STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

Andrea Barton Reeves, J.D.
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

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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, 2021 through June 30, 2022.

Sincerely,

Andrea Barton Reeves, J.D.
Commissioner-designate
Connecticut Department of Social Services

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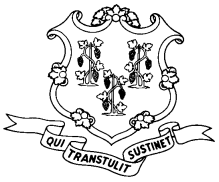

Medicaid Program Integrity-Legislative Report

Pursuant to Public Act No.13-293

Department of Social Services
Commissioner-designate Andrea Barton Reeves, J.D

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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;
- 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

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 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 CMAP's 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 Connecticut Medical Assistance Program. 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. Substantiates whether complaints received from various sources are valid and determines the proper disposition of the complaint.
- **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

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 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 07/01/21– 06/30/22

Audits were conducted on 83 providers. The total amount of overpayments identified due to audits was $4,513,751.97, the total amount of avoided costs identified was $2,256,875.99, and the total amount of overpayments recovered was $4,446,332.59. 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
Advance Practice Nurse Group	2	$421,170.81	$210,585.41	$271,396.36
Behavior Health Clinician	10	$466,886.00	$233,443.00	$117,247.33
Behavioral Health Clinician Groups	12	$546,438.52	$273,219.26	$253,014.11
BHH/TCM/Waiver Performing Provider	17	$965,306.07	$482,653.04	$965,306.07
Clinic	2	$188,249.95	$94,124.98	$25,002.02
DME	4	$181,231.00	$90,615.50	$166,913.81
Home Health	1	$27,580.00	$13,790.00	$11,491.70
Laboratory	-	-	-	$1,900,000
Optometrist	3	$130,116.00	$65,058.00	$39,986.82
Optometrist Group	9	$530,500.00	$265,250.00	$240,430.62
Pharmacy	13	$488,653.00	$244,326.50	$358,566.93
Physician Group	9	$567,332.83	$283,666.42	$96,691.03
Radiology	1	$287.79	$143.90	$287,.79
Total	83	$4,513,751.97	$2,256,875.99	$4,446,332.59

Note: Amount of overpayments identified is representative of audits closed in SFY 2022; however, overpayments recovered may be for audits conducted and closed prior to SFY 2022.

In addition to audits referenced in Table 1.1, the Audit Division also completed 134 miscellaneous reviews which resulted in identifying $864,653.66 of overpayments, $191,451.82 in avoided costs and $349,609.03 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
Self-reporting audits	5	$481,750.03	0	$200,545.36
Claims Analysis Integrity Reviews	129	$382,903.63	$191,451.82	$149,063.67
Total	134	$864,653.66	$191,451.82	$349,609.03

Audit Contractor Statistics 07/01/21– 06/30/22

15 audits were conducted by HMS Recovery Audit Contractor (RAC) which resulted in a total of $623,986.30 in overpayments identified, $311,993.15 in avoided costs identified and $464,593.04 in overpayments being recovered. [Table 1.3]

Table 1.3

Provider Type	Number of Audits	Amount of Overpayments Identified	Amount of Avoided Costs Identified	Amount of Overpayments Recovered
Dental	7	$303,889.13	$151,944.57	$250,256.12
Dental Group	8	$320,097.17	$160,048.59	$214,336.92
Total	15	$623,986.30	$311,993.15	$464,593.04

220 Long Term Care audits were conducted by HMS and Myers & Stauffer which resulted in a total of $18,801,047 in overpayments identified and $18,801,047 in overpayments being recovered. [Table 1.4]

Table 1.4

Contractor	Number of Audits	Amount of Overpayments Identified	Amount of Overpayments Recovered
HMS	121	$16,300,000	$16,300,000
Myers & Stauffer	99	$2,501,047	$2,501,047
Total	220	$18,801,047	$18,801,047

Special Investigations Division 07/01/21 – 06/30/22

Provider Investigations Unit

A total of 121 complaints were received. Table 1.5 identifies the number of complaints received for each source. See Table 1.7 for the number of complaints that resulted in referrals.

