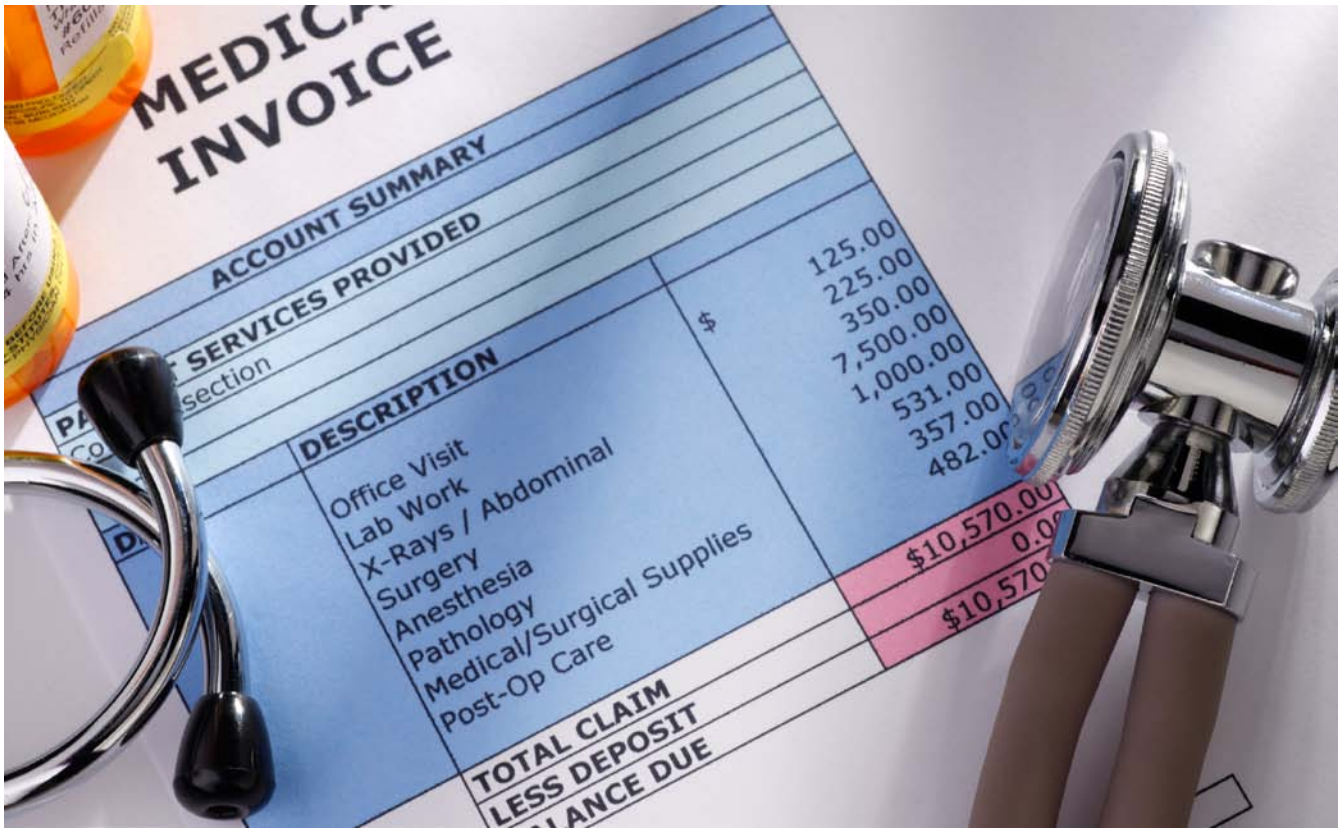
JLARC
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMISSION

REPORT TO THE
GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA



Interim Report: Fraud and Error in Virginia's Medicaid Program

HOUSE DOCUMENT NO. 12
COMMONWEALTH OF VIRGINIA
RICHMOND

DECEMBER 2010

In Brief

House Joint Resolution 127 (2010) directs JLARC to identify opportunities to reduce waste, inefficiency, fraud, and abuse in Medicaid.

In FY 2009, Virginia had known improper Medicaid payments of $38.9 million, which consisted of roughly equal amounts of fraud and error. In addition, up to $50.3 million in potential fraud or error was avoided by blocking improper claims before they were paid.

Errors in eligibility determination and delays in eligibility redeterminations likely result in improper Medicaid payments because some ineligible Virginians receive Medicaid-funded services.

Local departments of social services and the Department of Medical Assistance Services (DMAS) may not be fully investigating and prosecuting recipient fraud.

While the State's Medicaid Fraud Control Unit has reported over $700 million in recoveries from FYs 2005 to 2009, DMAS has received only $49 million.

The report includes recommendations to improve local department compliance with eligibility determination and redetermination requirements, encourage more fraud control activity at the local level, and give DMAS more flexibility to investigate claims prior to payment.

JLARC Staff for This Report

Hal Greer, Deputy Director
Ashley Colvin, Project Leader
Brad Marsh
David Reynolds

This report is available on the JLARC website at http://jlarc.virginia.gov

COMMONWEALTH of VIRGINIA

Glen S. Tittermary
Director

Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capitol Square
Richmond, Virginia 23219

(804) 786-1258

December 20, 2010

The Honorable Charles J. Colgan
Chair
Joint Legislative Audit and Review Commission
General Assembly Building
Richmond, Virginia 23219

Dear Senator Colgan:

House Joint Resolution 127 of the 2010 General Assembly directed staff of the Joint Legislative Audit and Review Commission to study the Commonwealth's medical assistance program (Medicaid). Specifically, staff were directed to examine the nature and extent of waste, inefficiency, fraud, and abuse in Virginia's Medicaid program, to compare those deficiencies with what occurs in Medicaid programs in other similar states, and to identify ways to reduce Medicaid waste, inefficiency, fraud, and abuse in Virginia.

This is a two-year study. This interim report was briefed to the Commission and approved for printing on October 12, 2010.

On behalf of the Commission staff, I would like to thank the staff at the Departments of Medical Assistance Services and Social Services and at the Medicaid Fraud Control Unit in the Office of the Attorney General for their assistance during this study.

Sincerely,

Glen S. Tittermary
Director

GST/mle

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Abbreviations Used Frequently in This Report

ADAPT	Application Benefit Delivery Automation Project
CMS	Federal Centers for Medicare and Medicaid Services
DBHDS	Department of Behavioral Health and Developmental Services
DHP	Department of Health Professions
DMAS	Department of Medical Assistance Services
DSS	Department of Social Services
FFY	Federal Fiscal Year
LEIE	List of Excluded Individuals/Entities
MCO	Managed Care Organization
MEQC	Medicaid Eligibility Quality Control
MFCU	Medicaid Fraud Control Unit (Office of the Attorney General)
MMIS	Medicaid Management Information Systems
OIG	Office of the Inspector General for the U.S. Department of Health and Human Services
PERM	Payment Error Rate Measurement
SNAP	Supplemental Nutrition Assistance Program (formerly Food Stamps)
TANF	Temporary Assistance for Needy Families
VDH	Virginia Department of Health

JLARC Report Summary:

Interim Report: Fraud and Error in Virginia's Medicaid Program

Key Findings

- In FY 2009, Virginia had known improper Medicaid payments of $38.9 million, which consisted of roughly equal amounts of fraud and error. In addition, up to $50.3 million in potential fraud or error was avoided by blocking improper claims before they were paid. Improper payments and blocked claims represent less than two percent of Medicaid spending. (Chapter 2)

- Errors in eligibility determination and delays in eligibility redeterminations likely result in improper Medicaid payments because some ineligible Virginians receive Medicaid-funded services. Federally required reviews in Virginia have shown that errors occur in about eight percent of eligibility determinations, on average, and most local departments of social services do not meet federal regulatory requirements for annual redeterminations of eligibility. (Chapter 3)

- Recipient fraud may not be fully investigated and prosecuted. In FY 2009, 37 of 120 local departments of social services did not investigate any cases of potential Medicaid fraud. Similarly, 97 local departments did not refer any Medicaid cases to a Commonwealth's Attorney for prosecution, and 17 did not forward a case to the Department of Medical Assistance Services (DMAS) for investigation. (Chapter 4)

- While Virginia's Medicaid Fraud Control Unit (MFCU) reports recoveries of over $706 million from FY 2005 to FY 2009, only $167 million of that amount has been received by Virginia and only $49 million has been received by DMAS. In addition, the MFCU, the Virginia State Police, and the Department of Health Professions have received a total of $104 million as a result of the unit's prosecutions. (Chapter 7)

Medicaid is the second largest program in Virginia's budget, accounting for more than $5.8 billion in fiscal year (FY) 2009. Looking ahead, the growing number of older Virginians and medical inflation are projected to increase Medicaid expenditures on aged recipients from one billion dollars per year in 2004 to between four and 11 billion dollars per year by 2030.

Because Medicaid is such a large program, even a relatively small proportion of improper payments (resulting from fraud, abuse, or errors) can be costly. In recognition of this concern, House Joint Resolution 127 (2010) directed the Joint Legislative Audit and Review Commission (JLARC) to study the Commonwealth's medical

assistance program, known as Medicaid, to identify opportunities for reducing waste, inefficiency, fraud, and abuse.

While the State has controlled Medicaid fraud and error to some extent, there appear to be opportunities to further reduce improper payments in Virginia. This interim report describes the complex effort, spread across several agencies, that the State relies on to control fraud and error, and includes several findings and recommendations. The final report will continue to examine the data on the amount of improper payments known to occur in Virginia, compare this amount with that occurring in other states, and recommend actions that may help further reduce improper Medicaid payments.

MEDICAID PROGRAM INTEGRITY ACTIVITIES ARE DESIGNED TO REDUCE IMPROPER PAYMENTS

Medicaid was created in 1965 to provide medical care to primarily low-income individuals and families. The cost of the program is shared between the federal government and the states, and in Virginia is administered by the Department of Medical Assistance Services (DMAS). States operate the Medicaid program within broad federal guidelines but have some flexibility in establishing eligibility standards, determining which services to provide, and setting payment rates. Virginia's 857,652 Medicaid recipients have access to various health care services from medical providers that are eligible to receive Medicaid payments. These services range from preventive and acute care services (such as hospitalizations) to long-term care services.

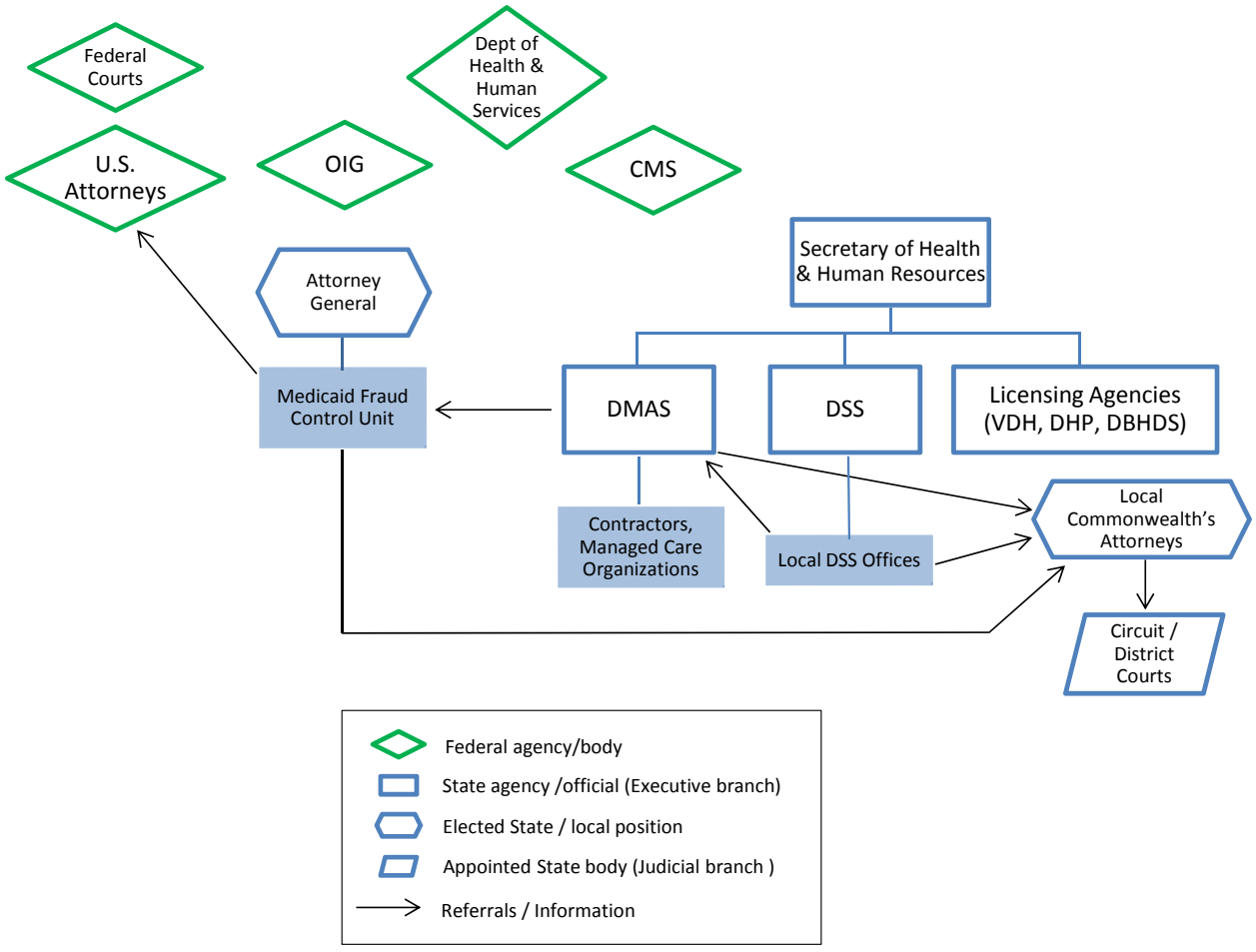
Although Medicaid is an entitlement program, it also operates as a vendor payment program. States have two options for paying providers: providers may be paid directly for individual services, an approach known as "fee-for-service," or states may use managed care organizations, which receive a flat fee to act as intermediaries between the Medicaid agency and providers in their managed care network. In Virginia, although fee-for-service payments comprise 70 percent of overall Medicaid expenditures, about 65 percent of all recipients are enrolled in managed care.

Although the mandate for this study speaks of waste, inefficiency, fraud, and abuse, each of these activities is generally thought of as an example of an "improper payment." Within the context of the Medicaid program, federal regulations define fraud as "intentional deception or misrepresentation" made to obtain unauthorized benefits. Because all improper payments are a drain on the State's general fund, State agencies use a variety of program integrity activities designed to prevent and recover improper payments. The primary State agencies that engage in these activities are DMAS

and the Department of Social Services (DSS) and local departments of social services. If these agencies identify that an improper payment likely resulted from fraud, the case is referred to either the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General or to a local Commonwealth's Attorney for prosecution. As shown in the figure below, the range of program integrity activities in Virginia involves agencies and other entities at the federal, State, and local levels.

Although fraud is discussed more often, federal efforts to reduce improper payments focus on the reduction of error and other inadvertent actions by providers and agencies. At the federal level, the Centers for Medicare and Medicaid Services (CMS), the agency in charge of Medicaid, identifies error by reviewing samples of Medicaid reimbursement claims paid by states to providers; CMS also

Responsibility for Medicaid Program Integrity Is Dispersed Among Many Agencies and Levels of Government



Source: JLARC staff.

reviews state efforts to reduce error made by agency staff when processing applications by individuals for Medicaid enrollment. The Office of the Inspector General for the U.S. Department of Health and Human Services (OIG), the agency that supervises all MFCUs, plays a role by annually recertifying all MFCUs and examining their relationship with the state Medicaid agency. The OIG also reports on the types of improper payments that occur, and has found that they can result from clerical errors, misinterpretations of rules, or poor recordkeeping.

Recent federal legislation has increased the program integrity activities required of DMAS. The Deficit Reduction Act of 2005 requires CMS to contract with auditors to review Medicaid claims. These contractors will operate independently of DMAS, but DMAS will be responsible for recovering the funds they identify. In addition, federal health care reform will increase both Medicaid enrollment and DMAS's program integrity responsibilities. One new responsibility will be the need for all state Medicaid agencies to retain contractor auditors, in addition to those retained by CMS, to identify improper payments and repay the federal share to CMS. Although DMAS's program integrity activities now focus on the fee-for-service program, these new activities will also need to extend to the managed care organizations.

KNOWN IMPROPER PAYMENTS AND BLOCKED CLAIMS EQUAL LESS THAN TWO PERCENT OF MEDICAID SPENDING

The mandate for this study directed JLARC to determine the extent of fraud and error in Virginia's Medicaid program. A comprehensive estimate is difficult to develop given that some fraud and error inevitably goes undetected, but a conservative estimate can be developed based on what is known to occur in a given year. Federally required reviews of Virginia's Medicaid program are currently underway and should provide additional data on the extent of error in Virginia; the findings from this review will be presented in the final report.

Based on available data, in FY 2009, Virginia's Medicaid program had $38.9 million of improper payments resulting from fraud and error. (Data on the amount actually recovered is unavailable.) This amount includes fraud prosecuted by the MFCU and Commonwealth's Attorneys as well as erroneous payments identified by DMAS through audits and other means. In addition, up to $50.3 million in avoided costs was realized through DMAS's use of prepayment controls that prevented payments for erroneous provider reimbursement claims. In total, the $89.2 million in improper payments and blocked claims represented less than two percent of Virginia's Medicaid expenditures in FY 2009.

ERRORS IN RECIPIENT ELIGIBILITY DETERMINATIONS CAN LEAD TO IMPROPER PAYMENTS

The Medicaid recipient eligibility process in Virginia is highly decentralized, involving DMAS, DSS, and each local department of social services. The responsibilities of each party are set forth in statute, regulation, and an interagency agreement. Under this framework, local departments of social services process Medicaid applications, ensure the ongoing eligibility of each individual and, if necessary, disenroll individuals from Medicaid.

Federally required reviews in Virginia have shown that errors occur in about eight percent of eligibility determinations, on average. This suggests some ineligible Virginians are receiving Medicaid-funded services. The most common errors involved shortcomings in the verification of income, including a lack of resource verification documentation in the case file, and individuals with incomes in excess of program limits.

Because each local department of social services is responsible for making eligibility determinations, it is likely that each department has a different eligibility error rate. Federally required reviews suggest that locality error rates likely vary substantially, but DSS and DMAS do not conduct the reviews in a manner that allows those rates to be determined. Given the likelihood of actual variation in error rates by locality, it is recommended that DSS and DMAS use a sample of cases when conducting reviews that is large enough to reasonably identify individual error rates for local departments of social services. This process could begin with a pilot study for selected local departments.

Most local departments do not meet federal regulatory requirements for annual redeterminations of eligibility, likely leading to improper Medicaid payments. Federal regulations require states to redetermine each recipient's Medicaid eligibility every 12 months. However, in each of the 36 months between January 2007 and December 2009, 70 of the 120 local departments did not complete all of the redeterminations that were due in a given month. Despite the variation at the local level, DSS central office staff note that 94.5 percent of all Medicaid eligibility redeterminations were made in a timely manner during calendar year 2009.

Although DMAS is ultimately responsible for complying with the federal requirement, it is difficult for DMAS to enforce this requirement since it has no authority over DSS or local departments. As noted by the Auditor of Public Accounts in earlier audits of DMAS and DSS, the need to ensure that only eligible recipients receive benefits "is a critical control and compliance issue." Although there do not appear to be express federal penalties for fail-

ure to make annual redeterminations, DSS needs to ensure local departments comply with federal requirements to provide for better control and compliance and prevent possible reductions in federal funding.

An initial review of the systems and processes used by local departments of social services indicates several potential opportunities to increase the detection of ineligible recipients and also reduce error in the eligibility determination process. These include the possibility of improving the verification of financial assets by using land records data maintained by the Supreme Court, and the use of information technology to reduce eligibility error. JLARC staff will undertake additional study to determine the potential to decrease fraud and error and include any findings or recommendations in the final report.

MEDICAID RECIPIENT FRAUD MAY NOT BE FULLY INVESTIGATED AND PROSECUTED

DSS and DMAS share responsibility for investigating suspected Medicaid recipient fraud and referring cases for prosecution. However, 37 of 120 local departments of social services did not investigate any cases of Medicaid fraud in FY 2009. Similarly, 97 departments did not refer any Medicaid cases to a Commonwealth's Attorney for prosecution, and 17 did not refer any cases to DMAS for further investigation.

Lack of fraud control activities by some local departments may be partly due to the loss of State funding and the fact that there are federal financial incentives to investigate other types of fraud. Since FY 2005, State general funding for fraud control has been steadily replaced by local funds. State general funding was eliminated altogether in FY 2009. In addition, the Supplemental Nutrition Assistance Program (SNAP) (formerly the Food Stamps Program) allows local departments to keep up to 35 percent of recoveries made in cases of fraud. In contrast, the Medicaid program does not offer any financial incentives. This lack of an incentive may explain why the number of Medicaid fraud cases investigated or identified for investigation from FY 2005 to 2009 was disproportionally lower than the number of SNAP cases investigated, despite the similar number of recipients in each program. To increase the incentive for local departments to detect and investigate Medicaid fraud, the report recommends that the General Assembly consider allowing local departments to retain some of the funds recovered from Medicaid fraud, a process used in some other states.

Because no performance standards exist for local fraud control activities, JLARC staff used a proxy. Staff estimated that if all local

departments performed at the level demonstrated by the typical locality that performs fraud control activities, the number of Medicaid fraud investigations would increase from 2,276 statewide to 3,555. The number of referrals for prosecution would increase from 78 to 653.

DMAS also has a responsibility to investigate recipient fraud, but it appears to lack the necessary resources. Therefore, the occurrence of fraud may be under-reported and prosecuted. The *Recipient Audit Operating Procedures Manual* notes the agency has a policy of first attempting to recover improper payments through DMAS's administrative recovery process, even in cases where evidence suggests fraud has occurred. This policy appears to be driven by, as the manual notes, the unit's "very limited staffing . . . resulting in the lack of resources to take all criminal cases around the state forward for prosecution."

The Recipient Audit Operating Procedures Manual notes the unit's "very limited staffing . . . resulting in the lack of resources to take all criminal cases around the state forward for prosecution."

Resource constraints likely contribute to the low proportion of recipient fraud prosecutions. From FY 2005 to FY 2009, only 100 (less than two percent) of the 7,339 referrals for investigation received by the Recipient Audit Unit resulted in a conviction of recipient fraud.

As a result of fraud prosecutions and administrative recovery actions, DMAS, local departments, and Commonwealth's Attorneys identified at least $12.4 million in improper payments on behalf of Medicaid recipients between FY 2005 and FY 2009. Of this total, about $10.5 million in overpayments was pursued by DMAS through its administrative recovery process. The remaining $1.9 million in improper Medicaid payments was due to recipient fraud.

VIRGINIA PROVIDER ENROLLMENT PROCESS RELIES ON SEVERAL AGENCIES TO FUNCTION PROPERLY

DMAS is responsible for enrolling all Medicaid fee-for-service providers, but not providers in managed care networks. Between FY 2005 and FY 2009, the number of billing providers enrolled in the fee-for-service program grew by 27 percent, or about 2,955 per year. DMAS's provider enrollment process relies upon self-disclosure and timely and accurate licensure decisions by other agencies. DMAS reports that it lacks sufficient authority to deny providers enrollment if they (1) meet certification and licensure requirements, (2) have not committed a Medicaid- or Medicare-related felony, and (3) have not been convicted of patient abuse.

One method used by DMAS's enrollment services contractor is a review of a database which lists all providers banned from Medicare and Medicaid by the OIG. CMS will not reimburse DMAS for services delivered by providers on this list. As of June 2010, 71

percent of the 1,080 Virginia providers who were banned by OIG were listed because their medical license had been suspended or revoked. The next most common reasons were conviction of program-related crimes (15 percent), felony convictions for controlled substances (five percent), and health care fraud (three percent).

Several aspects of the provider enrollment process merit further review. For example, DMAS only determines if the mailing address stated by a new provider is valid and does not verify if the provider actually provides services at that or any other location. In addition, some persons providing services, such as certain employees of home health care agencies, provide Medicaid-funded services but are not enrolled as providers themselves. DMAS also does not perform criminal background checks on enrolling providers, and is therefore reliant on determinations made by other entities. JLARC staff will continue to study these issues and include any findings or recommendations in the final report.

DMAS PROGRAM INTEGRITY ACTIVITIES HAVE REDUCED IMPROPER PAYMENTS, BUT IMPROVEMENTS ARE NEEDED

DMAS uses several different methods to ensure that provider claims for Medicaid reimbursement are valid. In FY 2009, these program integrity activities produced up to $67 million in avoided costs and funds identified for recovery. In FY 2009, DMAS processed over 35 million provider reimbursement claims at a total cost of $5.04 billion. These payments equaled 12 percent of Virginia's State budget for FY 2009.

The prior authorization process, which ensures that a service is medically necessary before it is approved for reimbursement, produced avoided costs of up to $25.6 million in FY 2009. In addition, DMAS's claims processing system rejected 39 percent of all fee-for-service claims because of violations of program rules, resulting in avoided costs of at least $11.8 million in FY 2009. Claims were most frequently blocked because the provider requested a higher payment than DMAS allowed. Other common reasons for blocked claims include the presence of other insurance coverage or recipient ineligibility.

DMAS audits of paid provider claims identified $15 million in improper payments for recovery in FY 2009. This equates to approximately $20,000 in identified overpayments per audit. These include overpayments or claims that should not have been paid according to Medicaid rules. The most common errors uncovered through audits are instances in which the medical record did not support the service that was claimed or cases where no medical record existed. Each of these errors can result in the denial of the

entire claim. These two error types constituted 40 percent of all errors in FY 2009.

A change to the Virginia Public Procurement Act is needed to increase pre-payment reviews. DMAS staff have stated that the statutory prompt payment requirement prevents additional pre-payment reviews of provider documentation. To enable DMAS to engage in more extensive pre-payment reviews and potentially reduce the amount of improper payments, the report recommends that the General Assembly consider giving DMAS an exemption from the prompt pay requirement if there is a reasonable basis to suspect that payment of the claim could be improper.

DMAS's ability to identify fraud and error committed by providers who are enrolled in managed care networks, or by the managed care organizations themselves, is limited because the organizations submit incomplete data on services they provide and the associated costs. Because of these and other data quality issues, DMAS staff report that these data are not used to identify potential improper payments resulting from fraud and error. As a result, $1.4 billion (27 percent) of all Medicaid expenditures in FY 2009 were not subject to review by DMAS for fraud and error. Although the managed care organizations are contractually required to conduct their own program integrity activities, DMAS remains responsible for ensuring that the funds were properly paid.

A federal review of a sample of claims paid by DMAS in federal fiscal year 2006 found that between two and six percent of claims in the sample were erroneous. The improper overpayments identified by the federal review amounted to 3.2 percent of the payments made for all claims in the sample reviewed by CMS. CMS then applied weights to the claims in order to more accurately represent all paid claims, increasing the 3.2 error rate to 5.5 percent. However, DMAS staff assert that the weighted estimate should have been adjusted because after CMS completed its review, some claims were found to be properly paid once providers submitted additional documentation. If these claims are removed, the error rate is reduced to 2.2 percent.

MFCU PROSECUTION OF FRAUD RETURNED AT LEAST $49 MILLION TO VIRGINIA'S MEDICAID PROGRAM

Although recipient Medicaid fraud is prosecuted by local Commonwealth's Attorneys, provider fraud is investigated and prosecuted by the MFCU. All of the cases investigated by the unit come from referrals, of which almost two-thirds are corporate whistleblowers. Convictions obtained by the MFCU, often in conjunction with other states and the federal government, most commonly involve home health providers and pharmaceutical manufacturers.

While the unit reports recoveries of over $706 million from FY 2005 to FY 2009, only $167 million of that amount has been received by Virginia. Of Virginia's share of all court-ordered awards, the amount awarded to DMAS because of Virginia Medicaid fraud is not known. Nor does the MFCU consistently track all of the funds that are actually collected by Virginia State agencies from these court-ordered awards.

DMAS data indicate that the agency received $48.7 million from the MFCU from FY 2005 to FY 2009.

Although the MFCU does not track all of the funds collected from court-ordered awards, DMAS tracks the funds it has received from the MFCU. From FY 2005 to FY 2009, DMAS data indicate that the agency received $48.7 million from the MFCU. This suggests that at most, seven percent of the $706 million reported by the MFCU resulted in actual collections for Virginia's Medicaid program.

Concern has been expressed that not all cases of potential fraud are detected or fully investigated. While the MFCU and DMAS appear to have a productive working relationship, better coordination between the agencies may improve fraud control efforts. The federal OIG indicates DMAS ranks in the lower half of all state Medicaid agencies in the number of referrals to the state's MFCU. The MFCU believes DMAS could refer more suspected cases of fraud, but DMAS staff note that the MFCU does not accept 25 percent of their referrals. This issue will be examined further for the final report.

The MFCU could also assume a role in analyzing Medicaid claims data instead of relying on DMAS to make a referral. It appears that Virginia's MFCU currently has the authority to analyze DMAS data on Medicaid provider claims to identify fraud, but has not taken advantage of this opportunity. A federal waiver granted to another state's MFCU suggests Virginia's MFCU may already be authorized to perform independent data analysis. The MFCU's director disagrees, stating that the unit lacks this authority and therefore must rely entirely on referrals.

