

FACT SHEET



Georgia Department of Community Health Office of Inspector General: Committed to Detecting, Reducing and Preventing Medicaid Fraud

Overview

The Georgia Department of Community Health's (DCH) Office of Inspector General (OIG) is composed of four units, each dedicated to prevent, detect and investigate possible fraud, waste and abuse.

- Medicaid Program Integrity -- Monitors Medicaid providers and members
- Internal DCH Investigations -- Examines allegations of fraud, waste and abuse by DCH employees, contractors, sub-contractors and vendors
- Provider Enrollment -- Reviews, evaluates and processes all applications for individual practitioner and facility enrollment in Georgia Medicaid and PeachCare for Kids[®]
- Office of Audits -- Conducts internal (DCH programs or personnel) and external (providers or members) audits and reviews

Systems in place create various barriers to entry for both providers and members as the first step in preventing fraud, ensuring that enrollment information is thoroughly vetted from the outset. The agency continues to work toward administrative simplifications that can also improve the audit and review process.

Additionally, the OIG works hand-in-hand with law enforcement agencies and the Office of the Attorney General, Medicaid Fraud Control Unit (MFCU) to investigate cases of provider fraud. Cases of member fraud are generally handled through local prosecutors.

Honor. Performance. Integrity.

The OIG is diligent in investigating fraud, waste and abuse. We have instituted several new programs, including Recovery Audit Contractors (RACs) and the member-directed Integrus/Medicaid Member Matching (Integrus/M3 -- known in many other states as the Public Assistance Reporting Information Program/PARIS).

The approach to our investigations is multi-faceted and layered. Detecting fraud, especially in the health care arena, is complex and goes far beyond examining payment data. Systems – human-based and technology-based – are used to review Medicaid data and information through the edits, audits and procedures to ensure that all aspects of the claim are appropriate and within federal and state guidelines.

The OIG's office also looks for patterns that might indicate improper payments and uses this information to further review claims on a broad basis for certain indicators. Then investigators drill down into the data to detect cases of fraud, waste and abuse.

PROGRAM SPOTLIGHTS

DCH/OIG has recovered more than \$56 million in the past two years.

The recovered funds are returned to the state and federal budgets at a rough estimate of 35 percent and 65 percent, respectively.

About Recovery Audit Contractors (RAC)

Recovery Audit Contractor-like procedures to audit and review Medicaid providers have been in place at DCH well before the mandate of the Affordable Care Act.

For the two years the RAC has been reviewing Fee-for-Service claims. OIG has recently begun RAC audits of the state's Care Management Organizations (CMO) to identify and recover overpayments and underpayments to these providers.

While many states report both identified and recovered fund amounts, DCH reports recovered funds only.

The state's RAC is Myers & Stauffer and OIG staff works in tandem with them to audit claims.

About Integrus/M3 (Medicaid Member Matching)

This new program involves searches of three enhanced databases to determine which Medicaid members are appropriately enrolled in Georgia Medicaid. The three databases include:

- **The Department of Defense/Office of Personnel Management Match** (identifying active or retired military and Federal employees to further verify income)
- **The Interstate Match** (duplicate payments made to the same client enrolled in more than one state)
- **The Veterans Administration Match** (identifying veterans receiving Medicaid who would be better served through Veterans benefits)

Integrus/M3 is an interagency program, spearheaded by DCH, that includes the Georgia Department of Human Services, the Georgia Department of Veterans Service, Department of Public Health and others working cooperatively to reach members.

Process Improvement Plan

The OIG has developed strategic imperatives that address the reduction of fraud, waste and abuse on all levels:

- To implement processes that will guarantee provider enrollment decisions will be made within 10 business days from the receipt of a completed application
- To develop and implement processes that will guarantee 80% of Program Integrity cases will be completed within 90 days
- To achieve an increase on return on investment of OIG initiatives by 100% in FY 2014
- To develop, evaluate and implement a balanced scorecard evaluation system, division wide that will enable efficient and effective evaluation of OIG staff performance and productivity.

Summary

DCH encourages reporting of fraud, waste and abuse through telephone, e-mail and online. All reports are investigated.

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