STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

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February 22, 2021

Honorable Catherine Osten, Appropriations Senate Chair
Honorable Toni Walker, Appropriations House Chair
Honorable Craig Miner, Appropriations Senate Ranking Member
Honorable Mike France, Appropriations House Ranking Member
Appropriations Committee Members
Legislative Office Building
300 Capitol Avenue Room 2700
Hartford, CT 06106

Honorable Marilyn Moore, Human Services Senate Chair
Honorable Catherine Abercrombie, Human Services House Chair
Honorable Jay Case, Human Services House Ranking Member
Honorable Eric C. Berthel, Human Services Senate Ranking Member
Human Services Committee Members
Legislative Office Building
300 Capitol Avenue, Room 2000
Hartford, CT 06106

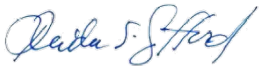
RE: PUBLIC ACT No. 13-293 - AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAD PROGRAM INTEGRITY

Dear Honorable Co-Chairs and Ranking Members of the Appropriations and Human Services Committee:

In accordance with Connecticut General Statute § 17b-99b, the attached joint report has been prepared by the Department of Social Services in coordination with the Office of the Chief State's Attorney and the Office of the Attorney General. The joint report represents the state's efforts to prevent and control fraud, abuse, and errors in the Medicaid payment system and to recover Medicaid overpayments.

Included in this report is a final reconciled and unduplicated accounting of identified, ordered, collected and outstanding Medicaid recoveries for all sources. This report is for activity during the period July 1, 2019 through June 30, 2020.

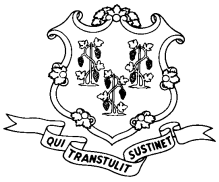
Sincerely,



Deidre S. Gifford, MD, MPH
Commissioner

DSG:JFM
Attachment

c: Neil Ayers, Office of Fiscal Analysis
Emily Shepard, Office of Fiscal Analysis
Holly Williams, Office of Fiscal Analysis
Kathleen Brennan, Deputy Commissioner
Michael Gilbert, Deputy Commissioner
William Tong, Attorney General
Kevin Kane, Chief State's Attorney
Alvin Wilson, Counsel/Government Relations Director



Medicaid Program Integrity-Legislative Report

Pursuant to Public Act No.13-293

Department of Social Services
Commissioner Deidre S. Gifford, MD, MPH

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Connecticut Department of Social Services

Making a Difference

Introduction

The Office of Quality Assurance ("QA") is responsible for ensuring the fiscal and programmatic integrity of programs administered by the Department of Social Services ("Department"). In addition, QA is responsible for ensuring the integrity of administrative functions of the Department. QA has five separate divisions, each with unique program integrity functions: Audit, Investigations and Recoveries, Special Investigations, Quality Control and Third Party Liability.

Audit Division

The Audit Division ensures compliance, efficiency, and accountability within federal and state programs administered by the Department by detecting and preventing mismanagement, waste and program abuse and ensuring that state and federal dollars are spent appropriately, responsibly, and in accordance with applicable laws and regulations. To achieve this objective, the Audit Division:

- Performs federally mandated audits of medical and health care providers that are paid through the various medical assistance programs administered by the Department;
- Reviews medical provider activities, audits claims, identifies overpayments, and educates providers on program integrity issues;
- Provides support and assistance to the Department's Special Investigations Division in the ongoing effort to combat fraud and abuse;
- Performs audits of the Department's operations, involving review of administrative and programmatic functions and the electronic data processing systems used in their support;
- Coordinates the Department's responses to all outside audit organization's reviews performed on the Department, including but not limited to, the State Auditors of Public Accounts and federal audit organizations;
- Reviews federal and state single audit reports and performs audits of financial, administrative and programmatic functions of the Department's grantees;
- Performs data analytics to identify aberrant billing activity and pursues collection of such overpayments; and
- Substantiates whether complaints received from various sources are valid and determines the proper disposition of the complaint including conducting an audit or forwarding to the Department's Special Investigations Division.