POTENTIAL OPPORTUNITIES MAY EXIST TO FURTHER REDUCE FRAUD AND ERROR

While the State has enjoyed some successes in controlling fraud and error, JLARC staff have identified certain issues which merit further review to determine if they have the potential to further reduce fraud and error:

- lack of coordination of the program integrity activities of State and local agencies;

- potential for delays in licensure decisions by other State agencies to hinder DMAS's efforts to disenroll unqualified providers from Medicaid;

- adequacy of DMAS's oversight of contractors, including the managed care organizations and contract auditors;

- adequacy of the criteria and processes used by DMAS and local departments to refer cases of Medicaid fraud for prosecution; and

- potential need for a Medicaid Inspector General to ensure that each of the State's program integrity activities are conducted in a systematic and effective manner, given the inability of DMAS to direct the program integrity activities of other State and local agencies.

Chapter 1

Medicaid Program Integrity Activities Are Designed to Reduce Improper Payments

In Summary

Medicaid is the second largest program in Virginia's budget, accounting for about $5.8 billion in fiscal year (FY) 2009. The federal government typically pays for half of the cost of Medicaid. Because Medicaid is so large, even a relatively small proportion of improper payments (resulting from fraud, abuse, or clerical errors) can be costly. To prevent improper payments, the Department of Medical Assistance Services (DMAS), in conjunction with State and local Departments of Social Services, conduct several program integrity activities. If these agencies identify instances of potential fraud, the case is referred to either the Medicaid Fraud Control Unit in the Office of the Attorney General or to a local Commonwealth's Attorney for prosecution. Recent federal legislation has increased the program integrity activities required of DMAS.

House Joint Resolution 127 from the 2010 General Assembly session directs the Joint Legislative Audit and Review Commission (JLARC) to study the Commonwealth's medical assistance program to identify opportunities to reduce waste, inefficiency, fraud, and abuse (Appendix A). The Department of Medical Assistance Services (DMAS) operates Virginia's medical assistance program, which includes Medicaid, the Family Access to Medical Insurance Security program, and Children's Health Insurance Program. The mandate, however, is directed only at the Medicaid program.

Medicaid is the second largest program in Virginia's budget, accounting for about $5.8 billion in fiscal year (FY) 2009. Of that $5.8 billion in expenditures, $340 million was paid to cover the Medicare premiums of individuals eligible for both Medicare and Medicaid. This report focuses on the approximately $5.4 billion in expenditures for medical services paid by DMAS directly or through the managed care system.

Medicaid is also Virginia's fastest-growing program, accounting for more of Virginia's budget growth during the period FY 2001 to 2010 than any other program (27 percent). Looking ahead, the growing number of older Virginians is projected to increase Medicaid expenditures on aged recipients from one billion dollars per year in 2004 to between four and 11 billion dollars per year by 2030.

Because Medicaid expenditures are so large, even low rates of improper payments (resulting from fraud, abuse, or errors) can be

costly. DMAS and the federal Centers for Medicare and Medicaid Services (CMS) share responsibility for protecting the fiscal integrity of Medicaid. DMAS has a more direct responsibility, and must ensure payments are properly made and that misspent funds are recovered. DMAS administers several program integrity and related activities designed to prevent, detect, and recover improper payments.

While the State has enjoyed some successes in controlling Medicaid fraud and error, there appear to be opportunities to improve these efforts and further reduce improper payments in Virginia. This interim report describes the complex effort, spread across several agencies, on which the State relies to control fraud and error and includes several findings and recommendations. The final report will continue to examine the data on the known nature and scope of improper payments occurring in Virginia, compare this amount with that occurring in other states, and recommend actions that may help further reduce improper Medicaid payments.

In conducting the research for this interim report, JLARC staff interviewed personnel at DMAS, State and local Departments of Social Services, and the Medicaid Fraud Control Unit in the Office of the Attorney General. JLARC staff also reviewed and analyzed reports, manuals, and data on the program integrity activities of these agencies. (Appendix B contains more details about these research activities.)

MEDICAID USES FEDERAL AND STATE FUNDS TO PROVIDE MEDICAL CARE TO ELIGIBLE RECIPIENTS

Medicaid was created in 1965 as Title XIX of the Social Security Act in order to provide medical care to certain individuals and families. The cost of the program is shared between the states and the federal government.

Flexibility Granted to States Results in Different Eligibility and Service Levels

States operate the Medicaid program within broad federal guidelines but have some flexibility in establishing eligibility standards, determining which services to provide, and setting payment rates. Decisions made by Virginia and other states have led to a wide range of standards for eligibility, service provision, and reimbursement levels. As noted by CMS, a person who is eligible for Medicaid in one state may not be eligible in another state. Neighboring states may provide different services or reimburse providers at different rates. The type and extent of program integrity activities also vary, reflecting different approaches and attitudes about the most appropriate means of preventing improper payments.

Compared to other states, Virginia's Medicaid program has more restrictive income eligibility requirements for recipients, covers fewer services, and does not provide coverage to some categories of recipients (such as childless adults) that are covered by many other states. In Virginia, Medicaid recipients have access to various health care services from medical providers that are eligible to receive Medicaid payments. These services range from preventive and acute care services (such as hospitalizations) to long-term care services (including nursing home care, community-based care through waiver programs, and end-of-life care).

Average Medicaid Expenditures Vary by Type of Recipient

In FY 2009, more than $5.4 billion in Medicaid expenditures was made on behalf of 857,662 recipients, at an average annual cost of $5,639 per person. Like other insurance programs, a relatively small proportion of Medicaid recipients accounted for a disproportionately large share of annual costs. This variation can be most directly seen by comparing the average cost of different types of recipients. In FY 2009, Medicaid payments for 480,947 children, who constituted 56 percent of all Medicaid recipients, averaged $2,320 per child. Similarly, for 139,530 adults, who represented 16 percent of beneficiaries, payments averaged $3,432 per person. In contrast, other groups had much larger per-person expenditures. Medicaid payments for 82,340 aged Virginians, who constituted ten percent of all Medicaid recipients, averaged $11,605 per person. Payments for the 154,845 Virginians in the blind and disabled eligibility category, who represented 18 percent of recipients, averaged $14,766 per person.

Federal Government Typically Pays 50 Percent of the Total Annual Cost of Medicaid in Virginia

The federal share, known as the Federal Medical Assistance Percentage, is redetermined each year and is based upon each state's average per capita income. As a state's per capita income increases, its federal matching percentage decreases.

In 2009, the federal American Reinvestment and Recovery Act provided states with a one-time increase in their Medicaid matching rate (from October 1, 2008 through December 31, 2010). This action temporarily increased Virginia's matching rate from 50 percent to as high as 61.59 percent for FY 2010 and the first half of FY 2011. Although the match can vary from year to year, some administrative activities, such as program integrity, are consistently matched at a 50 percent rate. However, any funds recovered by program integrity activities must be repaid at that year's current overall match rate.

Health care reform will increase federal matching payments. The federal match will be enhanced for eligibility categories that were not previously eligible for Medicaid in Virginia. When newly eligible individuals are required to be enrolled on January 1, 2014, the match for those individuals will be 100 percent; the match will slowly decline to 90 percent in 2020, where it will remain.

MEDICAID IS OPERATED THROUGH TRADITIONAL FEE-FOR-SERVICE AND MANAGED CARE PROGRAMS

Although Medicaid is most often thought of as an entitlement program in which eligible individuals are entitled to receive services, it also operates as a vendor payment program. States may pay health care providers directly, through an approach known as "fee-for-service," or use managed care organizations to act as intermediaries between the Medicaid agency and medical providers. Managed care is intended to provide a better means of controlling costs while improving the quality of and access to care.

Each approach has a different means of curtailing Medicaid expenditures. Under fee-for-service, providers are reimbursed for individual services. Under the managed care program, providers are paid a flat (capitated) annual fee. These differences are illustrated by variations in their payment structures, the processing of reimbursement claims, and the assignment of liability for improper payments.

Virginia's Medicaid Recipients Are Enrolled in Either Managed Care or Fee-For-Service

DMAS currently has five participating managed care organizations: Amerigroup, Anthem, Optima (Sentara Healthcare), Virginia Premier (MCV/VCU Health Systems), and CareNet (Southern Health). In geographic areas where two or more managed care organizations are available, certain Medicaid recipients must be enrolled with a managed care organization. In areas where no managed care coverage exists, all Medicaid recipients are enrolled in fee-for-service. In areas with only one organization, Medicaid recipients can choose either fee-for-service or managed care coverage.

Under fee-for-service, health care providers are reimbursed for each individual service or group of services. Each service has an associated fee or rate, and the provider reimbursement varies according to the number of services provided. DMAS administers the fee-for-service program directly (although some functions are performed by contractors), and is responsible for ensuring provider reimbursement claims are processed and paid in a timely manner. If DMAS determines that a claim was paid improperly, it must reimburse the federal government for its share of the payment within

60 days of discovering the improper payment. (As discussed below, this deadline was recently extended to one year.) The State is solely responsible for recovering funds from providers.

In contrast, under the managed care program certain contractors act as intermediaries between DMAS and health care providers. Each managed care organization receives a flat (capitated) monthly payment from DMAS based on the number of Medicaid recipients enrolled in its plan. The managed care organization is then responsible for processing and paying provider claims, and the difference between a managed care organization's capitated payment from DMAS, and the reimbursements the managed care organizations make to providers, constitutes the profit (or loss) experienced by each organization.

In addition to the managed care organizations, two other providers receive capitated payments for services to Medicaid recipients. DentaQuest provides dental service coverage to both managed care and fee-for-service enrollees. In addition, Logisticare provides coverage for non-emergency transportation services provided to fee-for-service enrollees.

Enrollment in Managed Care Is Increasing but Fee-for-Service Recipients Remain More Costly

Although fee-for-service payments comprise the majority of overall Medicaid expenditures, most recipients are enrolled in the managed care program. Of the $5.4 billion in Virginia's overall medical assistance expenditures in FY 2009, about 73 percent ($4.0 billion) was for recipients enrolled in the fee-for-service program. The remaining 27 percent ($1.4 billion) was paid to managed care organizations including the capitated rates paid for dental and non-emergency transportation services. Yet of the 857,652 recipients enrolled in Medicaid in FY 2009, 65 percent were enrolled in managed care and only 35 percent were enrolled in the fee-for-service program.

Fee-for-service recipients are, on average, older, receive services for mental retardation, are disabled, and receive long-term care services. Payments for fee-for-service recipients also tend to be higher, on average, due to the higher than average medical needs of the populations typically enrolled in Medicaid fee-for-service.

WASTE, INEFFICIENCY, FRAUD, AND ABUSE ARE EXAMPLES OF IMPROPER PAYMENTS

The study mandate specifically requires JLARC to study and describe the extent of waste, inefficiency, fraud, and abuse in Virginia's Medicaid program. Generally speaking, these activities are referred to as "improper payments." Although fraudulent or abusive

actions receive more attention, all improper payments pose a risk to the State's general fund. The need to identify all causes of improper payments is reflected in recent federal efforts to estimate payment error rates, which include costs resulting from human error, fraud, and all other violations of Medicaid rules.

Federal Efforts to Reduce Improper Payments Focus on Type of Error

As defined in the federal Improper Payments Information Act of 2002, the term "improper payment" means "any payment that should not have been made or that was made in an incorrect amount." This definition includes payments to an ineligible recipient or for an ineligible service, any duplicate payment or payments for services not received, and any payment that does not include a credit for applicable discounts.

Five Types of Improper Payments Occur Most Frequently in Medicaid. In response to the Improper Payments Information Act, CMS and the Office of the Inspector General for the U.S. Department of Health and Human Services (OIG) increased their efforts to identify errors that lead to improper payments. As defined by CMS, errors include inadvertent actions by providers as well as by state and local agencies. The OIG reports that improper payments can result from clerical errors, misinterpretations of rules, or poor recordkeeping. Audits conducted by the OIG indicate that the following five categories of improper payments occur most frequently:

- Billing for an item or service that lacks adequate documentation. When providers fail to maintain adequate medical records, claims reviewers cannot determine the extent of the services provided, their medical necessity, or whether they were even provided to a Medicaid recipient.
- Billing for medically unnecessary services, as determined by a claims reviewer who reviewed the medical records.
- Using incorrect medical codes. Providers are supposed to use standard codes when submitting Medicaid claims. In a coding review, claims reviewers determine whether the medical records support a lower or higher reimbursement code than was actually submitted.
- Billing for costs or services that Medicaid will not reimburse because they do not meet the State's reimbursement rules and regulations.
- Failing to properly bill a third party, such as Medicare or private insurance. When this occurs, or the state Medicaid agency fails to prevent it, Medicaid inappropriately pays a claim and may not be reimbursed.

Improper Payments Can Result From Errors Made by Providers and State and Local Agencies. CMS indicates that providers can inadvertently commit medical review errors when submitting a claim for reimbursement. Examples of these errors include

- missing or insufficient documentation,
- use of incorrect procedure or diagnostic codes,
- use of medically unnecessary services, and
- violations of policies and other administrative errors.

In addition, state and local agencies can make data processing and eligibility errors. Data processing errors include payment for duplicate items, services that are not covered by Medicaid or which should have been paid by a third party, and data entry and pricing errors. Eligibility errors occur when the misapplication of federal and State policies and procedures results in payment for services on behalf of an individual who was ineligible for Medicaid, or was eligible for Medicaid but not for the service received. Eligibility errors can also include instances in which a review of the recipient's case file indicates a lack of sufficient documentation to definitively determine eligibility status.

Some of these errors, and the improper payments that result, occur because of fraudulent activity. If program integrity activities indicate that the error may have been willful, and not inadvertent, then the responsible local or State agency refers this information to the appropriate law enforcement agency.

Intentional Action Distinguishes Fraud and Abuse From Error

Within the context of the Medicaid program, federal regulations only define "fraud" and "abuse." Fraud is defined as "intentional deception or misrepresentation" made to obtain unauthorized benefits. Fraud can be committed by a provider, applicant, recipient, agency staff, or contractor.

According to the National Health Care Anti-Fraud Association, the majority of health care fraud is committed by providers. One of the most common types of fraud, according to the OIG, is billing for services that were never rendered. This could occur when a provider knowingly bills Medicaid for a treatment or procedure that was not actually performed, such as blood tests when no samples were drawn or x-rays that were not taken. Because the distinction between error and fraud rests on intent, then the same activity (such as use of incorrect codes) could result from either error or fraud. Other common types of provider fraud include

- billing for more expensive services or procedures than were actually provided or performed ("upcoding"),
- performing medically unnecessary services,
- misrepresenting services provided (for example, billing a covered procedure code and providing a non-covered service),
- accepting kickbacks for patient referrals, and
- submitting separate bills for services that should be billed in combination, such as tests or procedures that are required to be billed together at a reduced cost ("unbundling").

Although both fraud and abuse involve intentional action, fraud may be committed without any services being rendered. In contrast, abuse involves the provision of health care. Abuse is defined as actions by providers or recipients that are "inconsistent with sound fiscal, business, or medical practices" and that result in unnecessary cost. Examples of abuse include

- billing and receiving payment from a recipient for the difference between the provider charge and the Medicaid reimbursement for the service,
- billing Medicaid a higher fee than private pay patients, and
- excessive charges for services or supplies.

Waste and Inefficiency Are Not Clearly Defined

Neither federal nor state law appear to define waste in the context of the Medicaid program, but the Government Accountability Office defines waste as "extravagant and unnecessary expenditures." Likewise, there does not appear to be a definition of inefficiency within the Medicaid program, but the study mandate defines it as "regulatory barriers" that increase State expenditures while potentially allowing fraud and abuse to occur.

SEVERAL STATE AND LOCAL AGENCIES ARE INVOLVED IN PREVENTION AND RECOVERY OF IMPROPER PAYMENTS

Several program integrity initiatives exist at DMAS and other agencies that are designed to limit improper Medicaid payments, including those containing elements of fraud and abuse.

Virginia's Medicaid Program Integrity Efforts Are Process-Based

Although Medicaid-related program integrity efforts are carried out by several State and local agencies, these efforts may be conceptualized as a continuum that is composed of four discrete steps. Generally speaking, these four steps apply to both recipients and

providers although each group is subject to different standards and processes.

The following two steps (eligibility determination and pre-payment processes) are *prospective* processes that are designed to prevent improper Medicaid payments before any payment is made:

1. The first step, eligibility determination, is intended to ensure that only eligible recipients and providers are enrolled in the Medicaid program.

2. Next, pre-payment processes are designed to ensure that providers are paid only for eligible recipients, are reimbursed only for appropriate amounts, and are paid only when the service was medically necessary.

The remaining two steps (post-payment reviews and prosecution and recoveries) seek to recover improper payments already made:

3. Post-payment review comprises a collection of processes intended to discover improper payments and investigate instances of recipient and provider fraud.

4. Lastly, prosecution and recovery processes vary for recipients and providers, and involve either administrative or legal (civil or criminal) processes.

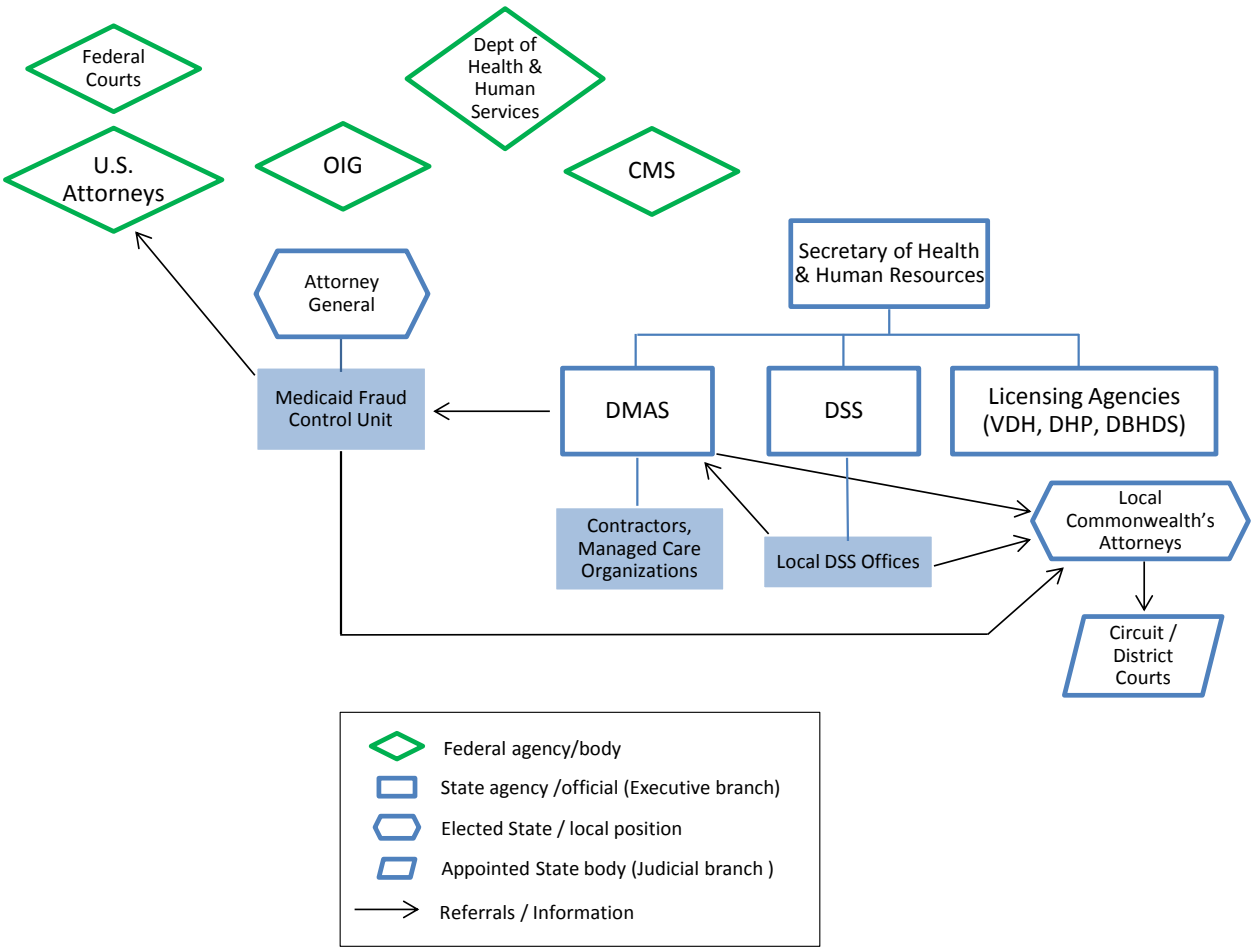
These steps are performed by DMAS and other State agencies, as discussed below and shown in Figure 1.

DMAS Reviews Claims Before and After Payment Is Made to Identify Improper Payments by Providers and Recipients

Several divisions and units within DMAS conduct activities that assist the agency with conducting its overall program integrity responsibilities, including the Policy Division and the Internal Audit Division. This review focuses on DMAS's Program Operations and Program Integrity divisions because they appear to be the most heavily involved in program integrity activities.

DMAS's Program Operations Division Processes and Reviews Provider Reimbursement Claims. The Program Operations Division and its contractors primarily use the Medicaid Management Information System (MMIS), an automated claims processing system, to detect errors. This is done by using a series of front-end claims verification controls to identify and block claims that exhibit known irregularities. The division has 85 staff allocated to the following four units, although only the first two units appear to be involved in program integrity activities:

Figure 1: Responsibility for Medicaid Program Integrity Is Dispersed Among Many Agencies and Levels of Government



Source: JLARC staff.

- Payment Processing evaluates, processes, and adjudicates claims and payments for various providers. As part of this, the unit monitors and supports the contractor that administers MMIS to ensure the system is accurately blocking claims with known errors.
- Customer Service deals with provider training and enrollment, including monitoring the contractor that enrolls providers and operating a helpline to address provider and recipient issues.
- Eligibility Enrollment acts as the liaison with other agencies for recipient enrollment issues. In addition, the division deals with issues that involve Medicaid recipients who are also eligible for Medicare.
- Medical Support includes doctors and nurses who assist in the agency's development of medical policies and in the in-

terpretation of Medicaid policies, including authorization of some procedures, review of agency programs, and provision of medical representation during appeals.

DMAS's Program Integrity Division Reviews Paid Claims to Identify Error by Providers and Recipients. The Program Integrity Division appears to be DMAS's primary means of fulfilling the federal requirement that every state's Medicaid plan include "program integrity" activities. Program Integrity staff look for improper payments by reviewing paid claims, using a combination of planned audits and investigations of referrals and complaints.

The division's current organization and duties resulted from a reorganization effort in FY 2006 which was intended to centralize and streamline DMAS's program integrity efforts into a single division. Previously, program integrity activities had been dispersed throughout DMAS's administrative structure. The division currently has 55 positions in three units:

- Provider Review works exclusively on the detection of improper payments, by investigating referrals, using data analysis, and conducting audits.

- Utilization Review audits focus solely on hospitals and community mental health providers. This unit also monitors the Prior Authorization contractor.

- Recipient Audit investigates referrals of potential error or fraud by recipients, and forwards cases to Commonwealth's Attorneys for prosecution or to DMAS's fiscal unit in order to recover improperly spent funds through an administrative process.

DMAS's creation of the Program Integrity Division has been noted by CMS as a best practice for state Medicaid programs.

The creation of a single division has been noted by CMS as a best practice for state Medicaid programs.

DSS Has a Role in Addressing Improper Medicaid Payments

In Virginia, DMAS enrolls providers into the Medicaid program, but local departments of social services are responsible for determining the eligibility of recipients and enrolling them into Medicaid. As part of a 2004 interagency agreement with DMAS, the State Department of Social Services (DSS) has direct responsibility to investigate suspected cases of Medicaid recipient fraud. According to the process laid out in the agreement, local departments are responsible for investigating and forwarding for prosecution cases of Medicaid recipient fraud that also involve fraud in most other public assistance programs. Meanwhile, DMAS is typically responsible for investigating and forwarding for prosecution cases of recipient fraud involving only Medicaid.

DSS is statutorily required to establish a statewide fraud prevention and investigation program for the public assistance programs it directly administers, and to detect and reduce eligibility determination errors. These program integrity activities are administered by the DSS central office, in conjunction with the five regional offices, and are designed to provide guidance and funding to public assistance investigators employed by local departments of social services. Local department investigators are responsible for investigating all suspected recipient fraud in public assistance programs, including Medicaid.

Local departments are also guided in their activities by their respective local boards of social services. Local boards are composed of three members selected by the local board of supervisors. Local boards have several responsibilities and functions, found in the *Code of Virginia*, including the ability to select the director of local department of social services (when this duty is not assigned to the board of supervisors).

Virginia's Medicaid Fraud Control Unit Established in 1982 to Investigate Medicaid Provider Fraud

In 1977, the federal government adopted the Medicare-Medicaid Anti-Fraud and Abuse Amendments of l977. The objective of these amendments was to "strengthen the capability of the government to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs…". More specifically, the legislation provided each state with the resources to establish a Medicaid Fraud Control Unit (MFCU) to investigate and prosecute provider fraud and abuse of long-term care facility residents.

Virginia's MFCU was created in 1982, after the Omnibus Reconciliation Act of 1980 provided permanent federal funding beyond the initial three-year period. Each MFCU receives an annual federal grant that pays for 75 percent of the its expenses. Because of this incentive funding, the units are subject to certain requirements and limitations. For instance, the units must employ attorneys, investigators, and auditors who work only on Medicaid fraud cases. In FY 2009, the unit employed 49 attorneys, auditors, and investigators to prosecute cases of Medicaid fraud and abuse. The MFCU is generally reimbursed by the federal government for 75 percent of its expenses. For FY 2009, the federal grant covered about 64 percent of MFCU's $4.9 million in expenditures.

The MFCU's statutory responsibilities are limited to audits and investigations of providers who are reimbursed by Medicaid (§ 32.1-320 of the *Code of Virginia*). In addition to its statutory responsibilities, each MFCU operates under the administrative oversight of the federal OIG and must be recertified annually. As part

of this process, the OIG reviews a unit's application for recertification and conducts periodic on-site visits. A key requirement of federal certification is that a unit must be separate and distinct from the state Medicaid agency. Federal regulations also prohibit any official from the Medicaid agency from having authority to review or overrule activities of the unit. Furthermore, a unit is prohibited from receiving funds from the Medicaid agency.

An additional federal certification requirement involves the execution of a memorandum of understanding between the Medicaid agency and the MFCU which outlines each agency's respective responsibilities and duties. CMS conducts reviews that evaluate the performance of MFCU, including an assessment of the relationship between MFCU and DMAS.

FEDERAL EFFORTS TO REDUCE IMPROPER PAYMENTS HAVE INCREASED SINCE 2002

Although Medicaid is jointly funded and administered by states and the federal government, until recently federal involvement in Medicaid program integrity efforts were much more limited. However, several recent developments point to an increased federal role in Medicaid program integrity.

Deficit Reduction Act of 2005 Strengthened Medicaid Eligibility Standards and Increased CMS's Program Integrity Duties

The Deficit Reduction Act of 2005 refined Medicaid eligibility requirements by tightening standards for citizenship and immigration documentation and strengthening the eligibility requirements for long-term care. Previously, Medicaid applicants usually "self-attested" to U.S. citizenship under penalty of perjury. After publishing final regulations, CMS implemented the act's requirements by requiring applicants to submit an original or certified copy of specific documents, including a U.S. passport, naturalization certificate, or certain religious or school records. Eligibility standards for long-term care services were strengthened in several ways, including by increasing the "look-back" period (the time frame in which income and assets are used in determining financial eligibility) from 36 months to 60 months, and disqualifying individuals whose homes exceed $500,000 in value.

In addition, the Deficit Reduction Act created new program integrity responsibilities for CMS. A key responsibility is the requirement for CMS to contract with auditors to review Medicaid claims, identify overpayments, and educate providers on program integrity issues. CMS has awarded contracts to several national auditing firms, who are referred to as Medicaid integrity contractors.

The advent of the federally directed Medicaid integrity contractors may create new operational challenges for DMAS. After a Medicaid integrity contractor concludes its review, CMS will send a final audit report to DMAS which must then notify all providers who were audited. Under federal law, DMAS must repay the federal share of the overpayment to CMS within a certain deadline, even if the State has not recovered the overpayment from the provider. (As noted below, this deadline only applies in cases in which the provider has not appealed the audit finding.) These requirements may place additional burdens on DMAS to respond to provider appeals and collect funds.

Federal Health Care Reform Will Increase Medicaid Enrollment

More recently, federal health care reform appears to have increased the requirements for state program integrity efforts. These requirements are found in two recently passed Acts, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

Beginning in 2014, the Acts expand some existing eligibility categories and require states to add new recipient categories. In combination, DMAS estimates that these changes will add between 270,000 and 425,000 more people to Virginia's Medicaid population, an increase of 32 to 50 percent.

Health Care Reform Adds New Federal and State Program Integrity Requirements

Several program integrity changes are required by federal health care reform, including changes to provider enrollment procedures, the establishment of internal program integrity procedures for certain providers, and a requirement that states use contract auditors to identify improper payments.

New Federal Requirements for Provider Enrollment Will Be Forthcoming. The reform requires the issuance of new federal rules on provider enrollment, including a directive to vary the level of screening according to the risk of fraud, waste, and abuse presented by each category of provider or supplier. Providers determined by the Secretary of Health and Human Services to pose a higher risk will also be required to undergo criminal background checks, fingerprinting, and unannounced site visits. Providers will also be required to disclose current or previous affiliations with any provider or supplier that has uncollected debt, or is not allowed to participate in Medicaid or other federal health care programs. Lastly, certain providers will be required to establish an internal program integrity process or compliance program; this will likely result in additional duties to report potential improper payments to DMAS.

