- This requires proving the state of mind of the individual must be defensible in a court proceeding

All Virginia MFCU recoveries represent fraud in Virginia’s Medicaid program

- A large portion of the recoveries reported by MFCU are from large national civil cases against pharmaceutical providers, in which only a portion of the recoveries are due to Virginia Medicaid provider fraud cases

All DMAS referrals to MFCU represent prosecutable fraud cases

- According to the MOU between DMAS and the MFCU, DMAS refers any case where there is a “suspicion of fraud” then works with MFCU as they investigate and develop the case

What is the relationship between DMAS and MFCU?

- The relationship between DMAS and MFCU has been lauded as a national best practice, and the PI director presented earlier this year at a national conference on improving the relationship between Medicaid agencies and MFCUs

Questions?

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