Georgia Department of Community Health

DCH
Office of Inspector General

Presentation to: DCH Board of Community Health

Presented by: Donald E. Pollard, Jr., Inspector General

March 12, 2015

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Mission

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing, and oversight.

We are dedicated to A Healthy Georgia.

OIG Functional Units

- Audits – John Hankins, **Audits Director**
- Data Integrity and Analysis (DIAT) – **Ramona Clark Program Director**
- Special Investigations (SIU) – **Karl Reimers, SIU Director**
- Background Investigations (BIU) – **Denise Matthews, TAC, BIU Director**

OIG Functional Units (con't)

- Provider Enrollment (PE) – **Nichole Thompson, PE Director**
- Program Integrity (PI) – **Terri Kight, PI Director**
- Third Party Liability (TPL) – **Lorraine McMillion, TPL Director**
- OIG Operations – **Tara Burks, Operations Support Manager**

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Office of Audits

- The purpose of the Office of Audits is to provide independent, objective assurance and consulting services designed to add value and improve the Agency's operations.
- The scope and assignment of audits is determined by the Inspector General; however, the Commissioner may at any time request the Inspector General to perform an audit of a program, function, or organizational unit.

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What is Data Integrity and Analysis?

DATA ANALYSIS

- *Analysis* of *data* is a process of inspecting, cleaning, transforming, and modeling *data* with the goal of discovering useful information, suggesting conclusions, and supporting decision-making.

DATA INTEGRITY

- *Data integrity* refers to maintaining and assuring the accuracy and consistency of data over its entire life-cycle, and is a critical aspect to the design, implementation and usage of any system which stores, processes, or retrieves data.

DIAT Responsibility: Systems Maintenance

The Georgia Medicaid Management Information System (GAMMIS) serves as the primary web portal for Medicaid, Peach Care for Kids and all related waiver programs administered by the Department of Community Health's Medical Assistance Plans Division.

- Identify issues and inconsistencies in GAMMIS subsystem affecting data integrity and quality.
- Assist to update GAMMIS changes to comply with DCH Policy and new requirements or Regulations.
- Surveillance Utilization Review (SUR) Subsystem Maintenance and Testing.

DIAT Responsibility: Qui Tams

Qui tam- From a Latin phrase meaning “he who brings a case on behalf of our lord the King, as well as for himself.” This provision allows a private person, known as a “relator,” to bring a lawsuit on behalf of the United States, where the private person has information that the named defendant has knowingly submitted or caused the submission of false or fraudulent claims to the United States.

- Most Qui tams are requested from Medicaid Fraud Control Units (MFCU) throughout the states.
- DIAT creates specific and detailed reports on behalf of state and federal agencies requirements to analyze Qui Tams affecting Georgia Medicaid.

Other DIAT Responsibilities

- **ICD-10- Integration and Testing**

  Modification to the GAMMIS and its Subsystems to incorporate ICD-10 diagnostic coding translation and updates for the purpose of accuracy in data and analysis.

- **EOMBs (Explanation of Member Benefits)**

  A random monthly mail out to Medicaid Members to verify billed services were received. DIAT Monitors and review Members' EOMB responses. Utilize the EOMBS to identify potential inappropriate and error billing issues.

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SIU Responsibilities

- Provider Investigations
- Recipient Investigations
- SIU Multi-Functional Role
- Unlicensed Personal Care Homes (PCH)

Provider Investigations

- All providers are reviewed by Program Integrity for compliance with policy.
- SIU investigates those providers suspected of committing fraud against the program.
- SIU reviews records, data, billing codes, patterns etc… in determining if fraud is being committed.
- Cases of a credible allegation of fraud are referred to the Medicaid Fraud Control Unit (MFCU).

Recipient Investigations

- SIU investigates Medicaid members suspected of committing fraud, or receiving benefits for which they are no longer eligible.
- A number of factors are considered including: eligibility determination, reported income, spouse/children reported in the home etc.
- SIU also handles the Public Assistance Reporting Information System (PARIS) Interstate Match.