States Will Be Required to Use Contract Auditors to Identify Improper Payments. DMAS will be required to establish contracts with one or more recovery audit contractors and subsequently recover any overpayments identified by these audits. (These auditors, and the recovery requirements, are in addition to the Medicaid integrity contractors that CMS is required to retain as a result of the Deficit Reduction Act.) The legislation also extends the deadline for repaying the federal share of any identified improper payments from 60 days to one year, so long as determination of the final improper payment amount is dependent upon conclusion of an ongoing judicial or administrative process.

Maintenance of Eligibility Requirements May Hinder Implementation of New Program Integrity Activities. Federal health care reform appears to maintain pre-existing requirements that prohibit states from tightening Medicaid eligibility standards. As a result, DMAS may not be able to take additional steps to reduce improper payments if those actions are construed by CMS to restrict Medicaid eligibility.

As noted above, the American Reinvestment and Recovery Act provided states with a one-time increase in their Medicaid matching rate. However, in order to access these funds each state had to ensure that its "eligibility standards, methodologies, or procedures" remained unchanged, and did not become more restrictive than those in effect on July 1, 2008. Under federal health care reform, states are similarly prohibited from implementing eligibility standards, methodologies, or procedures that are more restrictive than those in effect when the legislation was enacted. It appears this requirement will remain in effect through January 1, 2014, under Medicaid.

Chapter 2

Known Improper Payments and Blocked Claims Are Less Than Two Percent of Medicaid Spending

In Summary

In FY 2009, Virginia's Medicaid program had $38.9 million in improper Medicaid payments, which consisted of roughly equal amounts of fraud and error. Improper payments can result from errors made by providers, recipients, or by State agencies. However, the vast majority of identified improper payments come from providers, who accounted for 87 percent of error and 98 percent of fraud. In addition, an additional $50.3 million in potential fraud or error was avoided by blocking improper claims before they were paid, an amount which exceeds all identified improper payments. In total, these amounts represent less than two percent of Virginia's Medicaid expenditures.

Improper payments can result from error or fraud committed by agencies, providers, and recipients. Several program integrity initiatives exist at DMAS and other agencies that are designed to limit improper Medicaid payments, including those containing elements of fraud and error.

VIRGINIA HAD AT LEAST $39 MILLION IN IMPROPER PAYMENTS DUE TO FRAUD AND ERROR IN FY 2009

The mandate for this study directed JLARC to determine the extent of fraud and error in Virginia's Medicaid program. A comprehensive estimate of the amount of fraud and error in Virginia is difficult to develop given that some fraud and error inevitably go undetected. A conservative estimate can be developed based on known fraud or error from a given year. This includes fraud prosecuted by the Medicaid Fraud Control Unit (MFCU) and Commonwealth's Attorneys as well as improper payments identified by the Department of Medical Assistance Services (DMAS) through audits and other means.

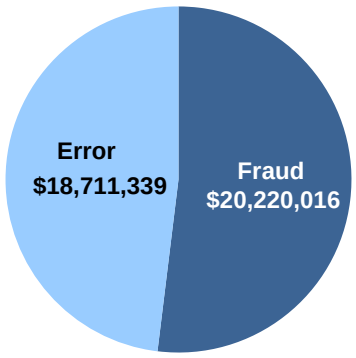
Based on these data, Virginia's Medicaid program had $38.9 million in fraud and error in FY 2009. Although subsequent chapters often present data from more than one year, this chapter uses FY 2009 data because it is the only year in which information on all types of identified improper payments are available. Federally required reviews of Virginia's Medicaid program, which are currently underway, should provide additional data on the extent of error in Virginia, and the findings from this review will be presented in the final report.

The amounts of fraud and error discussed in this chapter do not account for the proportion of these funds that are actually collected or recovered because data on those amounts are not presently available. JLARC staff will continue to investigate the collection rate (the percentage of funds identified for restitution or recovery that are actually received) and report these findings in the final report.

Majority of Improper Payments Due to Fraud

In FY 2009, Virginia had approximately $20.2 million in Medicaid fraud, which represents 52 percent of all improper payments (Figure 2). Of this amount, fraud by providers represented 98 percent, or $19.9 million. Provider fraud consists of court-awarded amounts from MFCU civil and criminal fraud cases against providers. While the total court-ordered awards in these cases exceeded the $20.2 million shown in Figure 2, these dollars represent the portion of those awards resulting from Medicaid fraud.

Figure 2: Majority of Improper Payments Resulted From Fraud (FY 2009)



Source: JLARC staff analysis of DMAS, MFCU, and DSS data.

Recipient fraud represented only two percent of known Medicaid fraud.

Recipient fraud represented only two percent of known Medicaid fraud. However, as discussed in Chapter 4 it appears that local departments are not fully investigating recipient fraud.

In FY 2009, DMAS and local departments of social services identified $341,353 in Medicaid recipient fraud. Medicaid recipient fraud consists of court-awarded amounts in recipient fraud convictions resulting from DMAS investigations, and the loss identified in Medicaid cases investigated and forwarded by local departments of social services to local Commonwealth's Attorneys for prosecution.

Errors Accounted for Almost Half of All Improper Payments

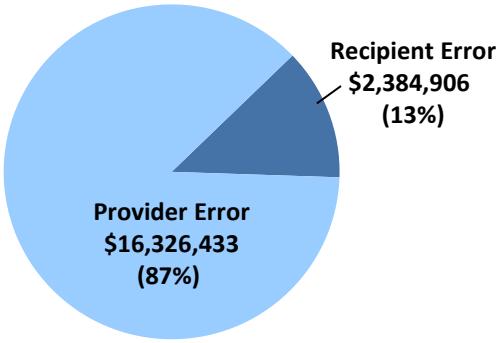
Of the $38.9 million in known improper payments, $18.7 million (48 percent) resulted from error. These non-fraudulent improper

payments resulted from error committed by agency staff, providers, or recipients.

Improper payments made to providers because of erroneous claims resulted in overpayments of $16.3 million, or 87 percent of all non-fraudulent improper payments in FY 2009 (Figure 3). This includes improper payments identified through audits by DMAS staff and contracted auditors, and retractions of capitation payments from managed care organizations.

Known non-fraudulent improper payments resulting from errors related to Medicaid recipients totaled approximately $2.4 million in FY 2009, or 13 percent of all non-fraudulent improper payments in that year. These overpayments resulted from various non-criminal eligibility errors, such as when recipients inadvertently gave inaccurate information. These funds are then identified for recovery through DMAS's administrative process.

Figure 3: Eighty-seven Percent of Non-Fraudulent Improper Payments Resulted From Erroneous Provider Claims (FY 2009)



Source: JLARC staff analysis of DMAS data.

$50 MILLION IN IMPROPER CLAIMS WAS BLOCKED IN FY 2009

In addition to the fraud and error discussed above, up to an additional $50.3 million in potential fraud or error was prevented in FY 2009 by using front-end controls that blocked or reduced improper claims before they were paid. This includes $25.6 million in services blocked by DMAS's prior authorization process because the requested services were deemed to not be medically necessary. It also includes $11.8 million in reduced claims identified by DMAS's Medicaid claims processing system. These reductions occur as a result of the system identifying improperly-filed claims and reducing them to the proper, lower reimbursement level. Lastly, up to $13 million in managed care premiums were avoided by disenrolling individuals who were no longer eligible for Medicaid.

These avoided payments exceeded the combined amount of improper payments resulting from fraud or error after payment was made. However, these avoided costs are likely underestimated because DMAS does not estimate the value of claims that are blocked entirely by its claims processing system, only the amount of the reduction in payment for claims determined to be too high. In combination, the $50.3 million in avoided costs from pre-payment controls, plus the $38.9 million in improper payments, is less than two percent of all Medicaid spending in Virginia in FY 2009.

Chapter 3

Errors in Recipient Eligibility Determinations Can Lead to Improper Payments

In Summary

The Medicaid recipient eligibility process in Virginia is highly decentralized, involving the Departments of Medical Assistance Services and Social Services, and each local department of social services. The responsibilities of each party are set forth in statute, regulation, and an interagency agreement. Under this framework, local departments of social services process Medicaid applications, ensure the ongoing eligibility of recipients and, if necessary, disenroll them from Medicaid. Eligibility determination errors and delayed eligibility redeterminations likely result in improper Medicaid payments because some ineligible Virginians receive Medicaid-funded services. Federally required reviews have shown that errors occur in about eight percent of eligibility determinations, on average, and most local departments do not meet federal regulatory requirements for annual redeterminations of eligibility. Improvements in the computer systems used to determine eligibility could help reduce local department error rates.

As discussed in Chapter 1, the resolution directing this study requires JLARC to describe the nature and scope of fraud or abuse of Medicaid by beneficiaries. This could include fraud or error by Medicaid applicants or recipients, such as the failure to report all sources of income. It could also include fraud or error committed by the agency staff who process Medicaid applications, including the failure to properly assess an applicant's financial resources. In either case, fraud and error can result in the expenditure of Medicaid funds on an ineligible individual.

Because both fraud and error can result in improper Medicaid payments, they each represent a financial risk to the State. As indicated in Chapter 1, Medicaid is one of the fastest growing programs in State government. This increase is driven in part by the increase in the Medicaid population. In FY 2009, a total of 947,762 individuals in Virginia were eligible to receive Medicaid. Of these beneficiaries, 857,662 received one or more Medicaid-funded services and were therefore counted as a Medicaid "recipient." Between FY 2005 and FY 2009, the number of recipients grew by ten percent (80,401), and over this period local departments of social services processed 681,805 applications for enrollment (or reenrollment) in Medicaid.

STATE AND LOCAL DEPARTMENTS OF SOCIAL SERVICES ARE RESPONSIBLE FOR DETERMINING MEDICAID ELIGIBILITY

The Medicaid recipient eligibility process in Virginia is highly decentralized. The Department of Medical Assistance Services (DMAS) administers the Virginia State Plan for Medical Assistance Services, which contains the eligibility requirements for Medicaid. The State Plan, which is promulgated in the *Virginia Administrative Code*, designates the Department of Social Services (DSS) as the entity with primary responsibility to determine an applicant's eligibility for Medicaid. The responsibilities of these agencies are defined in an interagency agreement between DMAS and DSS. The most recent version of this agreement was executed in 2004, and it has subsequently been modified several times.

Recipient Eligibility Determinations Are Performed by Local Department of Social Services Staff

In Virginia, local departments of social services receive and process most Medicaid applications. (Some applications are processed by DMAS, and some are received by other agencies and forwarded to DSS.) The current role played by local departments is consistent with their historical responsibility for determining eligibility for public assistance programs, which was statutorily assigned in 1938. In addition to applications for medical assistance, which local departments have processed since 1962, they also process applications for the Supplemental Nutrition Assistance Program (SNAP), formerly called Food Stamps, Temporary Assistance for Needy Families (TANF), and other public assistance programs. If a person applies for one program, but is ineligible, local department staff must assess their eligibility for other programs.

As JLARC reported in a 2005 study of DSS, the number of requirements for public assistance programs is considerable. The Medicaid, SNAP, and TANF manuals alone total more than 3,000 pages. Eligibility workers at local departments must be familiar with every requirement and keep up-to-date as the requirements change.

In order to determine whether applicants are eligible for Medicaid, local department staff must ensure that applicants meet several federal and State financial and non-financial criteria:

- Financial criteria include that applicants have income or assets below the threshold for the program for which they are applying, and that they have not transferred assets in the previous five years that would make them ineligible to receive Medicaid benefits.

- Non-financial criteria include that applicants have a valid Social Security number, are U.S. citizens or legal residents, and are residents of Virginia but are not incarcerated in a correctional center. Other non-financial criteria include that applicants meet the specific eligibility requirements associated with the designated categories of aged, blind, or disabled.

Local department eligibility workers determine eligibility through a combination of electronic and manual processes (Appendix C). Generally speaking, most of the information relied upon by local staff is provided by applicants and verified through databases maintained by other agencies and organizations. Although access to these electronic databases can increase accuracy and efficiency, this can be offset by the reliance on manual processes. For instance, eligibility workers must manually calculate applicants' income, determine the fair market value and residual equity of their financial resources, and then compare this information to income and resource limits, definitions of countable and liquid assets, exclusion criteria, and other requirements contained in several paper manuals.

DSS Must Effectively Oversee Local Department Eligibility Determinations to Ensure Proper Expenditure of State Funds

Under the DMAS-DSS interagency agreement, DSS must ensure that the information submitted by applicants is verified. Since local departments of social services determine the eligibility of persons applying for Medicaid, DSS must have a system for assessing whether local departments consistently ensure that only eligible individuals receive benefits.

DSS's Central and Regional Offices Oversee and Guide Local Staff. Staff in DSS's central office and five regional offices are responsible for providing oversight, guidance, and training to local department staff. The rules and processes used by local departments to determine Medicaid eligibility are contained in DSS's Medicaid manual. The manual is maintained by DSS's central office and is updated twice per year. Although the central office notifies regional and local offices of important changes, central office staff report that local departments are responsible for adhering to all changes.

The five regional DSS offices also have an oversight role, which primarily involves reviewing the compliance of local departments with program rules and assessing their performance on various outcome indicators. A key role involves the use of a review process known as "sub-recipient monitoring" that looks for errors in eligibility determinations for all public assistance programs administered by DSS. As part of this process, each regional office employs a Medicaid specialist who reviews individual local staff by as-

sessing the accuracy and timeliness of the Medicaid eligibility determinations they have completed. (This review is conducted using an assessment instrument developed by central office staff.) If a review uncovers errors, then the local department must provide DSS central office staff with a corrective action plan and also redetermine eligibility in any instances in which the review found errors.

Change to Risk-based Sub-recipient Monitoring Reviews Has Improved Efficiency. Prior to FY 2010, the frequency with which each local department was subject to sub-recipient monitoring was determined by the number of local staff and the size of the local departments' caseloads. Large offices were reviewed annually, medium offices were reviewed every two years, and small offices were reviewed every three years.

In FY 2010, DSS began selecting local departments for review based on the risk they present. The selection is guided by a review instrument that includes 21 factors such as the level of staff turnover, the increase in agency caseloads, and the presence of previous deficiencies. DSS intends to most frequently review all local departments presenting high levels of risk regardless of their size or the length of time since their previous review.

DSS central office staff report that the move to a risk-based process has allowed quality management staff to redirect their resources to the local departments facing the greatest administrative challenges. Although it is too early to assess the effectiveness of this new management tool, the change represents an improvement in the efficiency of DSS's oversight of local department eligibility determinations.

ERROR IN ELIGIBILITY DETERMINATIONS LEADS TO SOME IMPROPER PAYMENTS

In addition to the State-administered reviews conducted by DSS regional office staff, two federally-administered programs are also designed to measure Medicaid eligibility determination errors. The Payment Error Measurement Rate (PERM) program, was established in 2005 by the Centers for Medicare and Medicaid Services (CMS) with the goal of establishing national error rates. (As discussed in Chapter 6, PERM is also used to calculate error rates in the payment of Medicaid claims.) Another program, Medicaid Eligibility Quality Control (MEQC), was established in 1975 to determine state error rates. The PERM reviews are designed and conducted by CMS, whereas MEQC reviews are designed and conducted by each state in accordance with federal requirements.

PERM Reviews Indicate that Eligibility Error Rate Varies Greatly Between States and Results From Caseworker Error

CMS conducts PERM reviews on a rotating basis, such that all 50 states and the District of Columbia are reviewed once every three years. The most recent report discusses findings from the 17 states reviewed in 2009. (The review was based on data from federal FY 2008.) It indicated that the nationwide error rate for Medicaid recipient eligibility determinations in federal FY 2008 was 6.7 percent. For the 17 states reviewed by CMS, eligibility error ranged from less than one percent to approximately 20 percent. Moreover, these eligibility errors were found to result in 22 percent of all improper payments that occurred in federal FY 2008. The review also identified three leading types of errors:

- ineligible persons,
- persons for whom eligibility could not be determined, and
- persons who were eligible for Medicaid but not certain services they received.

As part of the 2008 PERM review, the primary causes of eligibility errors were identified by CMS. The most frequent causes were general caseworker mistakes, the misapplication of income and resources policies, and a lack of internal controls.

Currently, no eligibility error rate has been estimated for Virginia as part of the PERM program. However, Virginia was recently reviewed for eligibility determination errors, using federal FY 2009 data, and a final PERM report on this topic is expected to be completed next year.

MEQC Reviews Suggest That DSS Medicaid Eligibility Error Poses Financial Risk to the Virginia Medicaid Program

Virginia conducts annual MEQC reviews known as targeted pilots in which a particular concern is chosen for review. These targeted reviews can result from concerns identified during the sub-recipient monitoring process as well as concerns identified by DMAS and CMS. DMAS staff report that the use of pilots means that Virginia is not subject to a potential disallowance of federal funds.

MEQC Reviews Determine Statewide Error Rates by Assessing Errors in Local Department Medicaid Eligibility Determinations. As part of each review, DSS and DMAS staff cooperatively select a category of recipients to assess, such as children or long-term care recipients, and then randomly select and review case files. DSS staff or contracted auditors then record any technical and eligibility errors, notify the local departments of cases that require their

MEQC Reviews Identify Eligibility and Technical Errors

As part of the MEQC reviews, any identified problems are classified as either "eligibility" errors or "technical" errors.

An eligibility occurs error if an eligibility worker incorrectly calculated an individual's income and the individual was improperly enrolled in Medicaid.

In contrast, a technical error does not lead to an improper enrollment. For example, if an eligibility worker enrolled an applicant in Medicaid without verifying their income, but a subsequent income verification showed that the individual was in fact eligible, then a technical error occurred.

immediate attention, and work with local officials to create corrective action plans. Although DSS appears to assess whether local departments comply with corrective action plans, compliance is not consistently or systematically tracked in a manner that allows for the identification of compliance rates by locality or over time.

Number and Type of Errors Varies by Locality. The MEQC reviews do not use a sufficiently large sample of cases to calculate locality error rates. This is in part because the random selection of case files occurs on a statewide basis, and no minimum number are required to be selected from each locality. Despite this limitation, the MEQC reviews indicate that the absolute number and type of errors do vary by locality. For example, a 2007 review of 82 local departments found that Norfolk had 17 percent of all eligibility errors and Portsmouth had ten percent of all technical errors. Although actual locality error rates cannot be calculated, the data from the 2007 review suggests that error rates likely vary substantially across localities. Thirty-six localities had no error while eight localities had at least one error in every case reviewed.

Virginia MEQC Reviews Since 2007 Have Found Substantial Rates of Eligibility Error. Since 2007, DSS has completed seven MEQC reviews. These reviews found eligibility errors in three to 17 percent of Medicaid cases reviewed (Table 1). In addition, the reviews found technical error rates of six to 37 percent. These error rates varied between the different types of populations for which eligibility determinations were reviewed. For example, an eligibility error rate of three percent was found in a review of the resource determinations for Aged, Blind, and Disabled applicants. In contrast, an eligibility error rate of 13 percent was found in the same year for cases involving eligibility determinations for families and children.

Table 1: MEQC Reviews Consistently Indicate Errors Exist in the Medicaid Eligibility Determination Process (FYs 2007-2008)

Year	Type of Review	Eligibility Error	Technical Error	Total Error
2007	Overdue renewals for Aged, Blind, & Disabled cases	17%	n/a	n/a
2007	Resource determination for Aged, Blind, & Disabled	3	n/a	n/a
2007	Eligibility determinations for Family & Children cases	13	6%	19%
2007	Medicaid eligibility termination decisions by DSS	16	n/a	n/a
2007	General compliance of local eligibility determinations with Medicaid Policy	4	36	40
2008	General compliance of local eligibility determinations with Medicaid Policy	11	25	36
2008	General compliance of local eligibility determinations with Medicaid Policy	9	37	45

Source: JLARC analysis of DSS Quality Assessment reports and DMAS Eligibility Review Project reports.

Most Errors Involve Shortcomings in Verification of Income and Financial Resources. All but one of the reviews listed in Table 1 identified specific eligibility errors, and a total of 236 eligibility errors were identified (Table 2). The most common errors involved shortcomings in the verification of income, including a lack of resource verification documentation in the case file (56 instances), individuals with incomes in excess of program limits (41), and a lack of income verification documentation (29).

Table 2: Most Eligibility Errors Identified by MEQC Reviews Involved Recipients' Income or Resource Levels

Description of Error	Number of Occurrences
Resource verification missing	56
Excess income	41
Income verification missing	29
Eligibile with ineligible members	22
Excess resources	21
Non-financial requirements	20
Eligible with ineligible resources	17
Death	9
Other	7
Eligibility cancelled in ADAPT but not in MMIS	4
Incarceration	3
Recipient moved out of state	2
Social Security number not on file	2
Total	**236**

Source: DSS Quality Assessment Reports.

Reviews Should Assess Performance of Individual Local Departments of Social Services

While previous MEQC reviews suggest that localities have substantially different eligibility error rates, the MEQC reviews are not conducted in a manner that allows DSS or DMAS to determine locality error rates. Because each local department of social services is responsible for making eligibility determinations, some variation in local performance would be expected. This likely leads to differences in the timeliness and accuracy of Medicaid eligibility determinations and redeterminations, leading to local differences in eligibility error rates.

DSS staff report that they design the MEQC reviews in accordance with federal requirements. CMS must approve the design of all MEQC reviews, including the number of localities sampled, the recipient groups targeted, and the size of the sample selected by DSS staff. Federal code does require that samples drawn as part of an MEQC review be representative of the Medicaid population, but there is no federal requirement that the reviews use a statistically significant sample at the local level. Neither DSS nor DMAS considers the statistical significance of samples when designing

MEQC reviews, and do not calculate the confidence intervals as part of the MEQC review process.

Although DSS and DMAS are not required to design MEQC reviews to determine locality error rates, there is no prohibition on this approach. In fact, this approach has been recommended since at least 1988, when the Inspector General of the Department of Health and Human Services issued a report on *Eligibility Errors Resulting in Misspent Funds in the Medicaid Program*. The report noted that MEQC data do not accurately reflect errors in geographic areas of a state. The report noted that many states conduct targeted reviews of localities that are more prone to errors. Given the likelihood of actual variation in error rates by locality, as suggested by the samples examined during the MEQC reviews, DSS and DMAS should use a sample of cases of sufficient size to determine eligibility error rates at local departments of social services and reasonably measure variation in error rates between local departments. This process should begin with a pilot study for selected local departments.

Recommendation (1). In order to calculate Medicaid eligibility determination error rates for local departments of social services when conducting Medicaid Eligibility Quality Control reviews, the Departments of Social Services and Medical Assistance Services should use a sample of cases of sufficient size to identify error rates for local departments of social services. This process should begin with a pilot study that determines error rates for three representative localities and conclude with a report by October 1, 2011, to the Joint Commission on Health Care and the Secretary of Health and Human Resources on the results of the pilot. The report should also include the estimated cost of using a sample of cases of sufficient size to identify error rates for local departments under three approaches: (1) reviewing all local departments of social services on an annual basis, (2) reviewing a rotating group of local departments each year, and (3) reviewing targeted local departments each year, based upon the number of recipients, risk, or other pertinent factors.

DISENROLLMENT OF INELIGIBLE MEDICAID RECIPIENTS

Given the number of individuals who apply for Medicaid in any given year, it is likely that some number of persons will be improperly enrolled due to fraud or error. In addition, some people will lose Medicaid eligibility during the course of a year, owing to changes such as an increase in income. Therefore, DSS and DMAS need to regularly review recipient eligibility in order to identify those who are no longer eligible or were erroneously enrolled.

Most Common Reason for Disenrollment of Recipients Was Failure to Complete Required Paperwork

In FY 2009, DSS disenrolled approximately 214,000 individuals from Medicaid (Table 3). (Although some of these individuals may have regained eligibility, neither DSS nor DMAS data can identify the number of persons that were subsequently re-enrolled.) Local departments notify recipients when they are required to renew their eligibility, and recipients are responsible for reporting changes that may affect their Medicaid eligibility in the period between the annual renewals. Failure to report changes in income or other factors that affect eligibility can result in prosecution for fraud.

As shown in Table 3, the most common reason for disenrollment was failure by the individual to submit completed paperwork or fulfill other eligibility renewal requirements (48,832). A similar number of people were disenrolled because they no longer met the program's non-financial requirements (41,451).

Table 3: Most Common Reason for Disenrollment Was Failure to Complete Renewal Paperwork in a Timely Manner (FY 2009)

Reason for Loss of Eligibility	Number Disenrolled
Failed to Complete Renewal Paperwork	48,832
No Longer Met Non-Financial Requirements	41,451
Lost Virginia Residence	14,363
No Longer Met Income or Resource Requirements	12,943
Correspondence or Medicaid Card Returned	9,462
Maximum Coverage Received (Pregnant Women)	8,343
Child Reached Age 19	8,177
Enrollee Deceased	8,128
End of Year Automatic Cancellation	7,645
Recipient Requested Cancellation	6,814
Other	47,927
Total	**214,085**

Source: DSS data.

Not Completing All Medicaid Eligibility Redeterminations in a Timely Manner Likely Results in Some Improper Payments

Federal regulations require states to redetermine each recipient's Medicaid eligibility every 12 months, but most local departments do not appear to comply with this standard. In a given month, each local department must conduct a certain number of redeterminations. If a local department completes all of the redeterminations due in a given month, it would achieve a 100 percent redetermination rate for that month.

However, in the 36 months between January 2007 and December 2009, no local department achieved a 100 percent redetermination rate in every month. (Bath County had the highest performance,

achieving a 100 percent redetermination rate in 34 of 36 months.) More than half of all 120 local departments (70) failed to reach a 100 percent rate in any month (Table 4).

Table 4: Most Local Departments Did Not Achieve 100 Percent Redetermination Rate in Any Month (Calendar Years 2007-2009)

Number of Months When 100% Rate Achieved	Number of Local Departments
0	70
1- 6	34
7-12	6
13-24	9
25-36	2

Source: JLARC staff analysis of DSS data.

Currently, DSS targets a 97 percent redetermination rate. However, during the same three-year period noted in Table 4, only 13 local departments met the 97 percent target in each of the 36 months. Another 13 local departments did not meet the 97 percent target in any month, and another 31 departments did not meet the target at least half of the time.

Despite the fact that not all local departments met the target, DSS central office staff note that 94.5 percent of all Medicaid eligibility redeterminations were made in a timely manner during calendar year 2009. They add that the recent recession coincided with the three-year time period noted in Table 4, resulting in an increase in eligibility worker caseloads and a decrease in administrative funding. DSS central office staff assert that these factors have made it difficult for local departments to comply with the redetermination requirement and has led some local departments to prioritize initial eligibility determinations over completion of the annual redeterminations.

However, the presence of potentially ineligible recipients results in the improper payment of State funds. Over the course of their enrollment, changes in recipients' financial and non-financial circumstances may cause them to be ineligible to receive Medicaid services. If local departments do not redetermine eligibility in a timely manner, Medicaid may continue to improperly pay for services provided to individuals no longer eligible for the program.

Although DMAS is ultimately responsible for complying with the federal requirement, and the interagency agreement between DMAS and DSS requires local departments to "redetermine recipients' eligibility . . . no later than annually," it is difficult for DMAS to enforce this requirement since it does not have any authority over DSS or local departments. As noted by the Auditor of Public

Accounts in earlier audits of DMAS and DSS, the need to ensure that only eligible recipients receive benefits "is a critical control and compliance issue." Although there do not appear to be express federal penalties for failure to make annual redeterminations, DSS needs to ensure local departments comply with federal requirements to prevent possible federal disallowances.

Recommendation (2). The Department of Social Services should ensure all local departments of social services comply with the annual redetermination requirements specified in Title 42, Section 435.916 of the *Code of Federal Regulations* and report to the Joint Commission on Health Care, the State Board of Social Services, and the Secretary of Health and Human Resources on an annual basis the local departments that have not complied with this requirement.

OPPORTUNITIES MAY EXIST TO INCREASE DETECTION OF INELIGIBLE RECIPIENTS AND REDUCE ELIGIBILITY ERRORS

An initial review of the systems and processes used by local departments of social services indicates several potential opportunities to increase the detection of ineligible recipients and also reduce error in the eligibility determination process. In the area of asset verification, it appears possible to take steps that would improve access to land records. In other areas, JLARC staff will undertake additional study to determine the potential to decrease errors and include recommendations in the final report.

Verification of Financial Assets Could Be Improved by Using Land Records Data Maintained by the Supreme Court

As part of the application process, an individual must report all cash and other financial assets such as automobiles and real property. Local eligibility workers generally rely on signed client statements and other documentation submitted by applicants, and the extent to which individuals fail to properly disclose their assets is unknown. However, if a person owns an asset at the time they apply for Medicaid, there is an incentive to "hide" the asset from the eligibility worker by not reporting it.

In 1992, a JLARC report on *Medicaid Asset Transfers and Estate Recovery* estimated that eight percent of Medicaid applicants seeking nursing home benefits did not report their full assets. This estimate was determined by examining property records to see if the individual owned property during the previous three years. These records were typically maintained in "land books" in the offices of the commissioners of revenue or clerks of the circuit courts in the locality where the person applied for Medicaid. That report included a recommendation that clerks of the circuit courts conduct property checks for all persons applying for Medicaid benefits,

based on lists of new Medicaid applicants submitted by the local department of social services.