Investigations and Recoveries Division

The Investigations and Recoveries Division is comprised of two units; the Client Investigations Unit and the Resources and Recoveries Unit. The two units have investigation staff located at both central and statewide field office locations.

- **Client Investigations Unit** investigates alleged client fraud in various programs administered by the Department. This unit performs investigations via pre-eligibility, post-eligibility and other fraud investigation measures that include, but are not limited to, data integrity matches with other state and federal agencies. This unit also oversees the toll-free Fraud Hotline 1-800-842-2155 that is available to the public to report situations where it is perceived that a public assistance recipient, a provider, or a medical provider may be defrauding the state.
- **Resources and Recoveries Unit** is charged with ensuring that the Department is the payer of last resort for the cost of a client's care by detecting, verifying, and utilizing third-party resources; establishing monetary recoveries realized from liens, mortgages, and property sales; and establishing recoveries for miscellaneous overpayments.

Special Investigations Division

The Special Investigations Division is comprised of two units; Provider Investigations and Provider Enrollment. Integration of the Office of Quality Assurance's Provider Enrollment functions within the Special Investigation Division enhances the Connecticut Medical Assistance Program's (CMAP) program integrity. The review of provider enrollment applications is the first line of defense against fraud.

- **Provider Investigations Unit** is charged with the responsibility of coordinating and conducting activities to investigate allegations of fraud in the CMAP. When appropriate, credible allegations of fraud are referred to the Department's law enforcement partners pursuant to a memorandum of understanding (MOU). Parties to the MOU are the Office of the Chief State's Attorney, the Office of the Attorney General and the U.S. Department of Health and Human Services' Office of Investigations. Each entity is responsible for independently investigating the Department's referral to determine if a criminal and/or civil action is appropriate.
- **Provider Enrollment Unit** is responsible for the review and approval of all provider enrollment and re-enrollment applications, on an on-going basis. This Unit also shares responsibility for ensuring federal (42 CFR 455 Subpart B and E) and ACA requirements for provider enrollment are instituted and adhered to. Coordination of efforts between the Provider Investigations Unit and Provider Enrollment Unit strengthens Connecticut's program integrity efforts.

Quality Control Division

Quality Control Unit

The Quality Control Division is responsible for the federally-mandated reviews of Medicaid and the Supplemental Nutrition Assistance Programs (SNAP). A newly-established set of federally-required Medicaid reviews has been implemented under the Payment Error Rate Measurement program. Reviews of other CMAP programs and special projects may also be performed by this unit.

Claims Recovery Unit

The claims recovery unit is charged with processing overpayments resulting from changes in a client's eligibility, as well as the collection of already established claims. The claims are specific to the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families program, and state administered cash assistance programs.

Third Party Liability Division

The Third Party Liability Division is responsible for the Department's compliance with federal Third Party Liability requirements and recovering tax-payer funded health care from commercial health insurance companies, Medicare and other legally liable third parties. The Division manages programs that identify client third party coverage and recover client health care costs.

Audit Division Statistics 07/01/19– 06/30/20

Audits were conducted on 56 providers. The total amount of overpayments identified due to audits was $3,290,284, the total amount of avoided costs identified was $1,645,143, and the total amount of overpayments recovered was $3,516,954. See Table 1.6 for the number of audits that resulted in referrals. [Table 1.1]

Table 1.1

Provider Type	Number of Audits	Amount of Overpayments Identified	Amount of Avoided Costs Identified	Amount of Overpayments Recovered
Behavior Health Clinician	1	$51,805	$25,902	$1,350
Behavioral Health Clinician Groups	2	$18,690	$9,345	$370
BHH/TCM/Waiver Performing Provider	11	$862,898	$431,449	$862,898
Clinic	11	$676,915	$338,458	$475,640
Dentist	1	$50,000	$25,000	$64,067
Dentist Group	0	$0	$0	$61,634
DME	8	$892,662	$446,331	$976,416
Drug and Alcohol Abuse Center	1	$30,000	$15,000	$20,000
Home Health	4	$91,304	$45,652	$128,604
Optometrist	1	$20,000	$10,000	$20,000
Optometrist Group	0	$0	$0	$46,160
Pharmacy	13	$223,169	$111,585	$268,590
Physician	1	135,068	67,534	105,053
Physician Group	2	$237,773	$118,887	$426,119
Physical Therapist	0	$0	$0	$60,053
Total	56	$3,290.284	$1,645,143	$3,516,954