SIU Multi-functional Role

- SIU works frequently with staff from multiple teams within OIG and assists with conducting on-site reviews of Medicaid providers (at locations throughout the state) by interviewing staff, collecting information, copying records, and other functions as needed.
- Assists the Financial Management Division (Benefits Recovery) with locating providers who have outstanding accounts receivable balances.

Unlicensed Personal Care Homes

- SIU works in conjunction with Healthcare Facility Regulation Division (HFRD) to assist their surveyors while investigating suspected unlicensed personal care homes.
- SIU investigators assist HFRD in relocating residents from unlicensed personal care homes to licensed facilities.
- In the past few months, SIU staff have assisted HFRD at 36 different locations involving unlicensed personal care home investigations.

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The DCH Terminal Agency Coordinator (TAC)

- Completed Terminal Operator Training and TAC Certification Course to become a certified TAC Operator.
- The administration of Security and Integrity training and Security Awareness training to DCH Staff.
- Is responsible for ensuring that DCH is in compliance with state (GCIC) and federal (NCIC) rules and regulations. GCIC Council Rule 140-2-.16.
- POC for matters relating to CJIS information access. The TAC administers CJIS systems programs with the agency and oversees the agency's compliance with CJIS systems Policies.

OIG Background Investigations Unit General Responsibilities

DCH Employees	Georgia Criminal Background Check Financial Check	Policy 023	Human Resources
DCH Contractor	Georgia Criminal Background Check Financial Check	Policy 023	Human Resources
State Purchasing Card (P-Card)	Georgia Criminal Background Check Financial Check	O.C.G.A. § 50-5-83	Human Resources
Personal Care Homes – Owner Private Home Care – Owner Community Living Arrangement – Owner Personal Care Homes – Licensing of Directors Personal Care Homes – Director or Employee During Abuse Investigation	FBI Criminal Background Check	O.C.G.A. § 31-2-9 O.C.G.A. § 31-7-254 O.C.G.A. § 31-7-259	Healthcare Facility Regulation Division (HFRD)
Georgia Voluntary Background Check Program	FBI Criminal Background Check Registry Checks	The Affordable Care Act (ACA) Subtitle C, Section 6201	Healthcare Facility Regulation Division (HFRD)

OIG Background Investigations Unit General Responsibilities

DCH Employees and DCH Contractors - Responsible for providing:

- Georgia Criminal Background Check.
- Financial Check – Necessary for specified positions.
- Adheres to DCH Policy 023.
- Human Resources.

Impact of Work

- Helps reduce legal liabilities to DCH.
- Helps in the reduction of sanctions imposed against DCH due to non-compliance with GCIC and NCIC provisions.
- Helps prevent government abuse and waste.
- Helps provide for the health and safety of external and internal DCH customers.
- Helps provide safety for the elderly and developmentally disabled living in HFRD licensed facilities.
- Ensure that DCH is in compliance with state (GCIC) and federal (NCIC) rules and regulations.

Examples of Covered Crimes

- A violation of Code Section 16-5-1, relating to murder and felony murder;
- A violation of Code Section 16-5-21, relating to aggravated assault;
- A violation of Code Section 16-5-24, relating to aggravated battery;
- A violation of Code Section 16-5-70, relating to cruelty to children;
- A felony violation of Title 16, Chapter 8, relating to theft;

Title 28. U.S.C., Section 534

Applicant Notification and Record Challenge

- Agencies must advise the applicant that procedures for obtaining a change, correction, or updating of an FBI identification record are set forth in 28 CFR 16.34.

- Agencies must provide the applicant with written notice that his/her fingerprints/biometrics will be used to check the criminal history records maintained by the GCIC and FBI when a federal record check is so authorized.

DISSEMINATION

- Cannot give out across state lines.
- Cannot give out to the subject's attorney.
- Cannot give out the existence/non-existence of CHRI in Fitness determination Letters to the employer.
- Cannot give out to the public.

*The agency may be named liable in a civil lawsuit.

OIG Functional Units (con't)

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Role of Provider Enrollment

- The PE unit is the gatekeeper for the enrollment of providers and practitioners for the Georgia Medicaid and PeachCare for Kids® programs. The enrollment process includes credentialing, endorsement and licensure verification to ensure that all providers are in good standing in the community.