Table 1.5

	Reason for Complaint							
Source of Complaint	Falsifying Documentation	Incorrect Procedure Billed	Other	Services Not Rendered	Upcoding	Client Paid Cash/Billed	Unenrolled/ Unlicensed Provider	Number of Complaints
Allied	61		2	1				64
ASO-Beacon			2	2		1		5
ASO-CHN			3	4		2		9
DSS-Community Options	1		1	2				4
Fraud Hotline	2		7	13		1	2	25
Law Enforcement			5	2	1			8
Other	1							1
Other-State Agency	1		2					3
REOMB-Gainwell				2				2
Total	66	0	22	26	1	4	2	121

A total of 52 investigations were opened of which 29 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 55 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	Community First Choice	2	1	2
Audit Division	Dentist Group	1	1	
Audit Division	Laboratory			1
Audit Division	Personal Care Services		1	2

Audit Division	**Pharmacy**			**1**
Audit Division	**Podiatrist Group**			**1**
Audit Division	**Therapist Group**		**1**	
Complaint	**Advance Nurse Practitioner Group**	**1**		**1**
Complaint	**Advance Practice Nurse**	**1**		
Complaint	**Autism Specialist Group**	**1**		**1**
Complaint	**Behavioral Health Clinician Group**	**1**	**2**	**1**
Complaint	**CT Home Care Program**	**1**	**2**	**1**
Complaint	**Community First Choice**	**16**	**10**	**5**
Complaint	**Extended Care Facility**	**1**		**1**
Complaint	**Home Health Agency**	**1**	**1**	
Complaint	**Hospital**	**1**		**1**
Complaint	**Optician Group/Optical Shop**			**1**
Complaint	**Optometrist Group**	**1**	**1**	**1**
Complaint	**Personal Care Services**	**4**	**1**	**6**
Complaint	**Physician**	**1**		**1**
Complaint	**Physician Group**			**1**
Complaint	**N/A**	**1**		**1**
Contractor	**Physician Group**			**1**
Data Mining	**Behavioral Health Clinician**		**1**	**1**
Data Mining	**Behavioral Health Clinician Group**			**4**
Data Mining	**Clinic**		**1**	
Data Mining	**CT Home Care Program**	**2**	**1**	**2**
Data Mining	**Dentist**	**2**	**1**	
Data Mining	**DME/Medical Supply Dealer**	**4**		**4**
Data Mining	**Laboratory**	**1**		**1**
Data Mining	**Optician**			**1**
Data Mining	**Physician Group**	**1**		**1**

Data Mining	**Therapist Group**			**1**
Law Enforcement State	**N/A**	**1**		**1**
Law Enforcement State	**Clinic**			**1**
Law Enforcement State	**CT Home Care Program**			**2**
Law Enforcement State	**Physician Group**		**1**	**2**
Law Enforcement Federal	**Behavioral Health Clinician**	**1**	**1**	
Law Enforcement Federal	**Behavioral Health Clinician Group**			**1**
Law Enforcement Federal	**CT Home Care Program**	**1**		**1**
Other	**Autism Specialist Group**	**1**	**1**	
Other	**Clinic**	**1**		**1**
Other	**CT Home Care Program**	**1**	**1**	
Other State Agency	**DDS**	**1**		
REOMB	**Optometrist Group**	**1**		**1**
Total		**52**	**29**	**55**

A total of $9,953,479 in overpayments in SFY 2022 was identified due to referrals to law enforcement. In addition, 5 fraud convictions were the result of DSS referrals.