More recently, in a 2007 MEQC review (the Aged, Blind and Disabled Resources Pilot) most of the eligibility errors (seven of 11) resulted from the failure of recipients to report assets that affected their eligibility for Medicaid.

To confirm the information reported by applicants, eligibility workers have access to certain databases, including vehicle title records at the Department of Motor Vehicles. However, until recently it has not been possible to similarly check for title to real property. Since JLARC last reviewed this issue, an electronic database of land records has been created. The Supreme Court of Virginia receives and stores land records information entered by clerks of the circuit courts in its Records Management System. Relevant information found in land records would include the current ownership of the property, its value, and any dates when ownership was transferred. While clerks are not required to use the Supreme Court system (many choose to use systems designed and operated by vendors), 75 circuit court clerks currently use the Records Management System. Construction of an appropriate interface may allow eligibility workers at local departments of social services to use this information to verify the real property assets located in Virginia of Medicaid applicants.

It appears that local DSS offices, with the cooperation of the Supreme Court, could be given electronic access to these databases and therefore be able to more thoroughly determine whether an applicant owns real property. This process may become essential beginning in 2013, at which time all states must perform asset verification for their Medicaid programs because of a requirement in the federal Supplemental Appropriations Act of 2008.

Additional Opportunities May Exist for DSS or DMAS to Use Information Technology to Reduce Eligibility Error

There may be other opportunities for DSS or DMAS to make improvements in their information technology (IT) systems to reduce error in the eligibility determination process. Taking advantage of these opportunities may require changes to the IT systems at DSS and DMAS. These systems include the Application Benefit Delivery Automation Project (ADAPT), which DSS and local departments use to enroll and disenroll individuals into Medicaid and other public assistance programs, and the Medicaid Management Information System (MMIS) at DMAS.

Local Departments May Be Able to Use Eligibility Redeterminations for Other Benefits to Redetermine Medicaid Eligibility. Because 62 percent of Medicaid recipients are also enrolled in SNAP, eligibil-

ity workers have the opportunity to use information provided on the SNAP application to determine if the individual is still eligible for Medicaid. However, changes to DSS's computer system may be needed to fully use this opportunity.

As noted in the 2005 JLARC report *Operation and Performance of Virginia's Social Services System,* the ADAPT system was not designed to help local staff track individual cases across multiple benefits programs. Although DSS staff have stated that local departments should be able to use the redetermination process for one public assistance program to redetermine eligibility for other programs, DSS does not have the ability to track whether this routinely occurs.

Proposed New IT System May Standardize Eligibility Processes and Thereby Reduce Error. DSS central office staff have stated that local departments vary greatly in their administration of Medicaid eligibility determinations. The variation includes differences in IT systems, staffing levels, and the degree of staff specialization (whether an eligibility worker determines eligibility for a single program or for several programs).

In addition to this variation, several weaknesses were identified by the APA in its 2010 report on *Enterprise Data Standards for Human Services*. A key weakness cited in the report was the lack of internal controls created by the presence of separate IT systems for each public assistance program. Because many individuals receive services from more than one public assistance program, an eligibility worker must enter demographic information in different systems. Subsequently, each system creates its own recipient identification number, which prevents DSS (or DMAS) from consistently tracking a person's receipt of different benefits. The high levels of manual data entry and lack of information sharing increase the likelihood of eligibility error and represent inefficiencies in DSS's administration of public assistance programs.

In response to these and other concerns, DSS has proposed to develop an enterprise delivery system. As proposed, the new system would create a single identification number per recipient that would be used for all benefit programs in which her or she is enrolled. DSS also proposes to create a single database that would contain an individual's demographic information for all public assistance programs. This would increase the efficiency of application processing and possibly decrease errors. Moreover, a single database would allow information entered during the redetermination process for one program, such as SNAP, to automatically update information needed for redetermination of Medicaid eligibility.

Chapter 4

Recipient Fraud May Not Be Fully Investigated and Prosecuted

In Summary

The Departments of Social Services and Medical Assistance Services (DMAS) share responsibility for investigating and referring cases of Medicaid recipient fraud for prosecution. However, 37 of 120 local departments of social services did not investigate any cases of potential Medicaid fraud in FY 2009. Similarly, 97 local departments did not refer any Medicaid cases to a Commonwealth's Attorney for prosecution, and 17 did not refer any cases to DMAS for further investigation. Lack of activity by some local departments may at least be partly due to decreased State funding and the absence of financial incentives to pursue recipient fraud. Less than two percent of the recipient fraud cases referred to DMAS for investigation led to a fraud conviction, which is partially attributable to DMAS's policy of pursuing an administrative remedy instead of prosecution even in cases in which there is evidence of fraud. From FY 2005 to FY 2009, DMAS and local departments identified $12 million in improper payments due to recipient fraud or error.

In Virginia, statute assigns both the Departments of Social Services (DSS) and Medical Assistance Services (DMAS) the responsibility to detect, investigate, and report suspected Medicaid fraud to law enforcement agencies. Both agencies are also required to recover improperly paid funds resulting from error or in cases where fraud cannot be established.

Medicaid recipient fraud presents a financial risk to Medicaid. Therefore, it is essential for DMAS, DSS, and local departments of social services to implement policies and processes that reduce the incidence of fraud and to better detect, investigate, prosecute and recover funds when fraud occurs.

CHANGES MAY IMPROVE DSS'S ABILITY TO DETECT AND INVESTIGATE MEDICAID RECIPIENT FRAUD

Statute requires DSS to establish a statewide fraud control program and authorizes local departments of social services to establish fraud investigation units (*Code of Virginia*, § 63.2-526). DSS also provides guidance and funding to the 120 local departments to investigate Medicaid and other types of public assistance fraud.

Role Played by Local Departments Depends Upon Type of Suspected Public Assistance Fraud

The DSS fraud control program is responsible for detecting fraud in each of the benefits programs the department administers, in-

cluding Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). However, each program places different responsibilities on local department staff. As a result, the extent to which local departments conduct investigations, and the role played by DMAS, depend upon the type of benefit program under investigation.

According to the interagency agreement between DMAS and DSS, local departments are required to forward two types of suspected fraud to DMAS, which subsequently conducts the Medicaid portion of the investigation: cases in which the individual only receives Medicaid, and cases in which the individual receives both Medicaid and SNAP. (These are referred to as "Medicaid-only" cases.) In the latter instance, local department staff retain responsibility for investigating suspected SNAP fraud.

However, when a case of suspected fraud involves Medicaid and other benefit programs (specifically, TANF, auxiliary grants, or general relief), local department staff retain responsibility for conducting the entire investigation. (These are referred to as "joint cases.") DMAS plays no role other than determining the length of time that the recipient was improperly eligible for Medicaid, and hence the resulting improper payment. Local departments are also responsible for deciding whether to refer these cases to the local Commonwealth's Attorney for prosecution and subsequently collect any funds awarded by the court.

Local Support and Resources for Fraud Control Vary

DSS central office staff report that the support by local departments of social services for fraud control varies. This is partially reflected by the fact that not all localities submit fraud control plans, which they are required to do before receiving fraud control funds. (Local fraud control activities are funded through a performance-based matching formula, as discussed below. Localities are reimbursed for fraud-related expenditures on a monthly basis, subject to the continued availability of funds.) If the central office deems a plan to be acceptable, fraud control funds can be dispersed to that locality.

The DSS central office assesses each local plan in two ways. First, the plan is compared with a guidance document known as the *Fraud Reduction and Elimination Effort* manual, which the central office has developed. Next, the central office determines whether the local department has established referral guidelines with the local Commonwealth's Attorney. For example, one local department fraud investigator indicated that the locality's Commonwealth's Attorney had agreed to accept cases of suspected re-

cipient fraud in which the amount in question was greater than $1,000, and in which intent could reasonably be established.

In FY 2010, 13 of 120 local departments did not submit fraud control plans. Currently, there is no independent requirement to do so unless fraud control funds are being sought. Central office staff indicate that these 13 localities may not have submitted a formal plan because they have low Medicaid enrollment (collectively they have only 2.4 percent of total Medicaid enrollment), and it may not be cost beneficial for them to commit more than a few hours per week to fraud control efforts. However, it may be cost beneficial from the State's perspective for each local department to have dedicated fraud control staff, but this may require additional State support.

In addition, central office staff state that local fraud control resources vary greatly among even those departments that submit plans. Moreover, central office staff note that they do not have the ability to ensure local departments actually comply with the fraud plans they submit to receive fraud program funds. JLARC staff will continue to review this issue and report any additional findings in the final report.

Lack of State Funding for Local Fraud Control May Discourage Efforts to Investigate Medicaid Fraud

State general funds for fraud control have decreased, and localities are not allowed to keep recovered funds, which provides little incentive for localities to aggressively investigate recipient fraud.

State General Funding for Local Fraud Control Activities Has Been Replaced With Local Funds. In FY 2005, half of local fraud control activities were paid for with State general funds ($2.4 million). However, the amount contributed by State general funds decreased to $508,000 in FY 2008 and was eliminated in FY 2009. In FY 2009, $5.2 million was allocated for local fraud control activities, and half of these funds came from the federal government. The other half came from the Fraud Recovery Special Fund (33 percent), which consists of local fraud recoveries from previous years, and direct local funding (16 percent).

Use of Special Fund Means Local Departments That Successfully Recover Fraudulently Expended Funds Subsidize Other Localities. The structure of the fraud recovery program appears to provide little incentive for localities to investigate fraud. All funds recovered by local departments are deposited into the Fraud Recovery Special Fund. However, the allocation of these funds is not based on the local contribution. Therefore, the funds recovered by the more aggressive or successful localities effectively subsidize the activities of every department that submits a fraud control plan.

Some Local Departments of Social Services May Not Be Adequately Investigating and Referring Medicaid Fraud Cases

Substantial differences in investigation and referral rates across localities suggest that some local departments are not actively engaged in fraud control activities. Although 83 departments investigated joint cases in FY 2009, 37 departments did not investigate any joint cases. Moreover, among the 83 departments that did conduct investigations, there is a wide range in the number of investigations per 1,000 Medicaid recipients. The rate varied from a low of 0.05 in one locality to a high of 51.8 in another.

There is a similar degree of variation in the number of joint cases referred to local Commonwealth's Attorneys for prosecution. In FY 2009, 97 of the 120 local departments did not refer any joint cases for prosecution. Of the 23 that did, the number varied from a low of 0.02 per 1,000 Medicaid recipients in one locality to a high of 4.6 in another.

There are similar variations in local department referrals of Medicaid-only cases to DMAS for investigation. In FY 2009, 17 local departments did not refer any Medicaid-only cases to DMAS for investigation by the Recipient Audit Unit. Among those that did, the number of referrals varied from 0.2 per 1,000 Medicaid recipients in one locality to 9.3 in another.

Statewide Investigations Would Increase if All Departments Performed at the Level of a Typical Active Local Department

Because no performance standards exist for local fraud control activities, nor is it clear how standards could be created without creating the perception of a quota, there is no established benchmark to use in determining whether the variation in the fraud-related performance between local departments is reasonable. To address this, JLARC staff estimated the statewide number of investigations and referrals that might exist if all local departments performed at the level demonstrated by the typical locality that had an active fraud control program (see sidebar). This estimation was conducted using a linear weighted average, as discussed in Appendix B. The linear weighted average was used as a way to find the typical level of activity among active departments, and was chosen as a compromise between the median and mean performance of active localities.

Performance of Typical Active Local Department

In FY 2009, the typical local department that had an active fraud control program investigated 2.8 joint cases per 1,000 Medicaid recipients, referred for prosecution 0.5 joint cases per 1,000 Medicaid recipients, and referred to DMAS for investigation 1.4 Medicaid-only cases per 1,000 Medicaid recipients.

These estimates indicate there may be a substantial underperformance by local departments. With regard to the number of investigations and referrals of joint cases to Commonwealth's Attorneys, a total of 2,276 joint cases were investigated by 83 departments. However, if all departments performed to the level of the typical locality, an additional 1,276 investigations would have been con-

ducted, for a total of 3,552 statewide (Table 5). Similarly, the number of referrals to Commonwealth's Attorneys would have increased from 78 to 653.

In contrast to the number of referrals by local departments to Commonwealth's Attorneys, 103 of 120 local departments referred at least one Medicaid-only case to DMAS. This resulted in a total of 1,040 cases of suspected recipient fraud. And if all localities had performed to the level of the typical locality, another 266 cases would have been referred to DMAS.

These estimates should not be viewed as a goal, but rather as a likely maximum number. But in the absence of performance standards for investigations and referrals, this kind of analysis could be used by DSS and DMAS to determine if local departments are potentially underperforming or failing to comply with their fraud control plans. In turn, DSS could target their reviews of local departments or provide additional training or other resources.

Table 5: Increase in Investigations and Referrals Would Be Expected if All Localities Performed to the Level of the Typical Active Locality (FY 2009)

Type of Activity	Number of Active Departments	Actual Number	Weighted Estimate
Investigation of joint cases	83	2,276	3,552
Referral of joint cases to Commonwealth's Attorney	23	78	653
Referral of Medicaid-only cases to DMAS	103	1,040	1,306

Source: JLARC staff analysis of DMAS enrollment data, DSS fraud statistical reports, and DMAS Recipient Audit Unit data on referral sources.

Fewer Medicaid Cases May Be Investigated Because of Financial Incentive to Investigate SNAP Fraud

DSS data indicate that over a five-year period, local departments and DMAS investigated fewer cases involving Medicaid (both Medicaid-only and joint cases) than cases solely involving SNAP or TANF. This may result in part from the financial incentives to investigate SNAP cases.

Disproportionally Low Number of Medicaid Cases Were Investigated. Although the number of SNAP recipients is only 14 percent higher than the number of Medicaid recipients, the number of SNAP investigations conducted from FYs 2005 to 2009 was disproportionally higher than the number of Medicaid investigations (Table 6). Similarly, the number of TANF investigations exceeded the number of Medicaid investigations, despite the fact that the TANF population is only one-fifth the size of the Medicaid population.

Table 6: Few Medicaid Cases Were Investigated (FYs 2005 to 2009)

Case Type	Total Investigations (FYs 2005-2009)	Investigation per 1,000 Recipients (FY 2009)
Medicaid-only case [a]	4,973	1.4
Joint case	10,887	3.1
TANF	11,796	12.0
SNAP	42,853	10.1

[a] Represents referrals made by local departments to DMAS for investigation.

Source: JLARC staff analysis of DMAS Recipient Audit Unit data and DSS fraud investigation statistical reports.

Financial Incentive for Investigating SNAP Fraud May Explain Lack of Emphasis on Investigating Medicaid Cases. Interviews with local department fraud staff and members of their professional organization (Public Assistance Investigators of Virginia) indicate that the decline in State general funding has increased the extent to which local departments respond to financial incentives. The primary incentive results from the ability of local departments to retain a percentage of funds recovered from their investigations of SNAP fraud. For example, the SNAP program allows local departments to keep up to 35 percent of the recoveries it makes in cases of SNAP recipient fraud, and 25 percent of recoveries for non-fraud cases. (These funds are deposited into the Fraud Recovery Special Fund.) In contrast, the Medicaid program does not offer any financial incentives.

To increase the incentive for local departments to investigate Medicaid fraud, the General Assembly may wish to consider allowing local departments to retain a portion of the funds recovered from convictions or administrative recoveries that result from a local department referral. This process is used in at least two other states, New York and North Carolina. North Carolina's Medicaid agency has been required since 2007 to provide a share of the state's savings to counties that successfully recover fraudulently spent Medicaid funds.

Recommendation (3). The General Assembly may wish to amend § 63.2-526 (D) of the *Code of Virginia* to add "medical assistance" to the list of federal benefit programs for which a portion of overpayment moneys collected or recovered as a result of Medicaid recipient fraud investigations and referrals conducted by local departments, shall be deposited to the Fraud Recovery Special Fund.

DMAS APPEARS TO LACK THE RESOURCES NECESSARY TO FULLY PURSUE MEDICAID RECIPIENT FRAUD

DMAS is statutorily required to investigate, detect, and deter fraud and other violations of Medicaid laws and regulations (*Code of Virginia*, § 32.1-321.1) Within DMAS, the Recipient Audit Unit, which is located within the Program Integrity Division, is responsible for detecting fraud, investigating referrals of Medicaid-only cases, and referring cases of suspected fraud to Commonwealth's Attorneys. DMAS is also responsible for recovering restitution amounts ordered by circuit courts in cases of recipient fraud, as well as recovering funds improperly spent in non-fraud cases.

Investigation of Recipient Fraud by DMAS Largely Results From Referrals From Local Departments of Social Services

Most of the referrals received by the Recipient Audit Unit during FYs 2005 to 2009 came from local departments of social services, which referred 4,973 Medicaid-only cases. This accounted for more than two-thirds of the 7,339 referrals received by the unit. Regardless of the referral source, when the Recipient Audit Unit receives a referral, it first works to determine whether sufficient information has been provided to indicate that an improper payment has been made and that fraud may have been committed. If so, DMAS identifies the periods of Medicaid eligibility and ineligibility for the recipient. This information allows DMAS to determine the potential amount of improperly paid Medicaid funds.

DMAS Fraud Investigators Appear to Use a Defined Process but Limited Resources Prevent Prosecution of All Potential Fraud

When the Recipient Audit Unit receives a referral, an investigator is assigned to the case. After determining that the referral is for a valid Medicaid recipient, and the amount of possible improper payments, the investigator must determine whether the case should be forwarded for criminal prosecution. If not, the case may be handled through an administrative recovery process.

DMAS Fraud Investigators Use Several Criteria to Determine If a Case Should Be Prosecuted. As described in the *Recipient Audit Operating Procedures Manual*, several factors influence whether a case is handled criminally or through the administrative process. The manual includes the definition of fraud used in the *Code of Federal Regulations* and contains a "Criminal Prosecution Evaluation Worksheet" that includes several criteria. For each case, it appears that the investigator must complete the worksheet, which is intended to assist the investigator in applying the federal definition to the circumstances of the case. The criteria on the worksheet include

- cost-effectiveness of prosecution (cases with less than $3,000 in improper payments are typically handled through the administrative recovery process);
- whether the Commonwealth's Attorney in the locality chooses to prosecute Medicaid fraud;
- whether fraud is indicated and sufficient evidence exists to prove intent or support criminal prosecution;
- whether the local department of social services files needed for evidence have been deleted or expunged; and
- whether the local department of social services made errors processing the case before forwarding it to DMAS.

After completing the worksheet, if the investigator determines that the case satisfies the definition of fraud and the amount of improper payments would be cost beneficial to pursue criminally, then it is referred to a Commonwealth's Attorney. Otherwise, an administrative recovery is pursued.

DMAS Often Attempts to Make an Administrative Recovery Before Prosecuting a Case of Medicaid Recipient Fraud. It appears that as a matter of policy, the Recipient Audit Unit often attempts an administrative recovery even if the case could be forwarded for criminal prosecution. In these cases, the recipient is given an opportunity to make restitution and warned that failure to do so may result in prosecution by a Commonwealth's Attorney. The manual notes that DMAS may forward these cases for prosecution even if a recipient does pay restitution.

As stated in the Recipient Audit Operating Procedures Manual, because of "very limited staffing," the unit "lack[s] the resources to take all criminal cases around the state forward for prosecution."

The apparent policy of pursuing some potentially criminal cases through an administrative process appears to be driven by limited staff and resources. As stated in the *Recipient Audit Operating Procedures Manual*, because of "very limited staffing," the unit "lack[s] the resources to take all criminal cases around the state forward for prosecution." This policy likely contributes to the low proportion of recipient fraud prosecutions.

Less Than Two Percent of Referrals to the Recipient Audit Unit Led to a Conviction of Recipient Fraud

From FYs 2005 to 2009, the Recipient Audit Unit forwarded 172 cases of suspected recipient fraud to Commonwealth's Attorneys. Of these, 124 were accepted for prosecution. (A Commonwealth's Attorney may decline to accept a referral because the evidence, or amount of improper payments, is insufficient. These decisions are made at the discretion of the Commonwealth's Attorney.)

However, 100 of the 124 cases accepted by a Commonwealth's Attorney resulted in a conviction; this represented 1.4 percent of the 7,339 referrals received by the Recipient Audit Unit during the period. A review of the sources of referrals to DMAS suggests not all provide sufficient information to warrant or support a referral by DMAS to a Commonwealth's Attorney for prosecution. Of the 100 convictions for recipient fraud, nearly two-thirds resulted from a local department referral to DMAS. In contrast, several other referral sources did not result in any convictions, including telephone or e-mail referrals and tips received through the recipient fraud hotline operated by DMAS.

AT LEAST $12.4 MILLION IN RECIPIENT FRAUD AND ERROR WAS IDENTIFIED BETWEEN FY 2005 AND FY 2009

The full extent of Medicaid recipient fraud and other improper payments in Virginia is not known because, as with other crimes, there is no means of detecting all potential instances. However, the nature and scope of known Medicaid fraud and improper payments in Virginia can be described. Between FY 2005 and FY 2009, at least $12.4 million in improper payments on behalf of recipients was identified by DMAS and local departments of social services.

These amounts do not account for the proportion of these funds that are actually collected or recovered because data on those amounts are not presently available. JLARC staff will continue to investigate the collection rate (the percentage of funds identified for restitution or recovery that are actually received) and report these findings in the final report.

Recovery of $10.5 Million in Improper Payments Was Sought Through DMAS's Administrative Recovery Process

If DMAS staff do not believe that sufficient evidence of fraud exists, but the recipient provided erroneous information that led to an improper payment, the agency attempts to recover the funds through an internal administrative process. However, if an improper payment resulted from an error committed by a local department eligibility worker, the recipient of those services is not required to repay the State for the costs of the services they received while improperly enrolled in the Medicaid program.

Of the 6,051 referrals to the Recipient Audit Unit from FYs 2006 to 2009, 2,508 cases were sent to the Fiscal Division for administrative recovery. As shown in Table 7, these cases had a combined improper payments amount of $10.5 million. (Although data on referrals and investigations are available for FY 2005, no data are available on the amount of improper payments resulting from the administrative recovery process in FY 2005.)

Table 7: DMAS Handles Most Improper Payments Through Its Administrative Recovery Process (FY 2006 to FY 2009)

Fiscal Year	Number of Cases With Overpayments	Loss Identified
2006	693	$3,897,088
2007	743	2,530,741
2008	465	1,722,841
2009	607	2,384,906
Total	**2,508**	**$10,535,576**

Source: JLARC staff analysis of DMAS administrative recovery data.

About $1.9 Million in Improper Payments Was Identified in Fraud Cases Referred for Prosecution From FY 2005 to FY 2009

As discussed previously, both DMAS and local departments are responsible for forwarding cases of suspected Medicaid recipient fraud to Commonwealth's Attorneys for prosecution. DMAS, which is responsible for investigating Medicaid-only cases, forwarded 172 cases to Commonwealth's Attorneys from FYs 2005 to 2009. These cases resulted in 100 convictions, in which the total restitution awarded by the court equaled $568,398 (Table 8).

Table 8: $1.9 Million in Losses in Fraud Cases Referred by DMAS and Local Departments for Prosecution (FY 2006 to 2009)

Fiscal Year	Restitution Ordered in DMAS Cases	Identified Loss in Local Department Cases
2005	$189,891	$257,355
2006	90,388	171,091
2007	87,769	284,355
2008	284,088	342,255
2009	106,153	235,200
Total	**$568,398**	**$1,290,256**

Source: JLARC staff analysis of DMAS Recipient Audit Unit data; DSS fraud investigation data.

In addition, the joint Medicaid cases forwarded by local departments identified a maximum of $1.29 million in improper payments. However, data on the actual restitution awarded are not presently available. Although local departments do report case outcomes and restitution amounts to DMAS, this information is not maintained by the Recipient Audit Unit, but rather is handled by the DMAS Fiscal Division. JLARC staff will continue to work with DMAS to identify outcomes of these cases and report the results in the final report.

Most Common Medicaid Recipient Fraud Conviction Was for Failure to Report All Income

Convictions of recipients for Medicaid fraud equate to less than one-half of one percent of the recipient population.

As noted above, since FY 2005 there have been 100 convictions of recipient fraud resulting from referrals by DMAS to Commonwealth's Attorneys. The number convicted equates to less than one-half of one percent of the Medicaid recipient population. The most common fraud convictions were for unreported income and prescription drug fraud (Table 9). These cases accounted for 45 percent of the restitution awarded by circuit courts.

Table 9: Most Medicaid Recipient Fraud Convictions Result From Failure to Report All Income (FY 2005 to FY 2009)

Fraud Allegation	Total Convictions	Total Restitution
Unreported Income	34	$340,870
Selling / Forging Prescriptions	30	30,316
Falsifying Documents	8	51,608
Doctor Shopping or Overutilization	6	5,424
Residency	5	14,384
Unreported Spouse	4	38,761
Card Sharing or Impersonation	3	208,502
No Qualified Child in the Home	3	12,848
Property Transfer	2	55,576
Unknown	5	40,001
Total	**100**	**$798,290**

Source: DMAS Recipient Audit Unit.

Chapter 5

Virginia Provider Enrollment Process Relies on Several Agencies to Function Properly

In Summary

The Department of Medical Assistance Services (DMAS) is responsible for enrolling all Medicaid fee-for-service providers, but not providers within managed care networks. DMAS's provider enrollment process relies upon self-disclosure and the licensure decisions of other agencies, and DMAS staff report they lack sufficient authority to deny enrollment to a provider if they (1) meet certification and licensure requirements, (2) have not committed a Medicaid- or Medicare-related felony, and (3) have not been convicted of patient abuse. Between FY 2005 and FY 2009, the number of billing providers grew by 27 percent, or about 2,955 per year. However, there are several potential shortcomings in the enrollment process. DMAS does not perform criminal background checks or verify the physical business presence of enrolling providers. Lastly, some persons providing services, such as certain employees of home health care agencies, provide Medicaid-funded services as employees of enrolled providers and are not enrolled as providers themselves.

In order to be reimbursed for providing services to Medicaid recipients, a provider must meet certain enrollment criteria. Because the federal government will not reimburse states for services delivered by unlicensed providers, or providers who have been convicted of Medicaid- or Medicare-related felonies, DMAS must ensure that such ineligible providers are not enrolled in Medicaid. Like the recipient eligibility process, the provider enrollment process is therefore an important part of Medicaid program integrity.

NUMBER OF PROVIDERS ENROLLED IN MEDICAID FEE-FOR-SERVICE PROGRAM INCREASED 27 PERCENT SINCE FY 2005

In FY 2009, a total of 69,519 "billing" providers were enrolled in the Medicaid fee-for-service program in Virginia (Table 10). A billing provider is an individual or organization who is enrolled as a Medicaid provider and who submits reimbursement claims to DMAS, such as an individual physician or a hospital. As noted below, a billing provider may not be the "servicing" provider who actually delivers services, which could include a nurse or home health care aide who works for an organization or a physician whose practice bills DMAS on behalf of the group.

Between FY 2005 and FY 2009, the number of billing providers enrolled in the fee-for-service program grew by 27 percent, or about 2,955 per year. However, due to DMAS's federally required 2007 transition from a site-based identification system to the National Provider Identifier process, the actual growth in the number of

Table 10: Number of Billing Providers Enrolled in Medicaid Fee-for-Service Program Increased by 27 Percent (FYs 2005 to 2009)

Fiscal Year	Number of Billing Providers
2005	54,753
2006	41,988
2007	51,925
2008	58,190
2009	69,519

Source: DMAS provider enrollment data.

Medicaid fee-for-service billing providers may be understated due to differences in provider enrollment and identification between the two methods. (The site-based identification system often involved a billing provider enrolling each site as a separate provider, while the National Provider Identifier system allows billing providers to bill from all sites with a single number.)

Medicare Crossover Providers

Medicare Crossover providers include any type of provider that treats Medicaid recipients who are also enrolled in Medicare. (DMAS data do not list these providers by the type of service they provide.) DMAS reimburses these providers for Medicare deductibles and coinsurance.

Group Providers

Group providers are a group of fee-for-service providers who share a tax identification number for billing or payment purposes and enroll with Medicaid as a Group Practice in addition to enrolling as individual practitioners.

In FY 2009, 38,614 of the providers enrolled in the fee-for-service program were physicians (such as general practitioners), representing approximately 56 percent of all enrolled providers. The next most common provider types were Medicare crossover providers (nine percent), group providers (six percent), and nurse practitioners (three percent). Although in-state general hospitals account for most of the reimbursement claims paid by the Medicaid fee-for-services program, they represent less than one percent of all enrolled billing providers.

DMAS'S PROVIDER ENROLLMENT PROCESS RELIES ON SELF-DISCLOSURE AND ACTIONS OF OTHER ORGANIZATIONS

All providers wishing to be reimbursed by the Medicaid fee-for-service program must apply to DMAS. In contrast, providers in Medicaid managed care networks do not apply for participation through DMAS, but are enrolled into a managed care network by the responsible managed care organization. Because providers may be enrolled through two different avenues, some providers only serve fee-for-service recipients while others only serve managed care enrollees; some providers serve both.

Most Providers in the Fee-for Service Program Are Able to Meet Medicaid Enrollment Criteria

If providers meet three key criteria, DMAS staff indicate that the agency lacks sufficient authority to deny enrollment. This differs from the ability of managed care organizations to base provider enrollment decisions on a broader set of criteria, including the need for a particular number or type of providers in their service area.