Provider Enrollment – Initial Enrollment

- Provider Enrollment oversees and monitors the review and processing of practitioner applications, conducted by DCH's fiscal agent Hewlett Packard Enterprise Services (HP).
- HP reviews and processes individual practitioner applications and DCH reviews facility enrollment applications such as hospitals and pharmacies.

Provider Enrollment – FY14 Stats

- For FY 2014,
- 37,943 enrollment applications were received.
- 37,093 enrollment applications were approved.
- A total of 22,208 physicians were enrolled into the Georgia Medicaid/PeachCare for Kids® program.
- Enrollment applications are within nine (9) days of a completed application.

Provider Enrollment – Requirements

- On September 1, 2014, DCH required that all facilities and suppliers enroll online through the Georgia Medicaid Management Information System (GAMMIS) at www.mmis.georgia.gov.
- As required by the Affordable Care Act (ACA), a fee in the amount of $542 for initial enrollment of only certain specified facilities and suppliers is collected.
- On January 1, 2015, all individual practitioners were required to enroll online through GAMMIS. Paper applications are accepted on a case-by-case basis.

Provider Enrollment – Revalidation Requirements

- In April 2014, DCH implemented Revalidation of Enrollment which is a requirement of the ACA.
- Revalidation will occur every five (5) years.
- Revalidation of Enrollment must be completed online at www.mmis.georgia.gov.
- Providers enrolled the longest in the Georgia Medicaid/PeachCare for Kids® programs were the first to revalidate their enrollment.

Provider Enrollment – Revalidation of Enrollment

- DCH and HP review the revalidation application, in part, to ensure the provider is licensed and properly credentialed and treating Medicaid members at the service location in GAMMIS.
- HP reviews the revalidation applications practitioners and DCH reviews the facilities and suppliers.

Provider Enrollment – Revalidation Stats

From April 2014 through January 2015

- 18,420 revalidation enrollment applications were approved.
- A total of 9,700 revalidation applications approved for the Georgia Medicaid/PeachCare for Kids® programs.

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Role of Program Integrity

- Identify and respond to provider and member fraud, waste and abuse within the Medicaid program through prepayment and post-payment safeguards.
- Assist providers with education and corrective action