Note: Amount of overpayments identified is representative of audits closed in SFY 2020; however, overpayments recovered may be for audits conducted and closed prior to SFY 2020.

In addition to audits referenced in Table 1.1, the Audit Division also completed 23 miscellaneous reviews which resulted in identifying $5,420,572 of overpayments, $619,446 in avoided costs and $4,965,235 of recovered overpayments. [Table 1.2]

Table 1.2

Type of Audit/Review	Number of Audits	Amount of Overpayments Identified	Amount of Avoided Costs Identified	Amount of Overpayments Recovered
Required self-reporting audits	12	$4,181,680	$0	$3,601,084
Claims Analysis Integrity Reviews	7	$286,036	$143,018	$414,235
Global Settlements/Medicaid Settlements	4	$952,856	476,428	$949,916
Total	23	$5,420,572	$619,446	$4,965,235

A total of 50 complaints were received. Table 1.3 identifies the number of complaints received for each source. See Table 1.6 for the number of complaints that resulted in referrals.

Table 1.3

	Reason for Complaint							
Source of Complaint	Falsifying Documentation	Incorrect Procedure Billed	Other	Services Not Performed	Upcoding	Client Paid Cash/Billed	Unenrolled/ Unlicensed Provider	Number of Complaints
Allied	14		7	3				24
CHN			2	2	1		1	6
DCP			1					1
DHHS			1					1
DSS	1		1	1				3
Fraud Hotline			6	1	1			8
Other	1		2	3				6
Provider			1					1
Total	16		21	10	2		1	50

Audit Contractor Statistics 07/01/19– 06/30/20

13 audits were conducted by HMS Recovery Audit Contractor (RAC) which resulted in a total of $424,943 in overpayments identified, $212,472 in avoided costs identified and $341,944 in overpayments being recovered. [Table 1.4]

Table 1.4

Provider Type	Number of Audits	Amount of Overpayments Identified	Amount of Avoided Costs Identified	Amount of Overpayments Recovered
Dental Group	13	$424,943	$212,472	$341,944
Total	13	$424,943	$212,472	$341,944

188 Long Term Care audits were conducted by HMS and Myers & Stauffer which resulted in a total of $11,991,379 in overpayments identified and $11,991,379 in overpayments being recovered. [Table 1.5]

Table 1.5

Contractor	Number of Audits	Amount of Overpayments Identified	Amount of Overpayments Recovered
HMS	113	$9,376,498	$9,376,498
Myers & Stauffer	75	$2,614,881	$2,614,881
Total	188	$11,991,379	$11,991,379

Special Investigations Division 07/01/19 – 06/30/20

Provider Investigations Unit

A total of 34 investigations were opened and 23 investigations were referred to law enforcement for further action. Per a memorandum of understanding, referrals to law enforcement include the Connecticut Office of the Chief State's Attorney – Medicaid Fraud Control Unit (MFCU); the Connecticut Office of the Attorney General (AG); and the United States Department of Health and Human Services, Office of Investigations, Office of Investigations (OI). A total of 19 investigations were closed by Provider Investigations and, if applicable, forwarded to the Audit Division for appropriate action. [Table 1.6]