Providers Are Generally Enrolled in the Fee-for Services Program if They Satisfy Three Key Criteria. Although DMAS requires providers to meet many criteria in order to enroll in the fee-for-service program, DMAS staff state that providers are generally entitled to enrollment if they

- meet the certification, licensure, and education requirements of the Virginia Board of Health Professions or other relevant State or federal entity;
- have not committed a Medicaid- or Medicare-related felony and therefore are barred from participation in Medicaid; and
- have not been convicted of patient abuse or other offenses that pose a risk to Medicaid recipients.

In addition to the need to meet these three criteria, a provider must also submit a valid application. Typically 15 to 20 pages in length, applications require providers to submit information such as a valid medical license number, a tax identification number, information on their practice's ownership structure, and a history of any criminal convictions. As the result of a change in DMAS policy implemented in October of 2009, failure to complete any of the required sections, or to fulfill enrollment requirements, results in the application being rejected.

Managed Care Organizations Can Choose the Number of Providers to Enroll in Their Networks. Unlike DMAS, Medicaid managed care organizations are not required to enroll all eligible providers who apply. Generally, managed care organizations only enroll the number and type of providers the organization feels are needed to serve the Medicaid population within the organization's geographic area. However, managed care organizations must still ensure that providers in their network meet the same criteria required of providers enrolled in the fee-for-service program.

DMAS Relies on Other Entities to Ensure Only Eligible Providers Are Enrolled in Medicaid

In the same way that DMAS relies on local departments of social services to enroll Medicaid recipients, DMAS relies on State agencies and other entities to perform most provider enrollment activities for the fee-for-service program. Such activities include licensure, enrollment, and verification of information submitted by providers when applying to the Medicaid program.

Most Provider Enrollment Activities Are Performed by DMAS's Provider Enrollment Services Contractor. DMAS's Program Operations Division has contracted with Affiliated Computer Services (ACS) to provide provider enrollment services. (ACS, a subsidiary of Xerox Corporation, also provides services to several other

states.) In Virginia, ACS conducts more than 90 services and processes related to provider enrollment, including application processing and verification. As a result, providers interact with ACS more frequently than with DMAS staff. Currently, DMAS pays ACS approximately $1.5 million per year to perform provider enrollment services.

Between FY 2008 and FY 2010, the provider enrollment contractor processed approximately 32,000 provider applications plus another 5,000 applications that were resubmitted with corrections (Table 11). This equates to approximately 240 applications per week, on average.

Table 11: About 240 Provider Applications Per Week Are Processed (FY 2008 to FY 2010)

	2008	2009	2010	Total
Applications Processed	10,370	11,411	10,511	**32,292**
Resubmittals Processed	1,905	1,186	1,920	**5,011**

Source: DMAS provider enrollment data.

DMAS Relies on Licensing and Certification Decisions of State Agencies and Other Entities. To verify the licensure and education information submitted by providers, DMAS executed interagency agreements with the Departments of Health Professions (DHP), Behavioral Health and Developmental Services (DBHDS), and Health (VDH). Using electronic databases at these three agencies, ACS verifies the licensure status of all providers seeking to enroll in Medicaid for whom licenses are required. ACS then re-verifies licensure status on a weekly basis to ensure all affected providers are still properly licensed.

To verify that a provider has no Medicaid- or Medicare-related felony convictions, or is not otherwise ineligible for Medicaid under federal rules, ACS uses the List of Excluded Individuals/Entities (LEIE), a database maintained by the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG) that lists all providers banned from Medicare and Medicaid by the OIG. CMS will not reimburse DMAS for Medicaid services delivered by providers listed in the LEIE. During FY 2008, the OIG added 3,129 individuals and entities to the LEIE. Most of the exclusions resulted from convictions for crimes related to Medicare or Medicaid, as in the following example:

Case Study

In Virginia, the owner of a rehabilitation facility was excluded for a minimum of 25 years based on his scheme to bill Medicaid for psychosocial rehabilitation services for

Medicaid beneficiaries who were not eligible to receive such services. In addition, the provider was convicted of various other charges, including income tax evasion. The provider was ordered to pay $2,604,500 in restitution and was sentenced to 151 months' imprisonment.

As of June 2010, 1,080 providers in Virginia were listed on the LEIE, and are therefore required to be excluded from participation in the Medicaid program. DMAS states that none of these providers are actively enrolled in either Medicaid fee-for-service or Medicaid managed care organizations. Among these providers were a small number of businesses, including at least one durable medical equipment provider and one long-term care facility. Approximately 71 percent (764) of Virginia providers listed in the LEIE were banned because their medical license had been suspended or revoked (Table 12). The next most common reasons listed were convictions for program-related crimes (15 percent), felony convictions for controlled substances (five percent) and health care fraud (three percent).

Table 12: Most Virginia Providers Are Listed in LEIE Because of License Suspension or Revocation (2010)

Reason for Exclusion	Number Listed
License suspension or revocation	764
Conviction of program-related crimes	158
Felony conviction (controlled substances)	52
Felony conviction (health care fraud)	32
Conviction for patient abuse or neglect	27
Default on health education loan or scholarship obligations	25
Fraud, kickbacks, and other prohibited activities	7
Conviction relating to non-health care programs	6
Misdemeanor conviction for controlled substances	3
Conviction related to obstruction of an investigation	1
Entities controlled by a sanctioned individual	1
Failure to meet statutory obligation to provide medically necessary services meeting professionally recognized standards	1
Total	**1,080**

Source: U.S. Office of Health and Human Services Office of the Inspector General.

SEVERAL ASPECTS OF THE PROVIDER ENROLLMENT PROCESS MERIT FURTHER REVIEW

Although most of DMAS's program integrity efforts are focused on the prevention of improper payments, it appears that there are several potential shortcomings in the provider enrollment process. As a result, some unqualified or fraudulent providers may be enrolled in the Medicaid fee-for-services program, and thereby pose a risk to patient safety or the financial integrity of Medicaid. JLARC

staff will continue to assess these issues and report on any findings in the final report.

DMAS Does Not Verify the Physical Business Presence of Enrolling Providers

Neither DMAS nor ACS verify the physical presence of a provider before they are enrolled. Instead, ACS only uses a software program to ensure that the address provided is known to the U.S. Postal System. Whether the provider is actually practicing at the supplied address is not verified. (The same process is used by the State Board of Elections to verify the residence of registered voters. However, the Department of Motor Vehicles recently began mailing driver's licenses to the reported address to deter fraudulent applications.)

Other states have found that merely relying on address verification may still allow fraudulent providers to enroll in Medicaid. In some instances, fraudulent providers may submit a valid address but no services are actually provided at that location. To prevent these instances, some other states take the additional step of actually verifying the physical presence of some or all providers during the application process.

Several approaches to verifying the business presence of providers could be implemented in Virginia, and staff at the Medicaid Fraud Control Unit believe that further steps are warranted. One measure that could be taken is to require local departments of social services to verify that providers actually practice at the reported address, an approach taken in New York. Alternatively, DMAS could verify the physical presence of a random sample of applicants, or target certain provider types that present greater risk of fraud.

DMAS Does Not Perform Criminal Background Checks on Enrolling Providers

DMAS does not currently perform criminal background checks on providers who are seeking to enroll in the fee-for-service program and instead relies on other sources for criminal history information. Although the need for these checks has not been established, the General Assembly has recently requested DMAS to study this issue as part of a larger review of the potential benefit of new program integrity activities.

Without Background Checks, DMAS Relies Upon Determinations Made by Other Entities. DMAS does not currently perform background checks on any providers enrolling in Medicaid fee-for-service, either in-house or through the provider enrollment contractor. Instead, DMAS relies on

- accurate and full disclosure of criminal histories by providers,
- accurate and timely completion of licensing and disciplinary proceedings by licensing entities,
- criminal history being present in the information shared by the certification or licensing entity, and
- accuracy of the LEIE database.

In cases in which a criminal history has been reported by the enrolling provider, ACS forwards the cases to DMAS for further review. In such instances, DMAS makes the final decision regarding whether a provider will be enrolled. If DMAS determines that a provider's criminal background presents a risk to patient safety or a financial risk to the program, enrollment will be denied. Although actual data are not tracked by DMAS, provider enrollment staff state that most cases sent for review are eventually rejected and the provider is denied enrollment. However, DMAS does have the authority to allow providers with non-Medicaid or Medicare related felonies to enroll in the fee-for-service program.

Recent Legislation May Result in Increased Use of Provider Background Reviews. Legislation passed by the 2010 Session of the General Assembly requires DMAS to study "options for a comprehensive system that utilizes external records" to perform several activities related to program integrity. The legislation directs DMAS to consider the use of "data related to provider eligibility including information about providers' criminal history or sanctions against providers in other states." DMAS is required to submit its report to the General Assembly by December 1, 2010, and JLARC staff will assess its findings as part of the final report. In addition, the recently enacted federal Patient Protection and Affordable Care Act will require criminal background checks for employees of long-term care facilities.

Not All Individuals Providing Services to Medicaid Recipients Are Licensed by a State Agency or Enrolled by DMAS

As discussed above, DMAS only enrolls billing providers in the fee-for-service program, and not necessarily all servicing providers. Although individual providers, small practices, and servicing physicians at hospitals must be enrolled individually and present valid certification or licensing, not all servicing providers are licensed individually or reviewed as part of the DMAS provider enrollment process. For example, DMAS enrolls home health care agencies as Medicaid providers, but not the individual employees of those facilities. Instead, DMAS relies on the agencies themselves to ensure that their employees have backgrounds and experience appropriate to their positions.

Because not all servicing providers are enrolled, DMAS does not necessarily know whether they have sufficient and relevant experience and training to provide appropriate care to Medicaid recipients. Nor does DMAS determine whether these servicing providers who are reimbursed with Medicaid funds are on the LEIE or are otherwise excluded from participation. In addition, DMAS cannot determine whether a facility is billing for more hours of services than can be reasonably provided by the number of staff employed by the organization.

At least one other state has decided to begin enrolling some servicing providers in addition to the billing provider that employs them. Beginning in 2005, Minnesota's Medicaid agency began to enroll individual personal care assistants in order to identify implausible claims for payment. This has allowed the state to identify 423 instances in which the Minnesota Medicaid agency paid claims for personal care assistants who reportedly worked more than 24 hours a day, including one instance in which a single personal care assistant was paid for 254 hours of service on a single day. JLARC staff will continue to review this issue.

Chapter 6

DMAS Program Integrity Activities Have Reduced Improper Payments but Improvements Are Needed

In Summary

DMAS uses several different methods to ensure that provider claims for Medicaid reimbursement are valid. The prior authorization process, which ensures that a service is medically necessary before it is approved for reimbursement, avoided costs of close to $25.6 million in FY 2009. DMAS's claims processing system, the Medicaid Management Information System, rejected or retracted reimbursement claims that violated program rules, avoiding costs of $26 million in FY 2009. Lastly, DMAS and contractor audits of paid provider claims identified $15 million for recovery in FY 2009. Although these activities produced avoided costs and funds identified for recovery of about $67 million, there appear to be additional opportunities to avoid costs. They include improved quality of managed care data, more extensive review of managed care claims, and additional resources dedicated to provider audits. Lastly, a federal review of a sample of claims paid by DMAS in federal FY 2006 suggests that between two and six percent of all claims paid in that year were erroneous.

Program integrity is a critical component of Medicaid program management which helps ensure that appropriate amounts are paid to legitimate providers for reasonable services provided to eligible beneficiaries. Before a reimbursement claim is paid to a provider, it must pass through several steps, including a prior authorization process and a series of manual and automated reviews. DMAS also audits claims after they are paid, to identify and recover payments for services that lack adequate documentation. In FY 2009, these program integrity activities produced up to $67 million in avoided costs and funds identified for recovery. In addition, program integrity activities create a deterrent effect that likely results in additional avoided costs.

PRE-PAYMENT REVIEWS INTENDED TO PREVENT IMPROPER PAYMENTS

In FY 2009, DMAS processed about 35 million reimbursement claims for medical services, submitted by more than 41,000 providers, and capitated payments submitted by the five managed care organizations. These claims were reviewed by a series of automated and manual front-end controls designed to identify irregularities and block claims that are not eligible for payment.

By blocking claims before they are paid, DMAS avoids the so-called "pay and chase" scenario wherein funds must be recovered from providers who (if fraud or error has occurred) may have fled or lack the funds needed to make restitution. These steps also increase operational efficiency, by limiting the need to audit a paid claim.

Prior Authorization Prevents Inappropriate Claims by Ensuring Services Are Medically Necessary

Federal regulations require state Medicaid programs to continually review and evaluate the utilization practices of providers and recipients. DMAS has addressed this requirement in part by implementing a prior authorization process wherein specific services must be approved before they are provided.

Prior authorization is intended to ensure that a requested service is medically necessary and will be provided within utilization levels set by DMAS policy. For some services, a prior authorization review will authorize a number of units of a service, such as counseling visits, based on accepted medical standards. In addition, some services require prior authorization after a certain level of use has been exceeded. In order to be considered for reimbursement, prior authorization must be obtained by the provider prior to service delivery or within specified program time requirements and prior to billing for these services. Services provided by managed care organizations are generally not subject to DMAS's prior authorization process, though these organizations may establish their own approval processes internally.

Only Certain Services Are Subject to Prior Authorization. DMAS staff indicate recent additions to the prior authorization process have been targeted to services with high per-unit costs. Currently, providers must seek prior authorization for more than 30 service categories, including

- inpatient services,
- mental health services,
- outpatient psychiatric services,
- durable medical equipment, and
- several waiver-based services.

DMAS Uses Contractors and Other State Agencies to Perform Most Prior Authorization Reviews. As allowed by federal regulations, DMAS uses a contractor, Keystone Peer Review Organization (KePRO) to conduct most prior authorization reviews. For FY 2010, DMAS paid $9.5 million to KePRO to provide these services. DMAS's contract with KePRO includes reporting requirements on customer satisfaction, program statistics, trends, and avoided costs. The following are examples of what is required of KePRO under the contract:

- Records establishing timely responses to providers (95 percent of all calls answered within three rings, queued no longer than three minutes)

- Program trend analysis, including number of reviews, rejections and reasons why, and recommendations for policy and procedural improvements.

In addition, DMAS employs a dental contractor to conduct prior authorization, and the Department of Behavioral Health and Developmental Services authorizes services provided under the Intellectual Disability Waiver. For certain other services, DMAS uses an internal prior authorization process.

Medicaid Management Information System Processes Provider Payments to Ensure Compliance With Regulations and Policy

Payments to Medicaid providers are processed by the Medicaid Management Information System (MMIS), a computer system that includes several subsystems corresponding to the different management functions DMAS must perform. As allowed by federal regulations, DMAS contracts with Affiliated Computer Services State Healthcare (ACS) to act as the fiscal agent and administer the MMIS. DMAS executed a four-year contract with ACS on July 1, 2010, replacing the previous fiscal agent (First Health Services Corporation).

The value of claims and payments processed by MMIS equaled 12 percent of Virginia's State budget for FY 2009.

In FY 2009, MMIS processed more than 35 million provider reimbursement claims and managed care organization payments at a total cost of $5.04 billion (Table 14). (This amount differs from the $5.4 billion in FY 2009 DMAS expenditures for medical services noted in Chapter 1 because not all of the transactions are processed through MMIS.) The value of claims and payments processed by MMIS equaled 12 percent of Virginia's State budget for FY 2009. While the number of claims and payments has declined since 2005, the associated costs increased by almost a billion dollars, or 24 percent, from FY 2005 to FY 2009. Over this period, the average payment per filed claim or payment increased 34 percent from $107 to $143.

Table 14: MMIS Processed More Than 35 Million Claims and Payments in FY 2009

Fiscal Year	Processed Claims and Payments	MMIS Expenditures
2005	37,849,066	$4,061,564,984
2006	35,852,457	4,340,026,434
2007	31,488,559	4,339,188,142
2008	32,984,894	4,674,855,776
2009	35,179,605	5,041,049,011

Source: JLARC staff analysis of DMAS data, including capitated payments to managed care organizations.

MMIS Processes Both Fee-for-Service Claims and Monthly Payments to Medicaid Managed Care Organizations. As discussed in Chapter 1, Medicaid recipients participate in either the fee-for-service or the managed care programs. MMIS processes claims from both programs. The monthly payments to managed care organizations are included in the amounts shown in Table 14, and comprise about 27 percent ($1.4 billion) of all MMIS expenditures and 21 percent (7,243,623) of all claims and payments in FY 2009.

In addition to the monthly payments, some individual medical services provided to persons enrolled in a managed care organization are also processed through MMIS. These so-called "carve out" services are not provided by the managed care organization but are instead provided by other medical providers, who bill DMAS directly. These claims are therefore processed like fee-for-service claims. For example, community mental health rehabilitative services are not provided by the managed care organization. As a result, all Medicaid recipients, including managed care enrollees, obtain these services directly from mental health providers.

Ten Provider Types Accounted for 89 Percent of Fee-for-Service Payments in FY 2009. Ten provider types accounted for 89 percent of all fee-for-service payments in FY 2009. As shown in Table 15, the largest percentage of fee-for-service payments were made to mental health and mental retardation providers (26 percent), followed by nursing homes (19 percent) and hospitals (17 percent). Although growth rates appear to vary substantially from one provider group to another, mental health and mental retardation providers have seen substantial growth (111 percent) over the past five fiscal years.

Fee-for-Service Claims Are Subjected to Several Automated Reviews That Apply Medicaid Policies and Rules. Almost all fee-for-service claims are processed through MMIS, which applies a series of automated reviews ("edits") to each claim before payment is approved. If a claim is blocked by an edit, MMIS generates an error message that tells the provider why the claim was blocked.

The edits are designed to ensure that all claims comply with Medicaid regulations and policies and that they are submitted only for valid Medicaid recipients. For example, certain edits are designed to ensure that prior authorization was obtained for those claims that require it, and that the authorized number of units of service was not exceeded. Although a single prior authorization request may authorize several units of service, such as counseling sessions or medical appointments, each unit of service will have a unique reimbursement claim. Like all claims, those services which are subject to prior authorization must successfully navigate all MMIS edits.

Table 15: Ten Provider Types Account for 89 Percent of All Fee-for-Service Payments (FY 2009)

Provider Type	FFS Payments FY 2009	Percent of FFS Payments FY 2009	MMIS Payment Growth FYs 2005-2009
Mental Health / Mental Retardation	$946,303,868	26%	111%
Skilled Nursing Home Non Mental Health	685,329,447	19	22
Hospital, In-state, General	605,781,865	17	26
Pharmacy	236,198,893	6	-62
Intermediate Care Facility--Mentally Retarded--State Owned	213,773,860	6	31
Physician	174,352,929	5	6
Personal Care	169,262,928	5	45
Psychiatric Residential Inpatient Facility	110,872,935	3	56
Durable Medical Equipment/Supplies	66,261,235	2	34
Intermediate Care Facility	44,179,427	1	-38
Top Ten Provider Types Subtotal	3,252,317,387	89	18
Total Fee-For-Service Payments	**$3,666,693,678**	**100%**	**20%**

Note: Table does not include managed care capitation payments, which equaled $1,374,355,333 and grew 36 percent from FY 2005-FY 2009.

Source: JLARC staff analysis of DMAS data.

Managed Care Organization Monthly Payments Are Processed by MMIS to Prevent Payment for Ineligible Recipients. In addition to fee-for-service claims, MMIS processes the monthly payments to the managed care organizations. However, because these payments do not represent direct payments to providers by DMAS, they are not processed using the same rules as fee-for-service claims. Instead, MMIS applies edits designed primarily to ensure that the identified Medicaid recipient is eligible and that the managed care organization has not already been paid for that person in that period. These and other edits rarely flag managed care organization monthly payments. Less than 0.1 percent of managed care monthly payments are blocked.

Managed Care Organizations Submit Incomplete Data on Services They Provide and Associated Costs

Although managed care organizations do not submit claims for individual services through MMIS for payment, they are required by their contract with DMAS to submit "encounter" data. (These data differ from the monthly payment claims processed by MMIS.) Like fee-for-service claims, encounter data are the primary record of services provided to Medicaid beneficiaries enrolled in Medicaid managed care. The data include information on the recipient, the direct provider of medical services, and the payment made by the managed care organization to the provider. Federal regulations require managed care organizations to ensure that data received from Medicaid providers are accurate and complete. For FY 2009,

managed care organizations submitted data on 17,674,103 encounters to DMAS. (These data are different than the 7,243,623 managed care payments discussed above.)

Although encounter data are similar to the information fee-for-service providers submit directly to DMAS, the agency only processes it through MMIS to evaluate the quality of the data, and no payments are made. During this process, each individual record in the data (a single "encounter") is evaluated, and encounters that contain significant errors are considered "fatal errors." A fatal error could include instances where the managed care organization paid an ineligible provider or paid for a service on behalf of an ineligible recipient. Fatal errors can also result from missing claims data. The contracts between DMAS and the managed care organizations require the organization to ensure that the encounter data as a whole has a fatal error rate of less than five percent. In addition, DMAS identifies instances in which the encounter data are missing data such as the date of admission, but these missing data are not treated as fatal errors and are thus not subject to any contractual limitation.

Combined, 3.4 percent of all encounter data received by DMAS had a fatal error in calendar year 2009. Individual managed care organizations had different fatal error rates. In calendar year 2009, these rates ranged from 1.3 percent to 7.7 percent. One managed care organization had an annual fatal error rate of 3.5 percent in 2009, but the rate had been as high as 14.3 percent in certain months.

In FY 2004, DMAS began a process designed to improve the encounter data. The agency hired a full-time data analyst and contracted with Thompson Medstat (now Thompson Reuters) to examine the encounter data, perform a risk assessment, and determine a corrective action plan. The contracted audit discovered substantial issues with the data, including lack of a valid Medicaid provider ID and some incomplete diagnosis and procedure codes. DMAS reports that because of financial constraints, the agency did not renew the contract with Thompson Reuters after FY 2007. JLARC staff will continue to review DMAS's use of encounter data for the final report.

Change to the Virginia Public Procurement Act May Facilitate Greater Use of Pre-Payment Reviews

Providers are requested to provide DMAS with supporting documentation for a claim, such as copies of medical records, as part of a post-payment audit. However, DMAS staff have stated that the prompt payment requirement in Article Four of the Virginia Public Procurement Act prevents additional pre-payment reviews of pro-

vider documentation. The act directs all agencies to pay for goods or services within "thirty days after receipt of a proper invoice by the state agency" (*Code of Virginia*, § 2.2-4347).

In contrast, Indiana's Medicaid program requires certain providers to submit supporting documentation before any payment is made. If a post-payment audit reveals excessive errors, or a referral is received from the Medicaid Fraud Control Unit, the Indiana program requires that provider to submit supporting documentation for all claims before any claim is paid, for a minimum of six months. Indiana program staff report that from 2005 to 2007, 15 providers stopped submitting any claims after being required to submit supporting documentation, and that these pre-payment reviews resulted in avoided costs of $4.5 million.

Indiana's Medicaid agency is allowed to take two months to review this documentation thoroughly before paying a claim. To enable DMAS to engage in more extensive pre-payment reviews, and potentially reduce the amount of improper payments, an exemption from Virginia's prompt pay requirement is needed. Although the potential effect of federal prompt pay regulations needs to be considered, they do not appear to bar this kind of review because an allowance is given for "claims from providers under investigation for fraud or abuse."

Recommendation (4). The General Assembly may wish to consider amending the Virginia Public Procurement Act (*Code of Virginia*, § 2.2-4347) to exempt the Department of Medical Assistance Services from the 30-day payment requirement so that the department can conduct a more extensive pre-payment review of a claim within a 90-day period if there is a reasonable basis to suspect that payment of the claim could be improper.

POST-PAYMENT REVIEWS INTENDED TO IDENTIFY IMPROPER PAYMENTS

After a claim has been processed by MMIS, selected claims are reviewed in order to identify those that were erroneously paid. These improper payments could include either overpayments or claims that should not have been paid according to federal or State Medicaid program rules. If DMAS determines that an improper payment was made, it can initiate an administrative recovery up to three years after payment was made. If audits by staff in the Program Integrity Division, or their contractors, detect irregularities that may constitute fraud, this information is supposed to be referred to the Attorney General's Medicaid Fraud Control Unit (MFCU).

Audit Plan Is Based on Assessment of Risk From Different Provider Types

Many of the audits conducted by the Program Integrity Division staff or their contract auditors are based on annual audit plans and compare medical charts to the claims filed by a provider to ensure that claimed procedures are documented and are consistent with Medicaid standards. These types of audits are done randomly across fee-for-service providers, but in some cases they are focused on particular providers as the result of referrals from various sources.

Program Integrity Division Uses Contract Auditors

DMAS contracts with national auditing firms to assist with provider review activities.

Clifton Gunderson, LLP conducts several types of audits, including hospice, physician, home health, pharmacy and durable medical equipment (DME) on-site reviews.

ACS Heritage conducts DME and pharmacy audits.

Health Management Systems conducts Diagnostic Resource Group (DRG) and behavioral health audits.

Since 2006, an annual audit plan has guided some of the planned audits conducted in a given year. This plan is based on an assessment of risk by different provider types, and is designed by an outside audit firm, Clifton Gunderson. The plan assigns a risk score to each of the 97 provider groups that submit claims to DMAS; scores are not assigned to individual providers within a peer group. The risk score for each provider group is calculated based on factors such as the size of providers in that group, the average dollar value of claims, the presence of a history of fraud or improper payments, the extent of existing government regulation, and the length of time since a provider in that group was last reviewed.

Risk scores, which are revised annually, are used to select provider types to review. The selection is then based on these scores along with DMAS's prior experience with the provider types, audits conducted by contractors, and specific provider type trends.

Other Planned Audits Are Based on Type of Provider

In addition to planned audits resulting from the annual audit plan, in which the selected provider types depend on the risk score, a separate unit of Program Integrity also conducts regular audits of hospitals and community mental health providers.

Hospital Audits Ensure Claims Documentation Supports the Services Provided. Because it is required to conduct routine utilization review audits on providers that provide inpatient and acute care services, DMAS audits acute care hospitals and freestanding psychiatric facilities. For these audits, staff pull random samples of claims for audit from targeted providers and conduct desk audits of those samples. These desk audits focus on documentation issues, such as a missing signature on an admissions certification.

In addition, a contractor conducts diagnostic related group (DRG) audits of hospital providers. Hospitals are paid mainly on a DRG basis, in which the payment for an array of services is based on the DRG code reported on the claim. These audits look to ensure that services which are included in the reimbursement for the DRG are

not being billed separately. In addition, these DRG audits examine whether the appropriate DRG has been reported based on the diagnosis in the medical record.

Community Mental Health Providers Are Audited to Ensure Services Are Provided by Qualified Staff. With the exception of one key difference noted below, the process used to audit community mental health providers is similar to the process used to audit hospitals. Staff audit "outlier" providers whose claims exceed the normal range for their peer group, as identified by analyses conducted by DMAS staff. In addition to their in-house audits, staff use a contractor to audit residential treatment facilities.

A key difference from hospital audits is that staff pay particular attention to whether the mental health provider used *qualified* staff to provide the service for which a claim was submitted. For example, the audit will attempt to determine if the staff person who provided a service had the required credentials or if a counseling session claimed to be conducted by a psychologist was in fact led by a certified counselor who was not a psychologist.

Data Analysis Is Used to Identify Particular Providers to Audit

Once the provider types, and the number of audits for each, are determined, Program Integrity staff use data analysis to look for individual providers with irregular claims within each selected provider type. The Surveillance and Utilization Review Subsystem, a part of MMIS, is used to create "exception reports" on claims that have already been paid. Program Integrity staff use the analyses to identify outliers by looking for billing patterns of individual providers that deviate from (are exceptions to) other providers of that type. By targeting their efforts on outliers, staff are more likely to audit providers to whom improper payments have been made.

Exception Reports Are Used to Review Medicaid Claims

The Program Integrity Division uses CS-SURS, a claims-based data mining software package, to determine which providers are exceeding the billing norms for their peer group. The system computes averages, standard deviations, and frequency distributions for peer groups of providers. Those providers who fall above or below the limits established for their peer group are identified as exceptions.

In addition to creating exception reports by provider type, staff conduct longitudinal trend analyses to identify service areas in which providers appear to be taking advantage of Medicaid policies. This is done by looking at changes in billing practices across time, both for individual providers and for provider types. For example, if the use of a given service substantially increased, it might represent a change in the way providers are billing. Although the change could be valid, it could also represent an attempt by providers to maximize revenue by changing the way they bill a service. Program Integrity staff report that these trend analyses are used to identify policy and procedure modifications that are needed to close loopholes, such as changes to edits in MMIS to catch improper practices on the front end.

Referrals and Complaints Take Precedence Over Planned Audits

In addition to planned audits, Program Integrity staff investigate referrals and complaints of atypical provider activities and allegations of fraud, waste, and abuse. DMAS staff report that referrals regarding allegations of patient abuse or fraud are prioritized.

Referrals come from a variety of sources, including DSS and other State agencies, Medicaid providers, and other units and divisions within DMAS. Table 16 lists provider referrals to the division by source. The largest referral source is DMAS itself, with referrals coming from DMAS's Internal Auditor and Program Operations Division, or as a result of audits conducted by the Program Integrity Division itself.