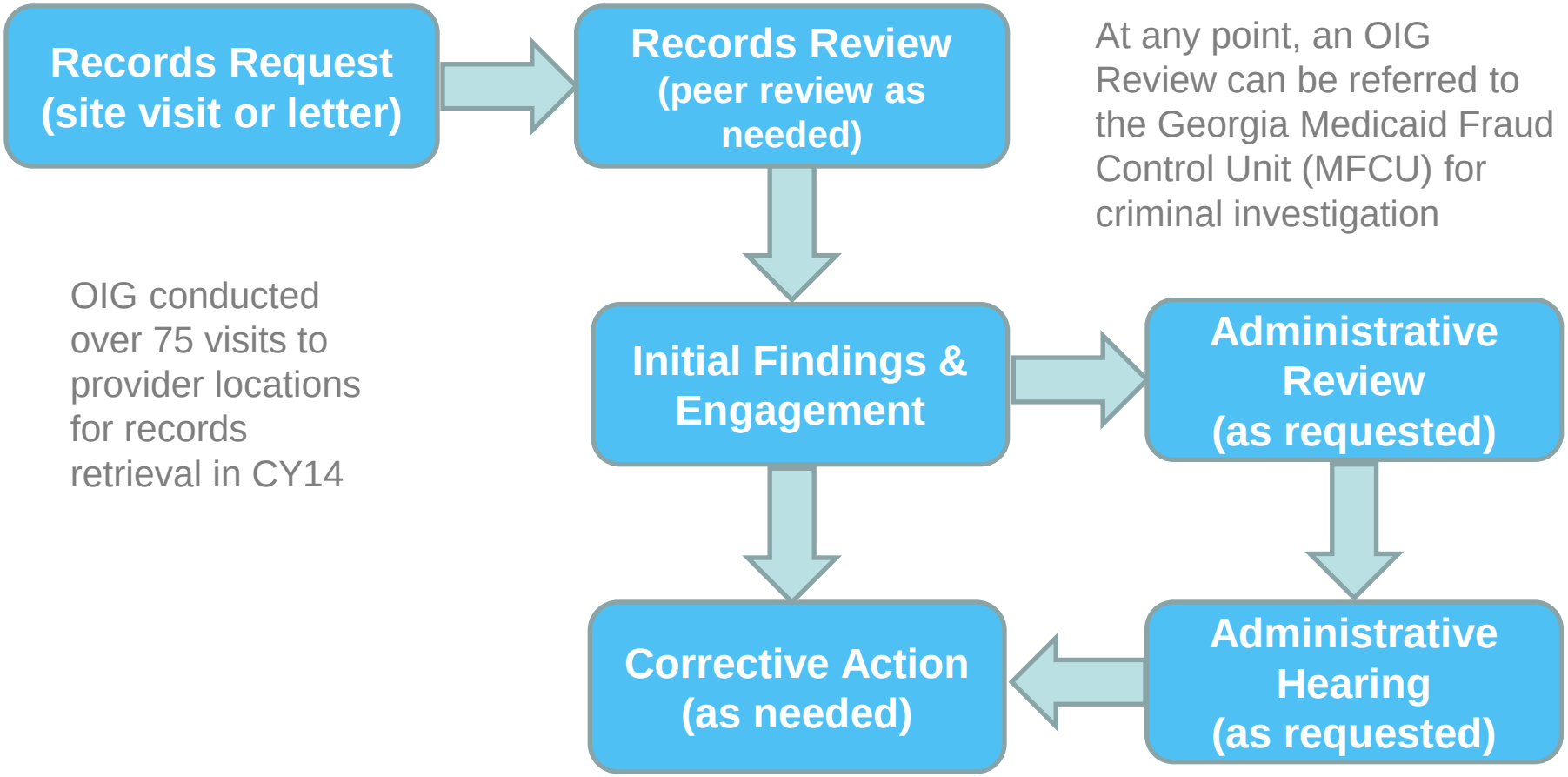
Program Integrity Responsibilities

- Utilization review of all provider types - (apx. 5000 reviews conducted annually to identify waste, fraud and abuse).
- Recovery Audit Contractor (RAC)
  - (42 CFR 455.502(b))
  - Contingency-fee based

Program Integrity Responsibilities (con't)

- Provider self disclosure of overpayments
  - *Part 1 Policies and Procedures Section 402.10*
- Prepayment review
  - *Part 1 Policies and Procedures Section 401.1*
- Member Lock-In
  - *Part 1 Policies and Procedures Section 109.1*

Key Steps in a PI Review



At any point, an OIG Review can be referred to the Georgia Medicaid Fraud Control Unit (MFCU) for criminal investigation

OIG conducted over 75 visits to provider locations for records retrieval in CY14

Possible Outcomes

- Providers and recipients adhere to Medicaid policy.
- Education – corrective action plan.
- Recoupment – the provider pays back the identified overpayment.
- Policy update – Quarterly.
- Criminal prosecution – Medicaid Fraud Control Unit.
- Other referrals – Healthcare Facility Regulation, licensing board(s).
- Prepayment Review.

Examples of Fraud, Waste and Abuse - Providers

- Billing for services not rendered.
- Up-coding - Billing a higher level of service than was actually performed.
- Submitting a claim under the wrong Member ID or Provider ID.
- Altering claims, records, etc.
- Billing for non-covered services as if they were covered services.
- Performing or obtaining services that are not suitable or medically necessary.

Examples of Fraud, Waste and Abuse - Members

- Obtaining benefits for children not in the home.
- Obtaining benefits with unreported spouse in the home.
- Unreported income.
- Allowing non member to receive services using member benefits.
- Falsification of application to obtain benefits.
- Receiving benefits in more than one state.

Provider Outreach

- **Engagements** – informal resolution of utilization reviews – OIG conducted over 150 provider engagements in CY14, less than 10% of which requested an administrative law hearing.

- **Corrective Action Plans** – provider plans to correct issues identified during utilization reviews.