Of the 29 investigations referred to law enforcement, 28 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	**26**
Seven months to twelve months	**2**
Thirteen months to twenty four months	**0**
Twenty five months or more	**1**
Total	**29**

In compliance with federal requirements under 42 CFR § 455.23, the Department initiated 13 temporary payment suspensions. At the end of SFY 2022 a total of 49 temporary payment suspensions were in place totaling $8,060,613 of which $5,360,241.75 in payments were captured during the SFY ($4,821,718.36 after disbursements). Six provider enrollments were terminated or suspended. [Table 1.8]

Table 1.8

Provider Type	Payment Suspensions initiated in SFY 2022	Payment Suspensions in place SFYE 2022	Provider Enrollments Terminated, Suspended or Excluded *
Acquired Brain Injury		1	
APRN	1	2	1
APRN Group			
Autism Specialist			
Autism Specialist Group	1	3	
Behavioral Health Clinician	2	12	
Behavioral Health Clinician Group	4	15	
BHH/TCM/Waiver Performing Provider			
Chiropractor Group			
CT Home Care Program	2	3	2
Community First Choice	8		
DDS – Employment & Day Support		1	
Dentist	1	2	
Dentist Group		2	
DME/Medical Supply Dealer	1	1	
Home Health Agency			
Laboratory			1

Optician			
Optician Group			
Personal Care Services	**4**		
Physician	**1**	**2**	**2**
Physician Group	**1**	**4**	
Therapist Group		**1**	
Total	**26**	**49**	**6**

*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 07/01/21-06/30/22

Investigations and Recoveries Division Statistics 07/01/21 – 06/30/22

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

A total of $20,550,224.00 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	**$2,487,780**	**$12,171,016**
Client Investigations	**$4,916,105**	**$975,323**
Total	**$7,403,885**	**$13,146,339**
Grand Total	**$20,550,224.00**	

Arrest Warrant Affidavits Completed Referred to State Prosecutors – SFY 2022

In SFY 2022, in addition to the cost avoidance and recoveries referenced in Table 1.9, the Client Investigations Division also completed and referred forty-two (42) arrest warrant affidavits to State Prosecutors for criminal prosecution. [Table 2.0]

During the period, twenty (20) recipients were arrested for Public Assistance fraud and ten (10) cases were court adjudicated.

Table 2.0		
Program	**# of Program Violations**	**Amount**
SNAP	**2**	**$9,384**
Child Care	**1**	**$0**
Total	**3**	**$9,384**

Administrative Disqualification Penalties - SFY 2022

In SFY 2022, the Client Investigations Division implemented administrative program disqualifications on 114 recipients [Table 2.1].

Table 2.1		
Program	**Recipient Disqualifications**	**Amount**
TFA	**2**	**$1,024**
SNAP	**111**	**$274,276**
Child Care	**1**	**$0**
Total	**114**	**$275,300**

Quality Control Division 07/01/21-06/30/22

Claims Recovery Unit

For SFY 2022, a total of 1213 claims were recovered by the Claims Unit totaling $1,465,583.64.

Third Party Liability Division Statistics 07/01/21– 06/30/22

A total of 2,360,245 claims were selected for billing to commercial health insurance and Medicare with a total amount billed of $312,364,276 for SFY 2022. Below is a breakdown of this information for the last three fiscal years. [Table 2.2]

Table 2.2

	SFY 2020		SFY 2021		SFY 2022	
	# of Claims	Amount Billed	# of Claims	Amount Billed	# of Claims	Amount Billed
Commercial Insurance	1,182,145	$197,487,175	1,077,385	$190,759,834	2,330,440	$292,223,256
Medicare	3,027	$6,511,264	21,516	$17,534,120	29,805	$20,141,020
Total	1,185,172	$203,998,439	1,098,901	$208,293,954	2,360,245	$312,364,276

A total of 291,352 claims were recovered from commercial insurance and Medicare with a total amount of $36,732,894 collected for SFY 2022. Below is a breakdown of this information for the last three fiscal years. [Table 2.3]

Table 2.3

	SFY 2020		SFY 2021		SFY 2022	
	# of Claims	Amount Collected	# of Claims	Amount Collected	# of Claims	Amount Collected
Commercial Insurance	194,291	$26,404,068	161,945	$20,258,642	283,898	$30,286,777
Medicare	2,700	$4,401,599	1,680	$2,439,091	7,454	$6,446,117
Total	196,991	$30,805,667	163,625	$22,697,733	291,352	$36,732,894

A total of 1,678,907 claims with a total amount of $305,486,073 were denied by commercial health insurance for SFY 2022. Below is a breakdown of this information for the last three fiscal years. [Table 2.4]

Table 2.4

SFY 2020		SFY 2021		SFY 2022	
Claims	Dollars	Claims	Dollars	Claims	Dollars
1,873,504	$357,773,069	1,480,529	$288,618,490	1,678,907	$305,486,073

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 for the last three (3) fiscal years the total number of commercial health insurance policies updated on Department client eligibility records and a breakdown of health insurance policies added to, changed on, or deleted from client eligibility records.