Table 16: Most Program Integrity Provider Referrals Are From Other Units Within DMAS

Source Type	FY 2005-FY 2009
DMAS	180
Other	65
Medicaid Fraud Control Unit	24
Recipient Friend or Family Complaint	12
Medicare/Other Insurance Carrier	10
Anonymous	9
Provider Employee	9
Recipient Complaint	7
Other Provider	5
Dept. of Behavioral Health and Developmental Services	4
Contractor	2
Comprehensive Services Act Office	2
Total	**329**

Source: JLARC staff analysis of DMAS data.

Provider Audits Examine a Sample of Claims

After deciding which individual providers to audit, as guided by audit plans, exception reports, or referrals, Program Integrity staff analyze a random sample of a selected provider's claims. The sample contains the records of 25 recipients and is typically drawn from a six-month period, although the time period can be adjusted based on claims history and the type of provider.

If sample claims from an individual provider contain irregularities that exceed the division's internal threshold of $5,000, or if the sample indicates a serious problem (such as consistently reporting a higher level—and thus more costly—code than is supported by the medical records), a full integrity review is conducted. Staff then begin an investigation in which a larger sample of that individual provider's claims are audited. After either type of audit is

conducted, DMAS issues a final findings letter that outlines any irregularities identified in the review.

Detection of Improper Payments Could Be Improved if Managed Care Organization Encounter Data Were Used

As mentioned earlier in this chapter, encounter data on services provided by managed care organizations have substantial data quality issues. As a result, DMAS's Program Integrity staff report that encounter data are not used to identify potential improper payments resulting from fraud and error. As a result, 17,674,103 managed care encounters were not subject to review by DMAS for fraud and error even though the use of these data may allow DMAS to improve its ability to identify outliers. While managed care organizations are not paid directly based on these encounter data, payments to managed care organizations accounted for $1.4 billion (27 percent) of all Medicaid expenditures in FY 2009.

Although DMAS does not review these data, the managed care organizations are contractually required to conduct their own program integrity activities. However, DMAS remains responsible under federal law to ensure federal dollars are appropriately expended. Fulfillment of this responsibility is hindered by the inability to use encounter data to ensure that the managed care organizations are properly paying providers and processing claims.

A 2009 report by the Inspector General for the Department of Health and Human Services, *Medicaid Managed Care Encounter Data: Collection and Use*, indicates that several states use encounter data to help detect fraud and abuse. The use of encounter data would also allow DMAS to expand its ability to detect improper payments within the fee-for-service data. For example, encounter data would allow DMAS to conduct more extensive outlier analyses (such as looking for providers who charge for more than 24 hours of service per day) by analyzing the claims submitted by both fee-for-service and managed care providers. However, the absence of certain information in the encounter data, such as the admission date, hinders this analysis.

DMAS IDENTIFIED IMPROPER PAYMENTS AND BLOCKED CLAIMS OF UP TO $67 MILLION IN FY 2009

DMAS uncovers or prevents improper payments through each of its three major program integrity activities:

- The use of the prior authorization process resulted in avoided costs of about $25.6 million, largely because providers requested services that were not deemed medically necessary.

- MMIS edits resulted in close to $26 million in avoided or retracted costs in both the fee-for-service and managed care programs, typically by reducing the requested payment, ensuring the provider was only paid the amount allowed by DMAS, and ensuring managed care recipients were still eligible.
- Lastly, the Program Integrity Division identified about $15 million in funds to be recovered by conducting audits of the medical documentation used to support paid claims.

Most of these processes are conducted only on fee-for-service claims, and not for services provided by the managed care organizations.

Prior Authorization Process Avoided Costs of Up to $26 Million in FY 2009

Because prior authorization is performed in large part by a contractor, KePRO, data on the nature and scope of activity in this area are based on those reports that are contractually required. However, analysis of these data is limited by the fact that some data are reported by provider type while others are reported only by larger service areas. In addition, KePRO calculates avoided costs by aggregating the value of all services for which a prior authorization request was denied. This may overstate the avoided costs, because some of these services may be requested and approved at a later point.

Prior Authorization Process Avoided Costs of Up to $133 Million From FY 2008 to FY 2010. From FY 2007 to FY 2010, the annual number of prior authorization requests grew from 212,437 to 290,000 (37 percent). (Data are not available before 2007.) Over that time period, the denial rate decreased from 12 percent to nine percent, but the potential avoided costs resulting from the prior authorization process grew by over 400 percent (Table 17).

Table 17: Prior Authorization Avoided Costs Have Increased as Denial Rate Decreased

Fiscal Year	Potential Avoided Costs	Denial Rate
2007	n/a	12%
2008	$17,552,232	11
2009	25,588,906	11
2010	89,511,737	9
Total FY 2008-FY 2010	**$132,652,875**	

Source: JLARC staff analysis of DMAS data.

In addition to the potential avoided costs estimated above, it is likely that additional avoided costs result from the prior authorization process because of the deterrent effect the process creates. For example, DMAS indicated that the documentation requirements of the process deter fraudulent claims. Once providers realize their claims will not be processed, they may not submit new claims. This deterrent effect is difficult to quantify, but is a valid consideration when examining the effects of pre-payment claims controls.

The large growth in potential prior authorization avoided costs in FY 2010 resulted largely from the introduction of new reviews for community mental health rehabilitation services. A requirement to review these services was added to the KePRO contract in August of 2009 at an annual cost of about $2 million, increasing the cost of that contract by 20 percent. Since the addition of these rehabilitation services to the prior authorization list, KePRO reports that potential avoided costs for outpatient services increased by $65 million. DMAS staff indicate that this category of services was added to prior authorization review because of heavy expenditure growth. From FY 2005 to FY 2009, expenditures on these services increased by 700 percent ($45 million to $366 million).

Formal Process to Initiate and Review New Prior Authorization Requirements Is Needed. Although the addition of community mental health to the list of services requiring prior authorization substantially increased the potential avoided costs, there does not appear to be any documentation of how the decision was made to add these programs or an analysis of the potential return on investment. A larger concern, however, is that DMAS appears to lack a formal process to identify opportunities of this nature. Although DMAS conducted a formal analysis at one time, in response to direction in the 2004 Appropriation Act, it appears that the agency only conducted this kind of analysis on a temporary basis.

A more regular analysis of the return on investment from prior authorization and tracking services with substantial expenditure growth would provide DMAS management with a means for better determining whether an increase in annual contractual expenditures was justified, the potential impact on access to care, and the degree to which the provider community would be affected. This analysis would also provide a baseline against which the future return on investment from these reviews could be measured.

Number of Prior Authorization Requests and the Denial Rates Vary by Provider Type. Five provider types accounted for 66 percent of all prior authorization requests in FY 2009 (Table 18). Of these five provider types, only physicians exceeded the average denial rate of ten percent. However, some other provider types with a smaller number of requests, not listed in Table 18, had denial

rates of up to 30 percent. For example, podiatrists make up less than one percent of requests but have a denial rate of 30 percent.

Although KePRO reports denial rates by provider type, it does not report avoided costs attributable to individual provider types or specific services. Instead, data on avoided costs are reported according to three service types: inpatient, outpatient, and waiver-based. Although these data are a useful means of examining the effectiveness of the KePRO contract as a whole, the lack of information on the avoided costs resulting from certain services or provider types does not allow DMAS to fully evaluate the avoided costs that result from prior authorization and make cost-beneficial adjustments. JLARC staff will continue to review this area for the final report.

Table 18: Prior Authorization Denial Rate Varies by Provider Type

Provider Type	Percentage of All Prior Authorization Requests FY 2009	Average Denial Rate FY 2009
Hospital, In-state, General	19.3%	8.1%
Durable Medical Equipment	19.3	6.8
Physician	13.4	11.4
Mental Health /Mental Retardation	7.5	9.2
Home Health Agency - Private	6.0	6.1
Subtotal, Top Five Provider Types	**65.5**	**8.3**
All Other Types	34.5	15.6
All Provider Types	**100.0%**	**10.8%**

Source: JLARC staff analysis of DMAS data.

MMIS Edits Produced Avoided Costs and Savings of $25.8 Million in FY 2009

As discussed above, MMIS edits are used to review individual fee-for-service claims to ensure they are complete and comply with Medicaid policies and regulations. DMAS staff indicate that MMIS is regularly modified as irregularities in processed claims are uncovered or as a result of legislative actions, such as limits on service provision. For example, the 2009 Appropriations Act gave DMAS the authority to eliminate reimbursement for hospital-acquired conditions in a manner similar to the process used by Medicare. In response, DMAS added an MMIS edit designed to ensure hospital payments are based only on conditions present at admission and not on conditions acquired while in the hospital.

If an edit in MMIS blocks a claim, a provider can submit a corrected claim for which they may be paid. Because some paid claims may replace previously blocked claims, DMAS does not calculate the costs avoided from blocked claims. However, DMAS does count

the costs avoided created when an edit reduces the cost of a claim. In addition, DMAS estimates the potential fiscal impact resulting from adjustments to edits or the addition of new edits, but the actual fiscal impact is not subsequently tracked. Tracking this fiscal impact centrally would help DMAS to more fully explain its total cost avoidance.

MMIS Edits Blocked 39 Percent of Submitted Claims in FY 2009. In FY 2009, MMIS processed about 28 million claims. Of these, 39 percent were blocked. As shown in Table 19, ten provider types filed 89 percent of all claims. In fact, just two provider types, physicians and pharmacies, accounted for 57 percent of all claims.

Table 19: Ten Provider Types Filed 89 Percent of All MMIS Claims and 39 Percent of Claim Requests Were Denied (FY 2009)

Provider Type	Total MMIS Requests FY 2009	Percent of MMIS Requests FY 2009	Denial Rate FY 2009
Physician	8,437,535	30%	50%
Pharmacy	7,429,423	27	39
Mental Health Mental Retardation	2,137,105	8	10
Durable Medical Equipment/Supplies	1,695,539	6	35
Hospital, in-state, General	1,426,518	5	28
Independent Laboratory	1,026,202	4	38
Medicare Crossover	953,491	3	72
Personal Care	765,451	3	16
Skilled Nursing Home Non Mental Health	533,269	2	18
Transportation	359,397	1	25
Subtotal, Top 10 Provider Types	**24,763,930**	**89**	**n/a**
Other	3,172,052	11	n/a
Total, All Provider Types	**27,935,982**	**100%**	**39%**

Source: JLARC staff analysis of DMAS data. Does not include capitated payments to managed care organizations.

DMAS Estimates $11.8 Million in Avoided Costs Due to MMIS Edits for Fee-for-Service Claims in FY 2009. MMIS edits reduced the costs of paid claims by $11.8 million in FY 2009. The majority of these avoided costs came from an edit that "pends" emergency room claims for further review. DMAS then reduces the reimbursement from the emergency rate to the lower non-emergency rate where appropriate, resulting in avoided costs of $8.9 million in FY 2009.

In addition to the emergency room "pends," DMAS reports an annual avoided cost of $2.6 million from a proprietary software program known as ClaimCheck. This program is intended to ensure that all claims are coded in accordance with industry standards and federal requirements. (Providers must use designated medical codes on reimbursement claims to indicate the diagnosis and type of service provided.) ClaimCheck is designed to detect coding dis-

Unbundling and Rebundling of Procedure Codes

Either intentionally or unintentionally, a provider may submit a claim that lists two or more service codes when instead, a single, more comprehensive service code exists that should have been used. For example, instead of listing a comprehensive code for an appendectomy, the provider may "unbundle" the operation by listing the individual codes for each service provided as part of the appendectomy.

The potential exists for abuse because the provider receives a higher reimbursement by billing for individual services instead of the comprehensive service.

crepancies automatically, including cases where a provider has submitted a claim for which the service does not reasonably match the diagnosis, or instances where the provider has "unbundled" services on a claim. As of January 1, 2009, all claims, except for specific procedure codes identified as waiver and substance abuse services, are subject to ClaimCheck. Another similar set of edits called the Correct Coding Initiative saved an additional $240,000 in FY 2009.

In addition to these identified avoided costs, it is likely that avoided costs result from the deterrent effect created by the use of edits. As in the case of prior authorization, this deterrent effect is difficult to quantify but is a valid consideration when examining the effects of front-end claims controls over time.

Claims are most frequently blocked because providers request higher reimbursement than DMAS allows. As seen in Table 20, 18 percent of all blocked claims result from the provider requesting a higher payment than the amount allowed by DMAS. (Of the 1.9 million claims blocked for this reason, 87 percent come from physicians.) Other common reasons for blocked claims include other insurance coverage or recipient ineligibility. These include instances in which the patient was covered by another form of insurance, such as Medicare, or in which the patient was ineligible for Medicaid on the day of service.

Table 20: Six Reasons Accounted for 51 Percent of All Claims Blocked by MMIS (FY 2009)

Reason for Blocked Claim	Count	Percent of All Errors
Claim request exceeded allowed reimbursement	1,982,841	18%
Patient covered by managed care organization	951,022	9
Patient covered by Medicare	877,779	8
Patient not eligible on day of service	680,304	6
Patient has other insurance	631,769	6
Invalid provider identification number	390,735	4
Subtotal, Top Six Errors	**5,514,450**	**51**
Other Errors	5,306,661	49
Total Errors	**10,821,111**	**100%**

Source: JLARC staff analysis of FY 2009 DMAS data.

DMAS Prevented or Retracted Improper Payments of $14 Million for Managed Care Recipients. In addition to blocking improper fee-for-service payments, DMAS also uses MMIS to block and retract improperly-paid managed care capitation payments. On a regular basis, MMIS generates a letter which is sent to recipients to confirm their mailing address. If this mailing is returned as undeliverable, DMAS halts capitation payments for that individual and disenrolls

them from Medicaid. DMAS indicates that this practice resulted in avoided costs of up to $13 million in FY 2009.

Another practice involves the retraction of capitation payments for persons who are deceased. On a monthly basis, DMAS receives a list of deceased individuals from the Department of Health. Because this reporting often lags the actual date on which a recipient died, payments on behalf of deceased recipients occur but are then retracted. In FY 2009, $1 million in improper payments were retracted from managed care organizations.

Provider Audits Identified $15.3 Million in Overpayments in FY 2009 Resulting From Provider Errors

In FY 2009, Program Integrity staff conducted 409 audits which identified $7.7 million in overpayments to providers. More broadly, from FY 2005 to FY 2009, Program Integrity staff conducted a total of 1,711 audits which identified $33.9 million in overpayments to providers (Table 21). This equates to approximately $20,000 in identified overpayments per audit.

Table 21: Program Integrity Conducted 1,711 Audits and Identified $33.9 Million in Overpayments (FY 2005-FY 2009)

Fiscal Year	Total Audits	Total Identified Overpayments
2005	262	$4,010,150
2006	263	7,139,542
2007	437	7,089,801
2008	340	7,961,231
2009	409	7,692,393
Total	**1,711**	**$33,893,117**

Note: These amounts exclude audits conducted by contract auditors.

Source: DMAS data.

In addition, DMAS hired several contract auditors, and their audits identified an additional $7.6 million in overpayments. (The process used by DMAS and contract auditors to select providers and then conduct the audit will be reviewed as part of the final report.)

The amounts shown in Table 21 do not account for the proportion of funds that are actually collected or recovered, because data on those amounts are not presently available. JLARC staff will continue to investigate the collection rate (the percentage of funds identified for restitution or recovery that are actually received) and report these findings in the final report.

Sixty-seven Percent of Audits From FY 2005 to FY 2009 Uncovered Overpayments. Table 22 illustrates the effectiveness of audits as measured by the proportion of audits that resulted in an identified overpayment. Of the 1,711 audits conducted from FY 2005 to FY 2009, 1,147 (67 percent) identified some overpayment. As seen in the table, the different types of audits conducted by the DMAS Program Integrity Division vary in the proportion of audits uncovering overpayments.

Table 22: Approximately Two-thirds of Program Integrity Audits Uncover Some Improper Payments

Type of Audit	Audits FYs 2005-2009	Percent of Audits With Findings	Findings FYs 2005-2009
Provider Review Unit	893	65%	$8,226,450
Mental Health	264	81	3,600,936
Hospital	490	71	19,459,929
Other	64	n/a	2,605,802
Total	**1,711**	**67**[a]	**$33,893,117**

[a] Does not include "Other," as outcomes for those cases were unavailable.

Source: DMAS data.

Appeals Reduced Identified Overpayments by Less Than Two Percent. Any findings of overpayments are subject to the DMAS appeals process, should a provider choose to avail themselves of that process. Through the appeals process, a provider can challenge the findings of an audit by presenting additional documentation, or asserting that the findings are in error.

Of the 1,147 cases with identified overpayments, only 57 (five percent) were appealed. Of those 57 cases, administrative findings were upheld in 23 of them. The remaining cases were successful on appeal and resulted in a reduction of $491,087, or about 1.5 percent of the overpayments identified in audits over the FY 2005-2009 period.

Three Provider Groups Were Subject to 75 Percent of All Audits. From FY 2005 to FY 2009, three types of providers (hospitals, mental health and mental retardation providers, and physicians) were the subject of 75 percent of program integrity audits and accounted for 74 percent of all identified overpayments (Table 23).

Most of the identified overpayments ($19.6 million) were from hospitals, but this is equivalent to only 0.7 percent of hospital payments in that timeframe (over $2.7 billion.) Two other provider groups, psychiatric residential inpatient facilities and personal care providers, were subject to less than two percent of audits and yet accounted for 14 percent of all identified overpayments for the five-year period.

Table 23: Most Audits Are Performed on Three Provider Types, but Overpayments Per Audit Vary Substantially by Provider Type (FYs 2005-2009)

Provider Type	Total Audits	Total Identified Overpayments	Average Overpayment/ Audit	Overpayments as % of Total Payments
Hospital, In-state, General	498	$19,644,244	$39,446	0.7%
Mental Health / Mental Retardation	337	3,613,513	10,723	0.1
Psychiatric Residential Inpatient Facility	9	3,126,814	347,424	0.7
Physician	439	1,585,101	3,611	0.2
Personal Care	14	1,556,889	111,206	0.2
Other	414	4,366,557	10,547	0.1
Total or Average	**1,711**	**$33,893,117**	$19,809	0.2%

Source: DMAS data, FYs 2005-2009.

Audits Uncover Issues With Claims Documentation and Improper Billing. The most common errors uncovered through audits are instances in which the medical record did not support the service that the provider billed, or no medical record existed. Each of these errors can result in the denial of the entire claim. Although DMAS does not appear to track the number or type of errors by provider type, at an aggregate level these two error types constituted 40 percent of all errors in FY 2009 (Table 24.) Other errors indicate that the claim is valid, but should have been billed at a lower reimbursement level. One specific example of this is the unbundling of individual blood chemistry tests instead of charging for all of the procedures together as a panel.

Table 24: Most Audits Uncover Issues With Inadequate or Missing Claims Documentation and Improper Billing (FY 2009)

Error Type	Number	Percent of All Errors
Medical record does not support service billed	1,687	24%
No written documentation	1,064	15
Medical record documentation supports lower service level reimbursement	1,019	14
Medical record documentation indicates more appropriate code	586	8
Blood chemistry tests inappropriately unbundled	498	7
Other Error	2,294	32
All Errors	**7,148**	**100%**

Source: JLARC staff analysis of DMAS data.

DMAS PROGRAM INTEGRITY EFFORTS HAVE POSITIVE RETURN AND COULD BE EXPANDED

While the total scope of improper payments in Virginia's Medicaid system is unknown, a review conducted by the federal government indicated that errors exist in paid Medicaid claims. In addition, DMAS provider audits appear to uncover overpayments that ex-

ceed the cost of those audits. It may be in the State's best interest to expand its audit program.

Federal Payment Error Rate Measurement Review Suggests Two to Five Percent of Sampled Claims Contained Errors

The Centers for Medicare and Medicaid Services (CMS) conducts Payment Error Rate Measurement (PERM) reviews on paid Medicaid claims in each state. The goal of these reviews is to determine the nature and scope of errors. The most recent review of Virginia was conducted on data from federal fiscal year (FFY) 2006.

Types of Error Identified in PERM Reviews

Medical review errors occur when a payment is incorrectly made, based on a review of the medical documentation submitted, the relevant state policies, and a comparison to the information presented on the claim.

Data processing errors occur when a payment is incorrectly made because of a shortcoming in the state's Medicaid Management Information System, such as a missing automated control or edit.

The federal review did not identify any data processing errors (such as duplicate paid claims or payments for non-covered services). These are the types of claims issues that MMIS is designed to block, and the lack of such issues suggests that MMIS is properly processing claims. However, the PERM review found medical review errors such as those found during Program Integrity audits, including insufficient documentation and coding errors. CMS found that 47 (4.6 percent) of 1,021 claims sampled for the review contained some type of medical review overpayment error that DMAS had not previously identified (Table 25).

Table 25: Most Common Error From Federal Review Was Insufficient Documentation (FFY 2006)

Error Type	Number	Percentage of All Errors
Insufficient Documentation	18	38%
Procedure Coding Error	10	21
Policy Violation	7	15
No Documentation	4	9
Diagnosis Coding Error	4	9
Number of Units Error	3	6
Medically Unnecessary	1	2
Total	**47**	**100%**

Source: JLARC staff analysis of data provided by DMAS.

In addition to examining the types of errors, PERM also reviewed the overpayments resulting from the identified errors. As seen in Table 26, 63 percent of identified overpayments came from hospitals. (This is similar to the results of Program Integrity audits discussed above, which found that hospitals accounted for 58 percent of the identified overpayments in FYs 2005 through 2009.) Most of the hospital errors found by the PERM review are related to the use of incorrect diagnostic codes on claims, which result in a higher payment than is appropriate.

Table 26: Hospitals Account for 63 Percent of Overpayments Identified by PERM Review (FFY 2006)

Provider Strata	Total Errors	Total Identified Overpayments	Percent of Identified Overpayments	Average Overpayment/ Error
Hospital	5	$21,424	63%	$3,739
Clinic/Other Practitioners	19	5,686	17	272
Long-Term Care	5	5,322	16	1,064
Home and Community-Based Care	5	1,244	4	249
Prescription Drugs	10	344	1	34
Other	3	60	0	32
Total	**47**	**$34,079**	**100%**	**$677**

Source: JLARC staff analysis of data provided by DMAS.

PERM Review Found 3.2 Percent of Payments Were Improper

The improper overpayments identified by the PERM review ($34,079) amounted to 3.2 percent of the $1,079,617 in payments made for all claims in the sample. (Appendix B discusses the margin of error for these samples.) Weighting the sample based on the CMS methodology results in a higher error rate. Conversely, accounting for claims which were found to be valid after the review ended suggests that the error rate could be lower than 3.2 percent.

CMS Weighted Model Estimated Improper Overpayments of 5.5 Percent. In an attempt to adjust the PERM results to more accurately represent the universe of Virginia Medicaid claims, CMS weighted the sample based on provider types and the fiscal quarter in which the claim was filed. By adding a weight to the improper payments found in each claim, CMS effectively increased the $34,079 from the initial review to $58,990, which equates to 5.5 percent of the payments for the sample.

DMAS Adjustments Suggest Only 2.2 Percent of Payments in Error. DMAS asserts that the PERM estimate should be adjusted to account for several factors in order to accurately portray the extent of error in fee-for-service Medicaid claims. Subsequent to the PERM review deadline, providers submitted additional data that resulted in seven cases with identified overpayments being deemed appropriate. (In other words, no improper payments occurred.) This process is normally followed after an audit by DMAS, but CMS's deadline prevented this adjustment from occurring before the PERM review ended. If these concerns are taken into account, then the improper payments amount in the sample is reduced to $24,637, which equates to 2.2 percent of the payments for the sample.

DMAS also notes that since this review CMS has determined that its methodology was not fully capable of calculating a reliable

statewide error rate and estimating inappropriate overpayments. CMS has since changed its methodology for PERM reviews. Moreover, DMAS has implemented several major program integrity reforms since federal FY 2006, including full implementation of the group of MMIS edits known as ClaimCheck, an increase in the use of prior authorization, and implementation of a pharmacy utilization program. Each of these programs has the potential to reduce the number of errors that exist in fee-for-service Medicaid claims.

PERM Reviews of Federal FY 2008 Data Suggest DMAS May Have Fewer Errors Than Other States. In addition to the review of Virginia's Medicaid claims, CMS published a report on the findings from PERM reviews in 17 other states that were conducted using federal FY 2008 claims. As noted above, the 2006 PERM review of Virginia found medical review errors, but no data processing errors. In contrast, CMS's analysis of federal FY 2008 errors found in 17 other states indicates that data processing errors accounted for 37 percent of all errors. DMAS's lack of these errors suggests it fares better than some other states.

Positive Return on Investment for Program Integrity Division Suggests Additional Resources Would Be Beneficial

JLARC staff analysis of data provided by DMAS on expenditures by the Program Integrity Division, and the funds identified by provider audits for recovery, suggests that additional program integrity resources have the potential to identify the additional overpayments that the PERM estimates suggest may still exist. The analysis indicates that for every dollar invested in reviewing provider claims, $2.62 is identified for recovery for the Medicaid program (FY 2009). In addition, DMAS contract auditors identify $1.76 for recovery to the Medicaid program for every dollar expended on those contracts, on average. These amounts do not account for the fact that only a portion of these identified overpayments are actually collected or recovered because data on those amounts are not presently available. JLARC staff will continue to investigate the collection rate (the percentage of funds identified for restitution or recovery that are actually received) and report these findings in the final report.

Chapter 7

MFCU Prosecution of Provider Fraud Returned at Least $49 Million to Virginia Medicaid

In Summary

Virginia's Medicaid Fraud Control Unit (MFCU), a division of the Office of the Attorney General, prosecutes Medicaid provider fraud. Almost two-thirds of the MFCU's cases result from whistleblowers and are focused on pharmaceutical manufacturers. While the unit reports recoveries of over $706 million from FY 2005 to FY 2009, only $167 million of that amount has been received by Virginia. Of Virginia's share of all court-ordered awards, the total amount awarded to the Department of Medical Assistance Services (DMAS) because of Virginia Medicaid fraud is not known, but DMAS data indicate that the agency received $48.7 million from the MFCU over that five-year period. In addition, the MFCU, the Virginia State Police, and the Department of Health Professions have received a total of $104 million as a result of the unit's prosecutions. There may be opportunities to increase the detection and prosecution of fraud by improving coordination between DMAS and the unit and using MFCU staff to also analyze Medicaid data to identify fraud.

Although recipient Medicaid fraud is prosecuted by local Commonwealth's Attorneys, provider fraud is prosecuted by the State's Medicaid Fraud Control Unit (MFCU). Provider fraud usually involves providers willfully attempting to obtain larger reimbursements than they are due under Medicaid policy. MFCU prosecutions of providers who attempt to defraud Medicaid serve to deter providers of medical services from engaging in fraudulent or abusive behavior. In addition, convictions in these cases result in improper payments being recouped to the Medicaid program. Convictions of Medicaid fraud often lead to the removal of providers from the Medicaid system.

MFCU INVESTIGATES POTENTIAL FRAUD AND ABUSE REFERRED BY DMAS AND OTHER SOURCES

The MFCU, a division of the Office of the Attorney General, is tasked by Virginia and federal law with investigating cases of provider fraud against Medicaid and other federal health care programs. The unit also investigates abuse and neglect of residents of Medicaid-funded facilities. The unit receives referrals from a variety of sources, most frequently from corporate whistleblowers.

MFCU Is Funded Mainly Through Federal and Special Funds

Virginia's MFCU was established in 1982 to "conduct audits and investigations of providers of medical and other services furnished under medical assistance" (*Code of Virginia*, § 32.1-320). In addition to its statutory responsibilities, each MFCU operates under the administrative oversight of the Office of Inspector General of

the U.S. Department of Health and Human Services (OIG) and must be recertified annually. As part of this process, the OIG reviews a unit's application for recertification and conducts periodic on-site visits.

A key requirement of federal certification is that a unit must be separate and distinct from the state Medicaid agency. This separation of duties exists because the MFCU is also responsible for investigating potential fraud involving that agency's employees and contractors. Federal regulations also prohibit any official from the Medicaid agency from having authority to review or overrule activities of the unit.

In FY 2009, Virginia's MFCU employed 49 attorneys, auditors, and investigators to prosecute cases of Medicaid fraud and abuse. The MFCU is generally reimbursed by the federal government for 75 percent of its expenses. For FY 2009, the federal grant covered about 73 percent of MFCU's $4.9 million in expenditures (Table 27). Another 27 percent of MFCU's expenditures were covered by a fund established as a result of a $39.8 million settlement from the Purdue Frederick case in FY 2008. (More information on this case is provided later in this chapter.) The MFCU will use these funds indefinitely to provide the 25 percent State share of the unit's budget, as prescribed in the court order.

Table 27: Over 90 Percent of MFCU Funding Is From Federal and Special Funds (FY 2009)

Fund Source	Funds	Percent of MFCU Expenditures
Federal Grant	$3,543,939	73%
Settlement Fund	1,325,378	27
Total	**$4,869,317**	**100%**

Source: MFCU Annual Report, FY 2009.

MFCU Investigates Fraud and Elder Abuse

The MFCU investigates three major types of cases: Medicaid fraud, elder neglect or abuse, and misappropriation of a Medicaid patient's private funds. As seen in Table 28, the vast majority of MFCU investigations over the past five fiscal years have been cases of Medicaid fraud, with only 19 elder abuse cases and 16 patient fund cases.

In addition, the unit is authorized by federal law, with the approval of the inspector general of the relevant federal agency, to investigate fraud in other federally-funded health care programs if the case is primarily related to Medicaid.