Table 1.6				
Source	Provider Type	Investigations Opened	Investigations Referred to Law Enforcement	Investigations Closed
Audit Division	Advanced Practice Nurse Group	1	1	
Audit Division	Behavioral Health Clinician	1		
Audit Division	Behavioral Health Clinician Group	1		
Audit Division	Dentist	1	1	1
Audit Division	Dentist Group			1
Audit Division	Physician	1	1	
Complaint	Advanced Practice Nurse			1
Complaint	Behavioral Health Clinician	2	2	
Complaint	Physician	1		
Complaint	Behavioral Health Clinician Groups	3	2	
Complaint	Clinic			1
Complaint	Dentist Group		1	1
Complaint	DME/Medical Supply Dealer	1	1	
Complaint	PCA	1		1
Complaint	Physician Group	2	2	
Contractor-Pulse Light	Behavioral Health Clinician			1
Contractor-Pulse Light	Dentist Group			3
Contractor-HMS	Dentist Group	1		2
Data Mining	Advance Practice Nurse Group	1		
Data Mining	Behavioral Health Clinician	6	5	3
Data Mining	Behavioral Health Clinician Groups	1	1	1
Data Mining	Physician Group	1	1	
Data Mining	Therapist Group	1		
Law Enforcement Federal	Behavioral Health Clinician Groups	1	1	
Law Enforcement Federal	Physician	1		
Law Enforcement State	Behavioral Health Clinician Groups	1	1	
Law Enforcement State	Dentist Group	1	1	
Other State Agency	DDS	1	1	1
Other State Agency	Dentist Group		1	
Provider Enrollment	Behavioral Health Clinician	3		

Provider Enrollment	**Behavioral Health Clinician Group**			**1**
Provider Enrollment	**Therapist Group**			**1**
Total		**34**	**23**	**19**

A total of $1,931,909.63 in overpayments in SFY 2020 was identified due to referrals to law enforcement. In addition, 2 fraud convictions were the result of DSS referrals.

Of the 23 investigations referred to law enforcement, 23 were completed by the Special Investigations Division within 12 months or less. Table 1.7 identifies the length of time that elapsed from the opening of the investigation to the closing of the investigation (referral).

Table 1.7

Time Range	Investigations Completed and Referred to Law Enforcement
Less than one month to six months	**22**
Seven months to twelve months	**1**
Thirteen months to twenty four months	**0**
Twenty five months or more	**0**
Total	**23**

In compliance with federal requirements under 42 CFR § 455.23, the Department initiated 24 temporary payment suspensions. At the end of SFY 2020, a total of 37 temporary payment suspensions were in place totaling $3,663,468.21. 5 provider enrollments were terminated or suspended. [Table 1.8]

Table 1.8

Provider Type	Payment Suspensions initiated in SFY 2020	Payment Suspensions in place SFYE 2020	Provider Enrollments Terminated, Suspended or Excluded *
Acquired Brain Injury	1	1	1
APRN		1	
Autism Specialist			
Autism Specialist Group			
Behavioral Health Clinician	6	7	2
Behavioral Health Clinician Group	7	13	1
BHH/TCM/Waiver Performing Provider		1	
Chiropractor Group			
CT Home Care Program			
DDS – Employment & Day Support			
Dentist	1	2	
Dentist Group	1	2	
Home Health Agency			
Laboratory	1	3	
Optician		1	
Optician Group			
Personal Care Services	6		
Physician	1	1	1
Physician Group		4	
Therapist Group		1	
Total	24	37	5

*This number includes providers terminated as follows: 1) "for cause" per section 6501 of the ACA, when terminated under Medicare or other State Plan, 2) per a state imposed suspension, or 3) federal exclusion.

Investigations and Recoveries Division Statistics 07/01/19 – 06/30/20

The below information is supplemental to information required by Public Act No. 13-293.

A total of $25,853,273 in avoided costs and recoveries are reported from the Investigations and Recoveries Division. [Table 1.9]

Table 1.9

Unit	Cost Avoidance	Recoveries
Resources and Recoveries	$1,322,387	$19,446,269
Client Investigations	$4,198,085	$886,532
Total	$5,520,472	$20,332,801
Grand Total	$25,853,273	

Arrest Warrant Affidavits Completed/Referred to State Prosecutors – SFY 2020

In SFY 2020, in addition to the cost avoidance and recoveries referenced in Table 1.9, the Client Investigations Division also completed and referred sixteen (16) arrest warrant affidavits to State Prosecutors for criminal prosecution. [Table 2.0]

During the period, six (6) recipients were arrested for Public Assistance fraud and eleven (11) cases were court adjudicated.