Table 2.5

SFY 2020				SFY 2021				SFY 2022			
Additions	Changes	Deletions	Total	Additions	Changes	Deletions	Total	Additions	Changes	Deletions	Total
130,209	164,871	933	296,013	266,572	172,484	1,192	440,248	415,993	282,209	16,684	714,886

A total of 1,035,562 health care claims were denied due to client health insurance or Medicare, resulting in a total amount of $1,169,260,387 in cost avoidance for SFY 2022. [Table 2.6]

Table 2.6

Other Payment Source	Number of Claims	Dollar Amount
Commercial Insurance	670,691	$696,642,220
Medicare	364,871	$472,618,167
Total	1,035,562	$1,169,260,387

Table 2.7 identifies the Medicaid dollar amount of Home Health and Skilled Nursing Facility services recovered through Medicare appeals for SFY 2022.

Table 2.7

Provider Type	Dollar Amount
Home Health	$154,742
Skilled Nursing Facility	$10,822,796
Total	$10,977,538

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	5.25
Investigations and Recoveries Division	1.99
Special Investigations Division	5.45
Third Party Liability Division	59.03

Projected Cost Savings

Audit Division

The Audit Divisions projected cost savings for SFY 2023 are $18,158,622. [Table 2.9]

Table 2.8	
Description	**Amount**
Audit Adjustments	$11,264,786
Audit Cost Avoidance	$5,632,393
Other Adjustments	$840,962
Other Cost Avoidance	$420,481
Total	$18,158,622

Investigations and Recoveries Division

The Investigations and Recoveries Division projected cost savings for SFY 2023 are $20,479,804. [Table 3.0]

Table 3.0	
Description	**Amount**
Resources & Recoveries	$12,485,804
Client Investigations	$7,994,000
Total	$20,479,804

Special Investigations Division

The Provider Investigations Unit projected cost savings for SFY 2023 are $4,000,000. [Table 3.1]

Table 3.1	
Description	**Amount**
Payment Suspensions	$2,000,000
Global Settlements	$2,000,000
Total	$4,000,000

Third Party Liability Division

he Third Party Liability Division projected cost savings for SFY 2023 are $650,000,000. Table 3.2 identifies the projected cost avoidance, health insurance and Medicare recovery and Medicare Maximization recoveries for SFY 2023.

Table 3.2	
Description	**Amount**
Cost Avoidance	$650,000,000
Benefit Recovery	$25,000,000
Medicare Maximization Recoveries	$10,000,000
Total	$685,000,000

New Initiatives to Prevent and Detect Overpayments

Audit Division

Provider Audit Unit:

- Increase the integrity review program focusing on billing abnormalities uncovered during provider audits and external audits.
- Prepare audit plan and begin to perform audits on Federally Qualified Health Centers (FQHCs) and Ambulance providers.
- Enhancements to the Pulselight platform including the continued conversion of the MATS audit database to Quality Assurance Tracking System (QATS) and EVV data.
- Integrate and train new audit staff.
- Educate newly enrolled providers.
- Network/meet regularly with policy divisions.
- Strengthen policies and procedures.

- Quality Assurance staff expansion to increase the number of provider types audited and amount of related recoveries.

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 are initiated on all required fraud referrals.
- Enhancements to the Pulselight platform including the conversion of the RAPS database.

Provider Enrollment:

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

Third Party Liability Division

- The Department will implement a home health Medicare Maximization Program pilot project to perform reviews of dual eligible clients denied Medicare coverage for home health services.
- New Regulatory Compliance team to work closely with contractors to strengthen recovery efforts.
- Develop and recommend system edits to increase claim denials.