Table 28: Most MFCU Investigations Are Cases of Medicaid Fraud (FYs 2005-2009)

Investigation Type	Number of Investigations	Percent of All Investigations
Fraud	305	89.7%
Elder Abuse	19	5.5
Patient Funds	16	4.7
Total	**340**	**100%**

Source: JLARC staff analysis of MFCU data.

Most Referrals Come From Corporate Whistleblowers and About One-Fifth Come From DMAS

The MFCU investigates potential cases of fraud referred from the Department of Medical Assistance Services (DMAS) and other State agencies, corporate whistleblowers, and other sources. The MFCU's mission is to examine these referrals and determine if a legal case for fraud exists. In cases where sufficient evidence appears to exist to support either a civil or criminal prosecution, MFCU attorneys work by themselves or with federal and local authorities to prosecute the cases in the appropriate court.

Establishment of MFCU's Civil Unit Has Led to an Increase in Whistleblower Cases. As shown in Table 29, the majority of referrals to the MFCU over the past five fiscal years have come from whistleblower (*qui tam*) cases. The civil investigation unit was created in FY 2005 with a primary mission of investigating whistleblower cases. This unit works with the Department of Justice and United States attorneys on nationwide cases that contain fraud against the Medicaid program. The majority of these referrals (79 percent) involve pharmaceutical manufacturers.

Table 29: Most MFCU Referrals Come From Whistleblowers (FYs 2005-2009)

Source	Number of Referrals	Percent of Referrals
Whistleblower (*qui tam*)	215	63.2%
DMAS	76	22.4
Private citizens	21	6.2
Law enforcement	10	2.9
Former employee complaint	4	1.1
HHS - OIG Investigation	3	0.9
Provider	3	0.9
Other	8	2.4
Total	**340**	**100.0%**

Source: JLARC staff analysis of MFCU data.

DMAS's Referrals to the MFCU May Be Low. DMAS is the second-largest source of referrals to the MFCU, accounting for about one-fifth of all referrals. Despite this, the MFCU's director raised con-

cern that the number of referrals from DMAS is too low, a concern that most MFCUs appear to have. Reports and data prepared by the OIG indicate DMAS is in the lower half of all states in terms of the number of referrals to Virginia's MFCU. According to 2006 data from the OIG, 21 MFCUs reported receiving fewer than 12 referrals each from their state's Medicaid agency. In that year, federal data indicate DMAS made only eight referrals.

As seen in Table 30, DMAS's records indicate an even lower number of referrals than what is reported by the MFCU and subsequently included in the OIG's reports. Although the MFCU's records indicate the unit received 76 referrals from DMAS from FY 2005 to FY 2009, DMAS only has records of 54 referrals over that same period. DMAS staff note that the MFCU only accepted 40 of the 54 referrals they provided, but MFCU staff indicate that in some cases the evidence may have been insufficient or the alleged action did not constitute fraud.

Table 30: DMAS Referrals to MFCU (FYs 2005-2009)

Fiscal Year	DMAS Referrals	Referrals Accepted
2005	7	6
2006	6	5
2007	15	13
2008	15	8
2009	11	8
Total	**54**	**40**

Source: JLARC staff analysis of DMAS data.

Most Referrals Are for Pharmaceutical Manufacturers

As shown in Table 31, the majority of MFCU referrals involve pharmaceutical manufacturers, which are not traditionally thought of as Medicaid providers. Of the 174 referrals for pharmaceutical manufacturers, 170 came from corporate whistleblowers as *qui tam* cases. According to the MFCU's Annual Report, pharmaceutical manufacturer fraud consists of illegal activities conducted to increase the market share of a particular drug. This can involve illegal kickbacks to physicians to encourage prescription of a certain drug. In addition, marketing campaigns by pharmaceutical manufacturers that encourage physicians to prescribe drugs for uses that have not been endorsed by the Food and Drug Administration are also considered fraud.

Table 31: Most MFCU Referrals Are for Pharmaceutical Manufacturers (FYs 2005-2009)

Provider Type	Number of Referrals	Percent of Referrals
Pharmaceutical Manufacturer	174	51%
Home Health	37	11
Nursing Home	26	8
Durable Medical Equipment	25	7
Physician	15	4
Nurse	8	2
Psychologist/Psychiatrist	7	2
Transportation	7	2
Laboratory	6	2
Mental Health	5	1
Dentist	4	1
Hospital	3	1
Other	23	7
Total	**340**	**100%**

Source: JLARC staff analysis of MFCU data.

MFCU PROSECUTES CIVIL AND CRIMINAL CASES IN FEDERAL AND STATE COURTS

Although the MFCU received 340 referrals during FYs 2005-2009, not all of those cases resulted in criminal or civil prosecutions. As shown in Table 32, only 60 referrals have resulted in a conviction while 111 referrals were investigated and closed because of insufficient evidence to take to trial. (Over that same period, the MFCU obtained a total of 85 civil and criminal convictions for fraud because some of these cases came from referrals received prior to FY 2005.) Almost half of the 340 referrals are still treated as open investigations.

Table 32: Many MFCU Referrals Do Not Result in Convictions (FYs 2005-2009)

Case Status	Number of Cases
Closed (conviction)	60
Closed (insufficient evidence)	111
Open	169
Total	**340**

Source: JLARC staff analysis of MFCU data.

MFCU Utilizes Both Civil and Criminal Prosecutions for Fraud

Before the MFCU established its Civil Division in FY 2005, all fraud cases were tried criminally. Establishment of the new division led to the MFCU prosecuting an increasing number of cases civilly. One of the advantages of civil prosecution is that the burden of proof is substantially lower. Instead of having to establish fraud "beyond a reasonable doubt," a prosecutor must only estab-

lish it by a "preponderance of the evidence." A potential disadvantage of proceeding civilly is that, unlike a criminal conviction, a civil conviction may not result in a mandatory exclusion from Medicaid participation. As seen in Table 33, the number and proportion of civil convictions have increased in recent years, but the majority of cases are still tried as criminal cases.

Table 33: Civil Cases Have Increased but Most Cases Are Still Criminal (FY 2005-FY 2009)

Fiscal Year	Civil Convictions	Criminal Convictions
2005	2	6
2006	4	10
2007	7	13
2008	10	12
2009	7	14
Total	**30**	**55**

Source: JLARC staff analysis of MFCU data.

MFCU Fraud Cases Are Tried In State and Federal Jurisdictions

Most of the MFCU's cases are tried in federal court, but in some instances criminal cases are prosecuted in State circuit and district courts with the concurrence of the local Commonwealth's Attorney (Table 34). Because Medicaid is a federal program, the MFCU has the ability to charge individuals under either the federal or State False Claims Acts, so both federal and State courts could have legal jurisdiction. However, all civil fraud cases are tried in federal court because all of the cases also involve either the federal government or other states. An advantage of this approach is that it allows the MFCU to leverage the resources of the federal Department of Justice by prosecuting cases in conjunction with a United States Attorney.

Table 34: Most MFCU Cases Are Tried in Federal Court (FYs 2005-2009)

Jurisdiction	Number of Cases	Percent of Total Cases
Federal Court	60	71%
Virginia Circuit Court	23	27
Virginia District Court	2	2
Total Cases With Convictions	**85**	**100%**

Source: JLARC staff analysis of MFCU data.

MFCU Fraud Cases Involve Many Provider Types

As shown in Table 35, the MFCU convicts a variety of provider types, but home health providers and pharmaceutical manufactur-

ers are the most common. As discussed earlier, pharmaceutical manufacturer cases result mainly from corporate whistleblowers and involve illegal marketing and kickbacks. Home health providers deliver personal and respite care services to Medicaid recipients in their homes. Case summaries from MFCU's *Annual Report* indicate that fraud committed by these providers includes providing services through unqualified personal care aides, falsifying records, and concealing the use of family members as personal care aides.

Table 35: Home Health and Pharmaceutical Manufacturers Are the Most Common Provider Types Convicted (FYs 2005-2009)

Provider Type	Number of Cases	Percent of Total Cases
Home Health	24	28%
Pharmaceutical Manufacturers	18	21
Nursing Home	10	12
Transportation	6	7
Durable Medical Equipment	5	6
Nurse	4	5
Mental Health	3	4
Physician	3	4
Hospital	2	2
Dentist	1	1
Laboratory	1	1
Other	8	9
Total	**85**	**100%**

Source: JLARC staff analysis of MFCU data.

In cases in which the MFCU participated in the prosecution, the vast majority of restitution, forfeiture, penalties, and other awards ordered by courts come from pharmaceutical manufacturers (Table 36). Most of these court orders result from the Purdue Frederick case that resulted in a $634.5 million award:

Case Study

On May 10, 2007, the Purdue Frederick Company, Inc., pled guilty to misbranding the drug OxyContin by marketing it to physicians as being less addictive and less subject to abuse and diversion than other pain medications. These claims were not supported by, or were contrary to, research findings. The company, along with its president, chief legal officer, and former chief medical officer, pled guilty. As part of the resolution, Purdue and the executives paid a total of $634.5 million to resolve its criminal and civil liabilities. Purdue forfeited $281 million to the United States, paid the United States and state governments $223 million to resolve liability for false claims made to Medicaid and other government health care programs, set aside $130 million to resolve private civil claims, and paid the maximum statutory

criminal fine of $500,000. The Commonwealth's recovery was $105 million of the $634.5 million, which went to several State agencies: Virginia State Police $44 million, MFCU $39.8 million (of which $34.5 million was paid by the three Purdue executives), Department of Health Professions $20 million, and Department of Medical Assistance Services $1.2 million.

Table 36: Cases Against Pharmaceutical Manufacturers Result in the Largest Amount of Total Court-ordered Restitution and Other Awards (FYs 2005-2009)

Provider Type	Total Civil and Criminal Court Orders	Civil Court Orders	Criminal Court Orders
Pharmaceutical Manufacturers	$726,988,822	$131,988,822	$595,000,000
Home Health	23,611,223	10,734,840	12,876,383
Durable Medical Equipment	5,847,820	1,891,621	3,956,200
Hospital	4,412,829	4,412,829	n.a.
Nursing Home	2,113,721	921,128	1,192,593
Other	1,593,402	1,348,089	245,313
Mental Health	1,497,744	n.a.	1,497,744
Transportation	975,462	n.a.	975,462
Physician	365,286	n.a.	365,286
Laboratory	279,265	279,265	n.a.
Dentist	93,190	n.a.	93,190
Nurse	5,878	n.a.	5,878
Total	**$767,784,641**	**$151,576,593**	**$616,208,048**

Source: JLARC staff analysis of MFCU data.

NOT ALL RECOVERIES REPORTED IN MFCU'S ANNUAL REPORT RESULT FROM VIRGINIA MEDICAID FRAUD

In its annual report, the MFCU states that the cases it conducts have resulted in "recoveries" of over $706 million. However, the MFCU appears to be reporting all restitution, forfeiture, penalties, and other awards ordered by courts in cases in which the MFCU participated. Using this figure does not clearly indicate the amount of fraudulent activity identified and prosecuted in Virginia and the funds actually received by Virginia State agencies as a result of the unit's activities. MFCU staff state that the annual report uses the term "recoveries" in response to federal direction.

Virginia Receives Only a Portion of Recovered Amount Stated in MFCU's Annual Reports

Of the $706 million reported in the MFCU's annual reports during FY 2005–FY 2009, only $167 million has been received by Virginia. The largest factor accounting for the difference is that $530 million was awarded to other states, the federal government, and private parties as part of the Purdue Frederick case.

An additional factor is that funds reported as recovered are not all collected. Funds were only collected in half of the cases successful-

ly prosecuted by the MFCU. From FY 2005 to FY 2009, 85 civil and criminal cases resulted in a conviction. Of this number, only 43 (51 percent) had collections recorded in the MFCU's database. Collections have been received for only 30 percent of the 55 criminal cases, and, on average, the MFCU only collects one of every three dollars awarded by the court in criminal cases. The MFCU's director reports that since many of these convictions result in a prison sentence, collection of these awards is difficult and can take many years.

Only a Portion of Funds Resulting From MFCU Prosecutions Result From Virginia Medicaid Fraud

The lack of clearly documented data on actual recoveries hinders a complete assessment of the funds the MFCU has recovered for the Virginia Medicaid program. For those prosecuted as civil cases, the MFCU indicates that it receives a reimbursement check from the Department of Justice, allowing the unit to track the funds due to Virginia Medicaid and the proportion of those funds that have actually been collected. Of the $152 million in court orders in civil cases from MFCU prosecutions, MFCU data show that $22 million was owed to Virginia's Medicaid program. In contrast to civil cases, MFCU data on criminal cases do not include any information on the actual funds recovered for DMAS or any other State agency.

DMAS data indicate that the agency received $48.7 million from the MFCU from FY 2005 to FY 2009.

Although the MFCU does not track all of the funds it recovers for the Virginia Medicaid program, DMAS tracks the payments the agency has received from the MFCU. From FY 2005 to FY 2009, DMAS data indicate that the agency received $48.7 million from the MFCU. This suggests that at most, seven percent of the recoveries reported by the MFCU in its annual report resulted in actual collections for the Virginia Medicaid program.

CONCERN HAS BEEN EXPRESSED THAT NOT ALL CASES OF POTENTIAL FRAUD ARE DETECTED OR FULLY INVESTIGATED

The MFCU and DMAS hold quarterly meetings to collaborate and improve the relationship between the two entities. Although recent federal reviews have lauded the effectiveness of this relationship, there appears to be some room for improvement. The MFCU's director believes that DMAS could be doing more to identify fraud and provide referrals, although DMAS notes that the unit declines 25 percent of the referrals they provide. The MFCU could take a more active role in the detection of potential Medicaid fraud to supplement the efforts of DMAS. JLARC staff will continue to review these issues and report any findings in the final report.

Working Relationship Appears Productive but MFCU Believes DMAS Could Refer More Suspected Cases of Fraud

DMAS's creation of the Program Integrity Division in 2005 as an agency-wide means of coordinating improper payment investigations appears to have increased the coordination of activities between DMAS and the MFCU. This coordination is important, and both CMS and the OIG indicate that an effective relationship between a state's Medicaid agency and its MFCU is essential to the success of program integrity efforts. A 2008 review of Virginia's program integrity efforts by CMS noted that the creation of the Program Integrity Division improved the relationship between DMAS and MFCU, stating that the "high level of cooperation between the PID and the MFCU [was] further evidence of the State's program strengths."

Notwithstanding the good working relationship between DMAS and MFCU, which was confirmed by both agencies, the MFCU's director raised concern about potential shortcomings in DMAS's program integrity efforts. This concern seemed to result from a belief by the director that DMAS is not providing MFCU with a sufficient number of referrals, suggesting that DMAS could do more to identify fraud or refer more cases for investigation. The MFCU director cited as one example the lack of effort by DMAS to verify the physical presence of providers before they are enrolled (as discussed in Chapter 5).

MFCU Could Also Assume Role in Analyzing DMAS Data to Identify Potential Fraud

The MFCU's director states that the unit lacks the authority to analyze provider claims for potential Medicaid fraud, and therefore the unit must rely entirely on referrals for their caseload. This suggests the MFCU must rely upon DMAS to accurately and completely identify all cases of potential fraud at their monthly meetings.

However, it appears that Virginia's MFCU already has the authority to analyze Medicaid provider claims data, in addition to DMAS, which would reduce the unit's reliance on referrals. In July 2010, Florida's Attorney General and the state's Medicaid agency jointly sought and received a federal waiver to allow the MFCU to perform investigative analyses. The joint letter to the Secretary of Health and Human Services did not ask for authority to conduct the analysis, but only for federal reimbursement for this activity.

Florida's request to use its MFCU to conduct data analysis as a supplement to the Medicaid agency's program integrity activities comes in response to a suggestion made by the OIG in 2006. In his

report to Congress, the OIG encouraged the use of demonstration projects, noting that

> State agencies and MFCUs may want to work through OIG and CMS to undertake demonstration projects intended to improve the detection, development, and referral of suspected Medicaid fraud. For example, several MFCUs expressed interest in data mining to identify suspected Medicaid fraud.

The OIG added that "federal regulation expressly prohibits federal reimbursement for such activity," but no indication was given that an MFCU is prohibited from conducting data analysis so long as reimbursement is not sought.

Given that both the waiver requested by Florida and the OIG's report only refer to a federal prohibition on the use of federal matching funds for this activity, it appears that Virginia's MFCU has had the authority to engage in data analysis of Medicaid provider claims. In addition, DMAS indicated that the MFCU has previously been given secure access to their claims data, but the MFCU no longer provides staff for this function. JLARC staff discussed the possibility of conducting data analysis with the MFCU director, who raised the concern that a waiver would be needed. He also noted that if Virginia sought a waiver it might result in a decrease of program integrity funds for DMAS, in exchange for providing these funds to the MFCU, which the director states was a condition of Florida's waiver. JLARC staff will continue to review these issues, including a determination of whether the MFCU could use the funds it received from the Purdue Frederick case in lieu of a waiver.

Chapter 8

Potential Opportunities to Further Reduce Fraud and Error

In Summary

While the State has enjoyed some successes in controlling fraud and error, JLARC staff have identified certain issues which merit further review to determine if they have the potential to further reduce fraud and error. They include coordination of the program integrity activities of State and local agencies, the adequacy of licensure decision-making by State licensing agencies, DMAS's oversight of managed care organizations and auditors, the effectiveness of local departments of social services in identifying the real property assets of applicants for Medicaid-funded long-term care services, the adequacy of criteria and processes used by DMAS and local departments to refer fraud for prosecution, the costs and benefits of additional program integrity activities, and the potential need for a Medicaid Inspector General. These issues will be further examined in the final report.

Controlling fraud and error in Virginia's Medicaid program is a complex effort that involves multiple entities and program integrity activities. While the State has enjoyed some successes, there appear to be opportunities to improve these efforts and further reduce improper payments in Virginia. This interim report has described the process and made some specific findings and recommendations, but it is apparent there are broader systemic issues that need to be addressed which will require further review. They include improvements in oversight and planning, greater coordination between State and local agencies, and central authority and accountability for all program integrity activities.

ISSUES IDENTIFIED IN THIS REPORT MERIT ADDITIONAL REVIEW

As discussed in the preceding chapters, several issues appear to prevent agencies from identifying all improper Medicaid payments and fraud. If these issues are addressed appropriately, the amount of money lost to error may be reduced and the amount of fraud identified and recovered by agencies may be increased. The first phase of this study identified several issues relating to fraud and error that will be examined further during the next phase and included in the final report. These issues include

- impacts of federal health care reform, including the use of new contract auditors by the Centers for Medicare and Medicaid Services (CMS) and the Department of Medical Assistance Services (DMAS),

- potential benefit of additional provider enrollment activities, such as verification of physical presence, use of criminal background checks, and improved identification of servicing providers, and
- the potential for Medicaid Fraud Control Unit (MFCU) staff to analyze DMAS's provider claims data.

POTENTIAL EXISTS TO FURTHER REDUCE IMPROPER PAYMENTS BY ADDRESSING CERTAIN ISSUES

In addition to these issues, JLARC staff have identified other research issues that merit further review to determine if they have the potential to further reduce fraud and error. The research activities anticipated for many of these issues include a review of program integrity procedures and methods used in other states, as directed by the study mandate.

Coordination of Agency Program Integrity Activities

In Virginia, Medicaid program integrity activities and responsibilities are dispersed through different units and divisions within DMAS, DSS, local departments of social services, the MFCU, and Commonwealth's Attorneys. In addition, DMAS must rely on several other entities, such as State licensing agencies and the Medicaid managed care organizations, to ensure the proper operation of Medicaid and compliance with federal regulations. DMAS's already limited ability to coordinate these disparate but related activities is hindered by a lack of adequate management tools and resources within DMAS and other agencies.

The lack of these tools prevents the agencies from acting in a coordinated manner, thereby limiting the effectiveness of any systematic effort to reduce fraud and error. Presently, coordination of activities between agencies is loosely directed by language in various interagency agreements, the Medicaid manual, and various State and federal statutes and regulations. As a result of this fragmented approach, the ability of the Medicaid program to adjust to the shifting nature of fraud and other improper payments, as well as changes in federal rules, may be hindered.

Improvements in Medicaid Planning May Reduce Improper Payments. Some programs within DMAS and other State agencies have developed fraud control plans, but existing fraud control planning at the agency level appears to be inadequate. Moreover, no Secretarial fraud control plans, or clear responsibility for their oversight, exist.

Although some units within the Program Integrity Division have adopted formal audit plans, no plan exists to coordinate, assess,

and realign the activities within the division. Moreover, DMAS lacks an accepted agency-wide definition of program integrity and an agency-wide program integrity plan. This kind of planning appears to be needed because some activities that are clearly involved in the prevention of improper payments, such as Medicaid Management Information System edits and other pre-payment controls, are not under the authority of the Program Integrity Division.

To ensure that coordination occurs, and both short-term and long-term goals are addressed, it may be useful for DMAS to build upon the program integrity improvements it began in 2005 by defining all of the activities that are related to program integrity and ensuring the related duties of different divisions are coordinated. This would include a systematic and documented plan for coordinating divisions such as Program Integrity and Program Operations, but also a consideration of how all activities related to improper payments are managed. For example, Chapter 1 noted that the Office of the Inspector General for the Department of Health and Human Services identified five categories of improper payments that occur most frequently. This includes the failure to ensure third parties are billed for the costs of care instead of Medicaid, an activity that DMAS does not presently define as a component of program integrity.

Although DSS has an agency-wide fraud control program, it lacks an agency-wide fraud control plan. Instead, the manual for each public assistance program contains information on the fraud control responsibilities of that particular program. However, DSS data indicate that two-thirds of all Medicaid recipients also receive benefits from the Supplemental Nutrition Assistance Program (formerly Food Stamps), suggesting that greater coordination of fraud control techniques and activities across programs would be beneficial. Although DSS has developed best practices for fraud control, and reviews local department fraud control plans for adherence to these guidelines, central office staff have noted that they lack the ability to ensure local departments comply with their fraud control plans. And because fraud control plans are only required if a local department is requesting fraud control funding, 13 localities have not submitted a fraud control plan to DSS.

At a Secretarial level, no fraud control plans or improper payment strategies appear to exist. Yet many of the concerns noted above involve a need to coordinate the activities of DMAS and DSS which, as peer agencies, can be difficult to accomplish at the agency level. In addition, because resolution of some issues, such as eligibility determination errors, may require either greater State oversight of local departments or the development of improved technology for processing eligibility determination decisions, a Sec-

retarial response appears warranted. However, the ability of the Secretary to properly address these concerns is hindered by the lack of agency-wide fraud control plans at all of the agencies within the Secretariat.

Lack of Statewide Definitions of Medicaid Fraud and Guidelines for Case Referrals May Hinder Effective Investigation and Prosecution. DMAS and other State and local agencies appear to lack a clear and consistent definition of Medicaid fraud. An exception is the interagency agreement between DMAS and the MFCU, but it only addresses provider fraud. The interagency agreement between DMAS and DSS lacks a definition of recipient fraud, and the definition of fraud used within DMAS may not be consistent with the definition used by DSS and local departments because of differences in the way the definition is operationalized. Moreover, it appears that local Commonwealth's Attorneys may use different definitions of fraud, or use different thresholds when determining the types of potential fraud that merit prosecution when reviewing a referral from DMAS or a local department.

Because responsibility for fraud control is diffuse, each agency involved in fraud control must agree on some basic principles, such as the definition of fraud, to ensure that program integrity activities are consistent system-wide. For example, DMAS relies heavily on local departments for referrals of suspected recipient fraud. Likewise, the MFCU relies upon DMAS for referrals of provider fraud. Yet because no consistent operational definition of fraud exists, DMAS and other agencies may use varying criteria and processes to determine which referrals merit full investigation, which investigations should result in referrals for prosecution, and which referrals for prosecution will be accepted by prosecutors.

Adequacy of Licensure Decision-making at Other State Agencies

DMAS relies upon licensing decisions made by the Virginia Department of Health Professions (DHP) and other State licensing entities in order to verify that providers applying for the Medicaid fee-for-service program are qualified to serve Medicaid recipients. DMAS has executed interagency agreements with several of these agencies in order to verify the licensure status of applicants. However, these agreements are silent on (and DMAS is unaware of) any issues relating to the quality of the data provided to DMAS or the adequacy of licensure decision-making. Out-of-date licensure files or delayed licensure revocation processes could result in the enrollment of providers with expired licenses or who pose a financial or safety risk to the Medicaid program and recipients.

In 1999, JLARC examined DHP and Virginia's health regulatory boards and found several concerns regarding the time required to process disciplinary cases. Most boards took in excess of one year on average to resolve disciplinary cases, and the Boards of Medicine and Psychology take in excess of two years on average. The report also found that many of the cases that took too long to resolve involved serious misconduct by a practitioner, and the delay in resolving these cases created unreasonable and unacceptable risks to public protection and public safety. JLARC staff will assess the current length of time required to process disciplinary cases involving providers that received Medicaid reimbursements and determine the impact (if any) this has upon DMAS's program integrity activities.

Sufficiency of DMAS's Oversight of Managed Care Organizations and Other Contractors

Like many other State agencies, DMAS has become increasingly reliant on contractors and other third parties. The most important of these groups, the managed care organizations, received $2 billion in funds in FY 2009 alone. DMAS has federal responsibilities to oversee the quality of care provided by managed care organizations and the adequacy of their program integrity functions. These responsibilities are based upon a growing national recognition that the use of managed care does not necessarily insulate the State from fraud.

For persons who are enrolled in managed care, reimbursement claims are submitted to the managed care organization, not DMAS. As a result, these claims are typically not subjected to DMAS's front-end claims verification controls and post-claim audits. Instead, it is the responsibility of each managed care organization to prevent improper payments and ensure that the providers in its network satisfy Medicaid requirements.

Per federal regulations, the contract between DMAS and each managed care organization requires each organization to have policies and procedures to detect, correct, and prevent improper payments. An initial review indicates that each managed care organization uses a process similar to DMAS's program integrity activities. However, it also appears that variation may exist between organizations. For example, while the contract requires each organization to "report incidents of potential or actual fraud and abuse," it appears that some organizations may only report those cases that meet their individual thresholds for referral. One managed care organization's program integrity plan states they only refer cases to the "appropriate authorities" if the investigation indicates improper Medicaid payments exceed $20,000.

Although the contract requires each managed care organization to perform these functions in lieu of DMAS, it remains DMAS's responsibility to ensure these functions are performed. For this reason, the Florida Office of Program Policy Analysis and Government Accountability recently recommended that Florida's Medicaid agency increase its oversight over managed care organizations. Presently, DMAS appears to exercise this oversight in part by requiring all managed care organizations to be annually accredited by the National Committee for Quality Assurance. Although the accreditation process mostly focuses on the quality of care, DMAS indicates that each managed care organization's fraud control process is reviewed to some extent. DMAS indicates that Virginia is one of only five states that require this accreditation.

JLARC staff will review the means by which DMAS ensures that its contractors adhere to contractual requirements, including the number of staff assigned to these responsibilities and their qualifications. In addition, JLARC staff will assess the procedures used by DMAS to audit its contractors to ensure that the data and other records they provide are supported by documentation. This includes a review of DMAS's oversight of its contract auditors to ensure DMAS provides these auditors with proper documentation, that the decision to audit selected provider types is in accordance with documented audit plans and objectives, and that the audit process does not pose unreasonable burdens on providers.

Effectiveness of Local Departments in Identifying Real Property Assets of Long-Term Care Applicants

In a 1992 study of Medicaid, JLARC staff reviewed paper records maintained by individual clerks of court and estimated that eight percent of applicants for Medicaid long-term care services failed to report all real property assets when applying for enrollment. Error in long-term care resource determinations poses a substantial financial risk to Medicaid because of the expense of long-term care services. Failure to identify all recipient assets hinders DMAS's subsequent ability to use estate recovery or other means of recovering improperly expended funds. As noted in Chapter 2, it may now be possible to use electronic data maintained by the Supreme Court to determine whether any recipients of Medicaid long-term care services failed to disclose all real property. JLARC staff will investigate if these data can be used to replicate the methodology from 1992. If so, it may be possible to calculate a new estimate of the percentage of long-term care recipients (if any) who failed to fully disclose all real property.

Adequacy of Criteria and Process to Determine Whether Cases Should Be Referred for Prosecution

Under the current system, investigators at DMAS and in local departments of social services appear to have substantial discretion in deciding which cases are referred for further investigation or prosecution. Given the relatively low number of cases that are referred for prosecution and the variation in recipient fraud prosecutions across localities, further examination of the referral process appears warranted. This will include a review of referral documentation as well as interviews with DMAS and local departments to better understand the referral criteria and processes.

Benefits and Costs of Using Additional Program Integrity Activities

The study mandate directs JLARC to identify program integrity activities used in other states that may decrease improper payments in Virginia. There appear to be potential opportunities to expand program integrity activities in Virginia, and JLARC staff plan to examine them, including their potential benefits and costs. These techniques include pre-payment analytics, the use of data from other states and Medicare to identify potential improper payments, and statistical extrapolation.

Potential Need for an Inspector General or Other Organizational Changes

The issues identified in previous chapters, and the emerging issues discussed in this chapter, suggest that organizational reforms may be needed to ensure that program integrity activities are conducted in a systematic and fully effective manner. These issues include the lack of adequate management tools and procedures within DMAS and other agencies, and the inability of DMAS to adequately coordinate its efforts with the program integrity activities conducted by other agencies. As the Auditor of Public Accounts has noted, DMAS cannot ensure that DSS or the local departments of social services fulfill their obligations because they

> are seen as equal entities within the structure of the state government, which prevents the Department [of Medical Assistance Services] from managing its agreement with Social Services.