Table 2.0

Program	# of Program Violations	Amount
SNAP	15	$75,128
TFA	1	$21,052
Total	16	$96,180

Administrative Disqualification Penalties - SFY 2020

In SFY 20, the Client Investigations Division implemented administrative program disqualifications on 160 recipients [Table 2.1].

Table 2.1		
Program	**Recipient Disqualifications**	**Amount**
SNAP	**144**	**$157,160**
Child Care	**3**	**$0**
TFA	**10**	**$8,555**
SAGA Cash	**3**	**$3,014**
Total	**160**	**$168,729**

Quality Control Division 07/01/19-06/30/20

Claims Recovery Unit

Since the establishment of the Claims Recovery Unit in January of 2019, a total of 685 claims have been recovered totaling $618,565.

Third Party Liability Division Statistics 07/01/19– 06/30/20

A total of 1,182,172 claims were selected for billing to commercial health insurance and Medicare with a total amount billed of $203,998,439 for SFY 2020. Below is a breakdown of this information for the last three fiscal years. [Table 2.2]

Table 2.2						
	SFY 2018		**SFY 2019**		**SFY 2020**	
	# of Claims	**Amount Billed**	**# of Claims**	**Amount Billed**	**# of Claims**	**Amount Billed**
Commercial Insurance	**1,789,828**	**$210,714,500**	**1,178,597**	**$191,644,385**	**1,182,145**	**$197,487,174**
Medicare	**8,571**	**$6,885,111**	**10,511**	**$9,732,477**	**3,027**	**$6,511,264**
Total	**1,798,399**	**$217,599,611**	**1,189,108**	**$201,376,862**	**1,185,172**	**$203,998,439**

A total of 196,991 claims were recovered from commercial insurance and Medicare with a total amount of $30,805,667 collected for SFY 2020. Below is a breakdown of this information for the last three fiscal years. [Table 2.3]

Table 2.3

	SFY 2018		SFY 2019		SFY 2020	
	# of Claims	Amount Collected	# of Claims	Amount Collected	# of Claims	Amount Collected
Commercial Insurance	238,767	$28,371,912	199,709	$24,193,555	194,291	$26,404,068
Medicare	2,819	$2,577,876	3,745	$5,002,814	2,700	$4,401,599
Total	241,586	$30,949,788	203,454	$29,196,369	196,991	$30,805,667

A total of 1,873,504 claims with a total amount of $357,773,069 were denied by commercial health insurance for SFY 2020. Below is a breakdown of this information for the last three fiscal years. [Table 2.4]

Table 2.4

SFY 2018		SFY 2019		SFY 2020	
Claims	Dollars	Claims	Dollars	Claims	Dollars
1,623,411	$311,078,734	2,065,148	$340,838,791	1,873,504	$357,773,069

Major reasons for commercial health insurance denial:

- Client did not have coverage that was in effect at time of service
- Health care service is not covered
- Deductible/copay was not met
- Health insurance plans maximum benefit for service had been met

Table 2.5 identifies the total number of commercial health insurance policies updated in the Department's client eligibility records; as well as, a breakdown of health insurance policies added, changed or deleted.

Table 2.5

SFY 2018				SFY 2019				SFY 2020			
Additions	Changes	Deletions	Total	Additions	Changes	Deletions	Total	Additions	Changes	Deletions	Total
161,223	83,990	5,601	250,754	68,751	161,266	627	230,644	130,209	164,871	933	296,013

A total of 596,389 health care claims were denied due to client health insurance or Medicare, resulting in a total amount of $570,938,462 in cost avoidance for SFY 2020. [Table 2.6]

Table 2.6		
Other Payment Source	**Number of Claims**	**Dollar Amount**
Commercial Insurance	**326,506**	**$266,302,140**
Medicare	**269,883**	**$304,636,322**
Total	**596,389**	**$570,938,462**

Table 2.7 identifies the Medicaid dollar amount of Home Health and Skilled Nursing Facility services recovered through Medicare appeals.

Table 2.7	
Provider Type	**Dollar Amount**
Home Health	**$506,474**
Skilled Nursing Facility	**$9,335,385**
Total	**$9,841,860**

Performance Standard

Table 2.8 identifies the return on investment (ROI) by division. ROI was calculated as (Division Recoveries + Cost Avoidance)/Division Cost.

Table 2.8	
Division	**Return on Investment**
Audit Division	**6.413**
Investigations and Recoveries Division	**2.884**
Special Investigations Division	**2.605**
Third Party Liability Division	**56.04**

Projected Cost Savings

Audit Division

The Audit Divisions projected cost savings for SFY 2021 are $23,500,000. [Table 2.9]

Table 2.9	
Description	**Amount**
Audit Adjustments	$13,000,000
Audit Cost Avoidance	$6,500,000
Other Adjustments	$3,500,000
Other Cost Avoidance	$500,000
Total	$23,500,000

Investigations and Recoveries Division

The Investigations and Recoveries Division projected cost savings for SFY 2021 are $21,223,956. [Table 3.0]

Table 3.0	
Description	**Amount**
Resources & Recoveries	$19,718,704
Client Investigations	$1,505,252
Total	$21,223,956

Special Investigations Division

The Provider Investigations Unit projected cost savings for SFY 2021 are $2,000,000. [Table 3.1]

Table 3.1	
Description	**Amount**
Payment Suspensions	$1,000,000
Global Settlements	$1,000,000
Total	$2,000,000

Third Party Liability Division

The Third Party Liability Division projected cost savings for SFY 2021 are $661,947,526 Table 3.2 identifies the projected cost avoidance, health insurance and Medicare recovery and Medicare Maximization recoveries for SFY 2021.

Table 3.2	
Description	**Amount**
Cost Avoidance	**$630,769,799**
Benefit Recovery	**$20,290,703**
Medicare Maximization Recoveries	**$10,887,024**
Total	**$661,947,526**

New Initiatives to Prevent and Detect Overpayments

Audit Division

Provider Audit Unit:

- Rolling out a new integrity review program focusing on billing abnormalities uncovered during provider audits.
- Integrate and train new audit staff.

Investigations and Recoveries Division

Client Investigations Unit:

- The Client Investigations Division will continue to monitor social media websites (I.e. Craig's List, Facebook) and utilize these social media sites as a viewing tool to uncover potential recipient SNAP trafficking.
- The Client Investigations Division continues to encourage staff development and to take advantage of federally reimbursed SNAP fraud conferences and training opportunities as they become available, as well as participate in monthly FNS headquarters fraud conference calls.
- The Client Investigations Division will continue to focus on increasing the number of arrest warrant affidavits referred for prosecution.
- The Client Investigations Division will continue to emphasize staff individualized training plans focusing on increased knowledge of the latest technological advances to combat fraud, waste and abuse.
- The Client Investigations Division will continue to cross-train staff to assist in enhancing knowledge of the workforce.
- The Client Investigations Division will continue to share investigation techniques, updates and best practices with statewide Investigations staff.

Special Investigations Division

Provider Investigations:

- Integrate and train new Forensic Fraud Examiners.
- Enhance the existing fraud referral process.
- Ensure timely payment suspensions on all required fraud referrals.

Provider Enrollment:

- Continue the effort to automate the required enrollment functions therefore making the process more efficient. This shift will allow DSS to focus their attention on the integrity of the CMAP rather than the processing of enrollment applications.

Third Party Liability Division

- The Department will implement a new point of enrollment health insurance identification program to identify client health insurance at the time the individual is granted eligibility, and a Husky B client health insurance identification program to satisfy the Balance Budget Act of 2018 third party liability requirements.