These concerns indicate that Medicaid program integrity activities may not occur in a rational, systematic manner but may instead be pursued using an ad hoc approach. Although improvements to planning, coordination, and other resources, including information technology, can help to address these issues, they may fail to ad-

dress the organizational issues that result from Virginia's current approach to the oversight of public assistance.

The current system results from an accumulation of separate decisions made over many years. The present role of DSS and local departments stems from the first use of local departments of public welfare in 1938 as a means of enrolling individuals into public assistance programs. This role was in keeping with the understood responsibilities of local government to provide for the public welfare, a duty that dated back to the local office known as Superintendent of the Poor. Subsequently, in 1962 the State began to fund medical assistance services, and this responsibility was added to the other public assistance responsibilities of local departments. In 1966, one year after Medicaid was enacted, the General Assembly authorized the establishment of a Medicaid program in the Commonwealth and assigned this responsibility to the Virginia Department of Health (VDH). Expenditures on Medicaid then grew to account for more than three-quarters of VDH's annual budget, leading to the creation of DMAS as a separate agency in 1980 in order to allow VDH to pay greater attention to its other responsibilities.

As a result of these separate decisions, the present system has several strengths and weaknesses. Among these is the reliance on local departments to perform recipient eligibility determinations. A 2005 review by JLARC of the social services system noted that Virginia's locally administered system allows local departments to tailor program strategies and operations to meet local needs. However, the study also noted that some local departments lack access to important resources, such as funding, and other departments fell well below performance targets and requirements in multiple program areas. More recently, the APA has noted that neither DMAS nor DSS "believe that they have the authority or the ability to hold the local departments of social services financially accountable for not performing," a lack of authority which hinders the successful pursuit of program integrity activities.

This concern about the lack of oversight over local departments is not unique to Virginia. The Office of the Inspector General for the Department of Health and Human Services (OIG) has noted that in states where the Medicaid agency is separate from the agency that administers food stamps and other public assistance programs, the timely completion of food stamp determinations comes first "because the agency is totally responsible for those programs." The OIG goes on to observe that "at the local offices, Medicaid is considered important, but the main focus for corrective action is on . . . food stamps." This observation was made in 1988, and since that time other states have responded to the need for improved oversight of Medicaid program integrity by making organizational

changes. In other states, such as North Carolina, a single statewide department has been used for many years to administer all public assistance programs, including Medicaid.

One organizational change adopted by several other states is the use of a Medicaid Inspector General. Although the roles, resources, and powers of these officials vary, they all appear to result from a recognition that a greater unity of purpose was required to ensure the success of program integrity activities. DMAS adopted elements of this model by creating a single Program Integrity Division in 2005, but the lack of adequate management tools, such as program integrity plans, and the indication that not all error is detected indicate that additional steps are needed within DMAS. Moreover, the Program Integrity Division (and DMAS itself) lacks authority over DSS and other agencies in the Health and Human Resources Secretariat, such as VDH and DHP. DMAS also lacks the organizational resources to effectively ensure that law enforcement agencies, including the MFCU and the Commonwealth's Attorneys, prosecute all cases of Medicaid fraud.

The present indications of financial risk to the Medicaid program resulting from the agency-specific and system-wide weaknesses discussed in this report, and the increased workload that appears likely to result from federal health care reform, suggests that additional authority, external to DMAS, may be required to ensure the successful coordination of the myriad program integrity activities now performed by several State and local agencies. JLARC staff will continue to examine this and the other issues discussed in this chapter and include further findings and recommendations in the final report.

JLARC Recommendations:

Interim Report: Fraud and Error in Virginia's Medicaid Program

1. In order to calculate Medicaid eligibility determination error rates for local departments of social services when conducting Medicaid Eligibility Quality Control reviews, the Departments of Social Services and Medical Assistance Services should use a sample of cases of sufficient size to identify error rates for local departments of social services. This process should begin with a pilot study that determines error rates for three representative localities and conclude with a report by October 1, 2011, to the Joint Commission on Health Care and the Secretary of Health and Human Resources on the results of the pilot. The report should also include the estimated cost of using a sample of cases of sufficient size to identify error rates for local departments under three approaches: (1) reviewing all local departments of social services on an annual basis, (2) reviewing a rotating group of local departments each year, and (3) reviewing targeted local departments each year, based upon the number of recipients, risk, or other pertinent factors. (p. 28)

2. The Department of Social Services should ensure all local departments of social services comply with the annual redetermination requirements specified in Title 42, Section 435.916 of the *Code of Federal Regulations* and report to the Joint Commission on Health Care, the State Board of Social Services, and the Secretary of Health and Human Resources on an annual basis the local departments that have not complied with this requirement. (p. 31)

3. The General Assembly may wish to amend § 63.2-526 (D) of the *Code of Virginia* to add "medical assistance" to the list of federal benefit programs for which a portion of overpayment moneys collected or recovered as a result of Medicaid recipient fraud investigations and referrals conducted by local departments, shall be deposited to the Fraud Recovery Special Fund. (p. 40)

4. The General Assembly may wish to consider amending the Virginia Public Procurement Act (*Code of Virginia*, § 2.2-4347) to exempt the Department of Medical Assistance Services from the 30-day payment requirement so that the department can conduct a more extensive pre-payment review of a claim within a 90-day period if there is a reasonable basis to suspect that payment of the claim could be improper. (p. 61)

Appendix A

Study Mandate

HOUSE JOINT RESOLUTION NO. 127

Directing the Joint Legislative Audit and Review Commission to study the Commonwealth's Medical Assistance program to identify opportunities to reduce waste, inefficiency, fraud, and abuse. Report.

Agreed to by the House of Delegates, February 8, 2010
Agreed to by the Senate, March 2, 2010

WHEREAS, public officials have an obligation to the citizens of Virginia to use the Commonwealth's resources wisely and appropriately; and

WHEREAS, medical assistance expenditures through the state Medicaid program represent the second largest category of expenditures by the Commonwealth; and

WHEREAS, Virginia's state Medicaid program is already a narrowly defined program that adheres closely to federal requirements and limits additional spending; and

WHEREAS, in spite of the narrowly defined scope of Virginia's Medicaid program, state medical assistance costs continue to rise in response to growing demand and increasing health care costs; and

WHEREAS, while most health care providers are honest, dedicated individuals and institutions striving to improve health and health care and comply with the complex statutory and regulatory requirements of the state Medicaid program, the very nature of such statutory and regulatory requirements may create a situation in which errors in billing or payments to health care providers result in inefficiencies, inaccuracies, and wasted resources; and

WHEREAS, a few health care providers engage in fraudulent or abusive activities or allow such fraud or abuse to occur, further wasting resources and increasing costs; and

WHEREAS, good government should seek to increase accuracy and efficiency, and reduce regulatory barriers to services that bring about inefficiencies and inaccuracies and allow fraud and abuse, resulting in increased expenditures and waste of state resources; and

WHEREAS, identifying, investigating, and correcting inefficiencies, inaccuracies, fraud, and abuse can result in savings to the Commonwealth; and

WHEREAS, the Commonwealth's Medicaid fraud detection unit, which is located in the Office of the Attorney General, is nationally recognized for its success in identifying and pursuing cases of inaccuracies in, and fraud and abuse of, the state Medicaid program by

health care providers and has recently garnered significant attention for its success in halting fraudulent activities by pharmaceutical companies; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Legislative Audit and Review Commission be directed to study the Commonwealth's Medical Assistance program to identify opportunities to reduce waste, inefficiency, fraud, and abuse.

In conducting its study, the Joint Legislative Audit and Review Commission shall (i) study past or current evidence of waste and inefficiency in the state Medicaid program, and describe the nature and extent of such waste and inefficiency; (ii) study and describe the nature and scope of fraud or abuse of the state Medicaid program by beneficiaries, providers, suppliers, manufacturers, or others who receive benefits from the state Medicaid program, if any; (iii) compare the nature and scope of waste, inefficiency, fraud, or abuse occurring in the Commonwealth with that occurring in other states that are similar to Virginia in terms of geography, demographics, or financial commitment to Medicaid; and (iv) identify programs in the Commonwealth and other states that have proven successful in reducing waste, inefficiency, fraud, or abuse of state Medicaid programs.

Technical assistance shall be provided to the Joint Legislative Audit and Review Commission by the Department of Medical Assistance Services. All agencies of the Commonwealth shall provide assistance to the Joint Legislative Audit and Review Commission for this study, upon request.

The Joint Legislative Audit and Review Commission shall complete its meetings for the first year by November 30, 2010, and for the second year by November 30, 2011, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Legislative Audit and Review Commission intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Appendix B

Research Activities and Methods

This chapter describes the research activities and methods the study team used to describe and assess the scope and nature of Medicaid program integrity efforts in Virginia; and the methods agencies use to detect, investigate, and recover funds in cases of Medicaid fraud and error (Table B-1).

The principal research methods included structured interviews, documentation review, literature review, and data analysis. JLARC staff also attended meetings and a training seminar on topics related to medical record-keeping and coding and Medicaid audits.

Table B-1: Application of Primary Research Methods to Study Issues

Study Issue	Structured Interviews	Documentation Review	Other Literature Review	Data Analysis
1. How Do State Agencies Ensure Only Eligible Applicants Are Enrolled in Medicaid?	✓	✓	✓	✓
2. How Is Recipient Fraud Addressed in Virginia?	✓	✓	✓	✓
3. How Do Providers Become Eligible to Provide Medicaid Services?	✓	✓	✓	✓
4. How Does the State Prevent Paying Ineligible Medicaid Claims?	✓	✓	✓	✓
5. How Does the State Detect Fraud or Error in Paid Medicaid Claims and Then Recover Funds?	✓	✓	✓	✓

Source: JLARC staff.

STRUCTURED INTERVIEWS

JLARC staff relied on the use of structured interviews as its primary means of collecting information and understanding all five issue questions, particularly the basic processes and procedures for program integrity enforcement in Virginia. Given its time constraints, the staff focused on interviewing staff at the key State agencies. Staff at local agencies, contractors, or provider associations were interviewed as time permitted.

Interviews With State and Local Agencies

JLARC staff met with staff at the primary State agencies with Medicaid program integrity responsibilities: the Departments of Medical Assistance Services (DMAS) and Social Services (DSS), and the Medicaid Fraud Control Unit (MFCU) in the Office of Attorney General. At DMAS, interviews were conducted with senior management, the internal auditor, and managers and staff within several divisions: Program Integrity Division (PID), Program Operations, Appeals Unit, Fiscal and Purchasing Division, and the Customer Service Section.

At DSS, JLARC staff interviewed the benefit programs director, the medical assistance programs manager, and the fraud program manager. Regional office staff were also interviewed to address unanswered questions regarding the roles of central and regional DSS staff in the oversight of LDSS eligibility determinations and fraud detection. In addition to central DSS staff, JLARC staff also conducted an interview with the director of fraud investigations at one LDSS (the president of the professional organization, as noted below).

JLARC staff also met with the director and staff of the MFCU to discuss its role in the prosecution of Medicaid-related provider fraud.

Meeting Attendance

During the planning phase of the study, JLARC staff attended several events related to Medicaid program integrity. For example, JLARC staff attended a Medical Society of Virginia and Virginia Hospital and Healthcare Association joint training session on Medicare and Medicaid audits. This May 11, 2010 meeting focused on the proper coding of medical claims for Medicaid, as well as the legal issues surrounding Medicaid and Medicare audits.

On May 13, 2010, JLARC attended a quarterly regional meeting of the professional organization of local department of social services fraud investigators, the Public Assistance Investigators of Virginia (PAIV). The conference brought together fraud investigators from local departments of social services around the Commonwealth to discuss issues surrounding program integrity in all public assistance programs, including Medicaid. At the conference, the study team explained the nature of the study and solicited email responses on the issues faced by these individuals regarding Medicaid fraud. In addition, the study team used the PAIV member email list to request similar information from any fraud investigators not in attendance at the quarterly meeting.

DOCUMENT REVIEWS

JLARC staff reviewed a variety of agency documentation, mostly from DMAS. Documents reviewed include DMAS's program integrity contracts and examples of the analyses used by DMAS to monitor performance of their program integrity tasks by contractors. In addition, program integrity efforts in DMAS were reviewed by examining examples of utilization reviews as well as desk audits. Audit plans and inter-agency agreements that DMAS has with other State agencies involved in program integrity activities were also examined.

OTHER LITERATURE REVIEW

JLARC staff identified and reviewed literature on best practices, including federal and state government reports, academic research studies, and congressional testimony on topics of Medicaid program integrity. Sources used include the Government Accountability Office, Florida's Office of Program Policy Analysis and Government Accountability, Utah's Office of the Legislative Auditor General, and the Centers for Medicare and Medicaid Services.

DATA ANALYSIS

JLARC staff used data analysis to describe the nature and scope of the Medicaid program, verify statements made by agencies in structured interviews and documentation, and quantify various agency activities related to Medicaid program integrity. The types of analysis included Medicaid spending, provider and recipient enrollments, error in the claims payment and recipient enrollment processes, fraud investigations and recoveries, and appeals.

Medicaid Provider Enrollment

In order to identify outcomes of the Medicaid provider enrollment process, and specifically the number and reasons for the disenrollment or termination of Medicaid providers, JLARC staff analyzed data provided by DMAS containing this information.

Program Integrity Efforts

JLARC staff analyzed data on Prior Authorization requests and denials, MMIS claims rejections, and post-payment provider audits Cost savings estimates for Prior Authorization and MMIS, and other data used to calculate a return on investment were also analyzed.

Provider Fraud Investigations and Prosecutions

JLARC staff examined data on the nature of the MFCU's caseload, including the source of their fraud referrals and the types of providers that they are prosecuting. MFCU data include information

on number and type of cases, their outcomes, and the amount of restitution.

Recipient Enrollment

In order to identify any differences in outcomes in the recipient enrollment among Virginia localities, JLARC staff used data provided by DSS detailing Medicaid applications, enrollments, and disenrollments by locality.

Recipient Fraud Investigations and Prosecutions

JLARC staff analyzed DMAS data on the outcomes of suspected cases of recipient fraud forwarded to Commonwealth's Attorneys, including whether the cases was accepted, the outcome of the trial, and the amount of restitution ordered.

Linear Weighted Average Methodology

The goal of this analysis was to calculate the expected performance of local department of social services fraud activities if all local departments performed to the level of the typical local department which had fraud investigation activity. Here, the "typical local department" is represented by the linear-weighted average (LWA) of local departments with at least one instance in each of the following situations:

- investigation of potential fraud,
- referral to a Commonwealth's Attorney for prosecution, and
- referral to DMAS for investigation.

The linear-weight average methodology was used due to the highly skewed nature of the data. For example, among the 83 local departments of social services that investigated cases of suspected Medicaid recipient fraud in FY 2009, the number of investigations per 1,000 Medicaid recipients ranged from a low of 0.06 (Portsmouth) to a high of 51.8 (Williamsburg).

In each of these three situations listed above, local departments that had zero instances were excluded from the linear-weighted average calculation. Subsequently, a linear-weighted average of the remaining local departments was calculated for each of the three situations.

The expected performance was calculated using the following steps:

1) Using DMAS and DSS data, the number of investigations, referrals for prosecution, and referrals by local departments to DMAS for investigation was calculated for each local depart-

ment on a per 1,000 recipients basis. (DSS data on the number of recipients per locality were used.) The calculations were completed for both FY 2008 and FY 2009.

2) Using SAS, the following data were calculated:

   a. Linear-weighted average for number of investigations per 1,000 by locality in FY 2008 and 2009.

   b. Linear-weighted average for number of referrals for prosecution per 1,000 by locality in FY 2008 and 2009.

   c. Linear-weighted average for number of referrals by local departments to DMAS for investigation per 1,000 by locality in FY 2008 and 2009.

3) Referring to the bullets in 2) above, the number of localities excluded from the LWA calculation were:

   a. 37 and 37

   b. 95 and 97

   c. 21 and 17

   As noted above, the calculations excluded localities with zero investigations or referrals per 1,000 recipients. With zero values included, the linear-weighted average number of investigations and referrals for prosecution was less than what actually occurred.

4) Finally, the expected number of investigations, referrals for prosecution, and referrals to DMAS by locality were calculated. This was done by multiplying the linear-weighted average amount by the number of recipients in each locality and dividing by 1,000.

Federal Payment Error Rate Measurement Review Suggests Two to Five Percent of Sampled Claims Contained Errors

As discussed in Chapter 6, the Centers for Medicare and Medicaid Services (CMS) conducts Payment Error Rate Measurement (PERM) reviews on paid Medicaid claims in each state. The most recent review of Virginia was conducted on data from federal fiscal year (FFY) 2006. As part of the review, CMS identified overpayments made for some claims in the sample. The improper overpayments identified by the PERM review ($34,079) amounted to 3.2 percent of the $1,079,617 in payments made for all claims in the sample.

In statistics, a "confidence interval" is used to indicate the reliability of an estimate. For a sample of this size (1,021), the confidence interval, or margin of error, for this estimate is 1.1 percent. Therefore, the range of potential error extends from 2.1 to 4.3 percent.

CMS Reported a Range of Potential Error of Zero to 11 Percent for Their Weighted Estimate of 5.5 Percent. In an attempt to adjust the PERM results to more accurately represent the universe of Virginia Medicaid claims, CMS weighted the sample based on provider types and the fiscal quarter in which the claim was filed. By adding a weight to the improper payments found in each claim, CMS effectively increased the $34,079 from the initial review to $58,990, which equates to 5.5 percent of the payments for the sample. CMS indicated, however, that this estimate could vary by another 5.5 percent. As a result, the range of potential error extends from zero to 11 percent.

Confidence Interval for DMAS Adjustments Suggests a Range of Potential Error of 1.3 to 3.1 Percent. DMAS asserts that the PERM estimate should be adjusted to account for several factors in order to accurately portray the extent of error in fee-for-service Medicaid claims. Subsequent to the PERM review deadline, providers submitted additional data that resulted in seven cases with identified overpayments being deemed appropriate. (In other words, no improper payments occurred.) This process is normally followed after an audit by DMAS, but CMS's deadline prevented this adjustment from occurring before the PERM review ended.

If these concerns are taken into account, then the improper payments amount in the sample is reduced to $24,637, which equates to 2.2 percent of the payments for the sample. The margin of error for this estimate is 0.9 percent, and so the range of potential error is 1.3 to 3.1 percent.

Appendix C

DSS Uses Several Systems to Verify Applicants' Medicaid Eligibility

Requirement	Verification Process and System	System Operator	State or Federal Requirement?
Valid Social Security number (SSN)	SSN verified through State Online Query (SOLQ) or State Verification Exchange System (SVES). Re-verified through data match with SSA.	SOLQ & SVES: Social Security Administration (SSA)	Federal
Legal Presence in U.S.	SSN verified through SOLQ or SVES.	SSA	State
Citizenship or alien status	Citizenship verified through SSA, by documents that show citizenship, or through the Birth Record Verification System (BRVS). Alien status verified through Systematic Alien Verification for Entitlements (SAVE). Lawful aliens' work requirement verified by SVES.	BRVS: Va. Dept. of Health. SAVE: Dept. of Homeland Security.	Federal
Virginia Residency	By client statement on signed application. Public Assistance Reporting Information System (PARIS) data match run annually to find persons receiving benefits in another state.	PARIS: Defense Manpower Data Center.	Federal/State
Assignment of rights to medical benefits & pursuit of absent parent	By client statement on signed application. Not verified.	N/A	Federal
Application for other benefits	By client statement on signed application. Not verified.	N/A	Federal
Institutional status requirements	By client statement on signed application. Not verified.	N/A	Federal
Meet covered group requirements	By client statement on application (for example: children, parents of dependent children); written verification from certifying entity (for example: pregnancy, disability; age for applicants over 65); SVES or SOLQ for disability that has been previously determined by SSA.	SSA	Federal
No disallowed asset transfer for individuals who need long-term care	By client statement on application; written documentation when necessary. Not verified.	N/A	Federal
Resources within limits appropriate to individual's covered group	By written or verbal verification from financial institution, insurance company, Division of Motor Vehicles (DMV), etc.	N/A	Federal. State also sets some resource limits
Income within limits appropriate to individual's covered group	Earned income through pay stubs, tax records, Work Number Verification System, and the Virginia Employment Commission (VEC). Unearned income through SOLQ, SVES, or issuing entity (pensions, etc.).	Va. Dept. of Taxation VEC	Federal; State sets some income limits

Source: Department of Social Services.

Appendix D

Agency Responses

As part of an extensive validation process, State agencies and other entities involved in a JLARC assessment are given the opportunity to comment on an exposure draft of the report. JLARC staff provided and discussed exposure drafts of this report with the Department of Medical Assistance Services (DMAS), the Department of Social Services (DSS), and the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General. Appropriate technical corrections resulting from comments provided by these entities have been made in this version of the report. This appendix includes written responses from DMAS, DSS, and MFCU.

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

GREGG A. PANE, MD, MPA
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

October 5, 2010

Mr. Glen S. Tittermary
Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capital Square
Richmond, VA 23219

Dear Mr. Tittermary:

Thank you for the opportunity to review and comment on the exposure draft of the report titled *Interim Report: Fraud and Error in Virginia's Medicaid Program*. We commend you and your staff's effort in its broad examination of the multiple program integrity efforts undertaken by the Department of Medical Assistance Services (DMAS) and our various partners in administering the Medicaid program; we take our role as steward for the significant state and federal resources invested in Medicaid and FAMIS very seriously. While we have had significant focus on program integrity at DMAS for the last several years, we are very interested in further enhancing our ability to deter fraud and abuse on the front-end, and to better identify fraud and abuse on the back-end in order to efficiently utilize the limited resources available to serve the vulnerable citizens in need of health coverage under Medicaid or FAMIS. As such, we greatly appreciate the collaborative nature of your staff's approach to researching and reporting on these issues, and look forward to that interaction continuing for the final report.

In the time allowed for our review, we have not attempted to verify every Medicaid-related statistic presented in the report, as we understand these data were primarily derived from information requested from and provided by my staff at DMAS. Your staff has done an excellent job summarizing the complexity of the multi-faceted interactions and processes established under Medicaid, and we appreciate their willingness to correct or clarify this information during the draft review process.

Regarding the specific recommendations, we offer the following comments:

Recommendation 1: In order to calculate Medicaid eligibility determination error rates for local departments of social services when conducting Medicaid Eligibility Quality Control reviews, the Departments of Social Services and

Medical Assistance Services should use a sample of cases of sufficient size to identify error rates for local departments of social services. This process should begin with a pilot study that determines error rates for three representative localities and conclude with a report by October 1, 2011 to the Joint Commission on Health Care and the Secretary of Health and Human Resources on the results of the pilot. The report should also include the estimated cost of using a sample of cases of sufficient size to identify error rates for local departments under three approaches: (1) reviewing all local departments of social services on an annual basis, (2) reviewing a rotating group of local departments each year, and (3) reviewing targeted local departments each year, based upon the number of recipients, risk, or other pertinent factors.

We certainly understand the impetus for this recommendation, and will consider this type of approach in our planning with the Department of Social Services (DSS) for future eligibility studies. The desire to establish locality-specific error rates and their potential application needs to be weighed against the current approach for reviews whereby we target suspected statewide issues in order to provide appropriate guidance or remediation across the spectrum of local departments. While focus on locality-specific issues would provide a corrective action plan for individual localities, it may not result in a broad application and improvement in the eligibility process. Both types of analysis appear worthwhile, so DMAS and DSS will need to consider how best to use the limited resources available for eligibility reviews.

Recommendation 2: The Department of Social Services should ensure all local departments of social services comply with the annual redetermination requirements specified in Title 42, Section 435.916 of the Code of Federal Regulations and report to the Joint Commission on Health Care, the State Board of Social Services, and the Secretary of Health and Human Resources on an annual basis the local departments that have not complied with this requirement.

We concur with this recommendation and support the resource needs of the local departments related to Medicaid eligibility determinations. We are hopeful that future improvements in eligibility systems automation will greatly enhance the redetermination rates and alleviate workload concerns at the local departments.

Recommendation 3: The General Assembly may wish to amend § 63.2-526 (D) of the Code of Virginia to add "medical assistance" to the list of federal benefit programs for which a portion of overpayment moneys collected or recovered as a result of Medicaid recipient fraud investigations and referrals conducted by local departments, shall be deposited to the Fraud Recovery Special Fund.

We have not reviewed the efficacy of this recommendation, but would certainly encourage local departments to increase activity related to fraud investigations and referrals.

Recommendation 4: The General Assembly may wish to consider amending the Virginia Public Procurement Act (Code of Virginia, § 2.2-4347) to exempt the Department of Medical Assistance Services from the 30-day payment requirement so that the department can conduct a more extensive prepayment review of a claim within a 90 day period if there is a reasonable basis to suspect that payment of the claim could be improper.

We will certainly investigate this recommendation further as we consider what tools might be available for enhanced pre-payment review. As noted in the draft report, we are concerned that federal requirements for prompt-payment may influence our ability to meet the intent of this recommendation even with *Code of Virginia* changes. However, we have not completed that analysis and are certainly open to increasing our ability to detect or deter inappropriate claims on the front-end.

DMAS stands ready to work with all interested parties to further explore whatever options the Governor and General Assembly believe appropriate in response to this report. Again, thank you for the opportunity to comment on the draft report.

Sincerely,

Gregg A. Pane, M.D., M.P.A.
Director

GAP/sf

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

COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

Office of the Commissioner

Martin D. Brown
COMMISSIONER

October 6, 2010

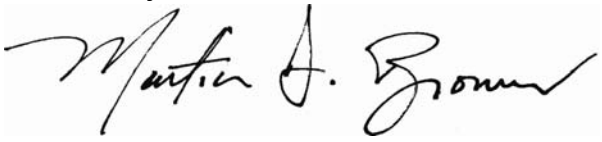
Mr. Glen S. Tittermary, Director
Joint Legislative Audit and Review Commission
General Assembly Building, Suite 1100
Capital Square
Richmond, Virginia 23219

Thank you for the opportunity to review the Joint Legislative Audit and Review Commission (JLARC) Exposure Draft on the *Interim Report: Fraud and Error in Virginia's Medicaid Program*. I also appreciate the opportunity that my staff had to meet with the project leaders to further discuss the draft. It is clear that the conversation facilitated the development of a stronger report.

We especially appreciate the discussion regarding the recommendation on the review of Medicaid cases with a sufficient sample size to determine error rates for local departments of social services. The discussion was very helpful and staffs agreed that the final report will include more specifics on the types of Medicaid cases to be reviewed, the review duration and the number of localities to be included in the pilot.

The Virginia Department of Social Services sees this study as an opportunity to improve current processes and to simplify current practices in a way that will enhance Medicaid fraud detection, prosecutions and collections. We look forward to further participation in the preparation of the final report.

Sincerely,



Martin D. Brown

801 East Main Street • Richmond, VA 23219-2901
http://www.dss.virginia.gov
(804) 726-7011 Fax: (804) 726-7015 TDD: (800) 828-1120

OCT - 7 2010

COMMONWEALTH of VIRGINIA

Office of the Attorney General

Kenneth T. Cuccinelli, II
Attorney General

900 East Main Street
Richmond, Virginia 23219
804-786-2071
FAX 804-786-1991
Virginia Relay Services
800-828-1120
7-1-1

October 7, 2010

Mr. Glen S. Tittermary, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Richmond, VA 23219

Dear Mr. Tittermary:

Thank you for the draft copy of your Interim Report: *Fraud and Error in Virginia's Medicaid Program*. We are very proud of our efforts to combat fraud in the Virginia Medicaid program. We will continue to work with the Department of Medical Assistance Services in an effort to protect the Medicaid program for Virginia's citizens. The Virginia Medicaid Fraud Control Unit will continue to expand its efforts to eliminate fraud and abuse in the Medicaid program, and to protect Virginia's most vulnerable citizens. If there is anything further we can do to help you as you study ways to combat fraud in Virginia's Medicaid program, please do not hesitate to ask.

With kindest regards, I remain

Very Truly Yours,

Randall L. Clouse
Director and Chief
Health Care Fraud and Elder Abuse Section
Medicaid Fraud Control Unit

RLC/pcl

JLARC Staff

Executive Staff

Glen S. Tittermary, Director
Harold E. Greer III, Deputy Director

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Robert B. Rotz, Senior Division Chief
Nathalie Molliet-Ribet, Division Chief

Section Managers

Paula C. Lambert, Fiscal & Administrative Services
Gregory J. Rest, Research Methods
Walter L. Smiley, Fiscal Analysis

Project Leaders

Aris W. Bearse
Justin C. Brown
Ashley S. Colvin
Martha L. Erwin
Eric H. Messick
Ellen J. Miller
Kimberly A. Sarte

Project Staff

Janice G. Baab
Jamie S. Bitz
Andrew B. Dickinson
Mark R. Gribbin
Anna B. Haley
Bradley B. Marsh
Joseph M. McMahon
David A. Reynolds
Tracey R. Smith
Massey S. J. Whorley
Christine D. Wolfe

Administrative and Research Support Staff

Joan M. Irby
Betsy M. Jackson

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Joint Legislative Audit and Review Commission

Suite 1100 • General Assembly Building • Capitol Square • Richmond, Virginia 23219
804-786-1258 • Fax 804-371-0101 • http://jlarc.virginia.gov