Provider Outreach (con't)

- **Prepayment Review** – review of medical documentation prior to payment of a provider's claim, as governed by Medicaid policy.
  - Providers placed in prepayment review after identification of unusual/aberrant billing practices, credible allegation of fraud.
  - Providers given monthly education about billing
  - Billing patterns reviewed every 6 months during prepayment review.
  - Over $19 million in cost savings during FY14.

Member Outreach

- **Lock In** - Management of members' utilization of pharmacy benefits for controlled substance prescriptions by limiting their access to one controlled substance prescriber and one pharmacy.
- Over 200 members on active Lock-In every day.
- Almost 100 members being watched either before or after Lock-In every day.

Recoveries

- FY 13 : $35.8 million
- FY 14: $31.1 million

*includes all types of recoveries (OIG, RAC, other vendors), excluding TPL

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Third Party Liability Overview

- The Third Party Liability (TPL) program identifies, maintains and recovers third party resources which are liable for the medical cost of the Medicaid member. Examples of third party resources include:

  - Private health insurance
  - Medicare
  - Employment-related health insurance
  - Court-ordered health insurance
  - Workers' compensation
  - Long-term care insurance

Third Party Liability Overview

The TPL Unit oversees the following programs:

- Health Insurance Premium Payment (HIPP)
- Children's Health Insurance Program Re-Authorization Act (CHIPRA)
- Casualty
- Estate Recovery (ER)
- Credit Balance Audits (CBA)
- Commercial Billings and Recoupments
- TPL File Maintenance
- Trust Operations; Miller Trust (MT), Special Needs Trust (SNT), Pooled Trust Programs and Trust Accounting.

Health Insurance Premium Payments (HIPP)

- The Omnibus Budget Reconciliation Act of 1990 mandated that states pay group health insurance premiums for Medicaid eligible individuals if the insurance plans are determined to be cost effective. The Balanced Budget Act of 1997 made the program optional. DCH implemented the HIPP program in 1994.
- Cost effective means that the costs to the Medicaid Agency for the health insurance premiums, the co-insurance and the deductible are expected to be less than the cost of care paid with Medicaid funds.
- Payments start upon the completion and approval of the application process.

Children's Health Insurance Program Re-Authorization Act (CHIPRA)

- February 2009, President Obama signed the Children's Health Insurance Program reauthorization Act of 2009 (CHIPRA). In 2010, DCH implemented the country's first CHIPRA program. CHIPRA offers new opportunities for States to provide premium assistance to children who are eligible for Medicaid, and have access to qualified employer-sponsored coverage.
- Members must be under 19 years of age and the employer must pay at least 40% towards the cost of the premiums.
- Payments for insurance premiums begin upon the completion and approval of the application process.

Casualty

- The Casualty program recovers Medicaid expenditures from verified third parties who are liable to pay for medical expenses incurred due to trauma or accident related injuries. Examples of casualty cases include:
    - Auto, Bicycle, Homeowner, Slip/Fall, Pedestrian, Medical Malpractice, Workers Compensation
- The authority and subrogation recovery rights are referenced in the following State and Federal citations:

O.C.G.A. 9-2-21	O.C.G.A. 49-4-148
O.C.G.A. 49-4-149	42 CFR 433.138

- Liens are filed for cases valued at $500.00 or more.

Estate Recovery (ER)

- Estate Recovery is a program, required by federal law, whereby the estate of the deceased Medicaid member reimburses the State for long term care and home and community-based services provided through Medicaid.
- Legal Statute: O.C.G.A. 49-4-147.1.
- ER rules: Chapter 111-3-8 http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/7/13/46190895111-3-8_estate_recovery_rules.pdf.

Estate Recovery (ER) (con't)

- The assets of the estate must value at least $25,000 or more.
- Recovery can be deferred if a surviving spouse, a dependent child under the age of 21 or a dependent child of any age who is disabled or blind still resides in the home.

Credit Balance Audits (CBA)

- The goal of the credit balance program is to identify overpayments made to providers by Medicaid through a claim level review of outstanding accounts.
- Medicaid providers are required to report overpayments to Medicaid quarterly utilizing the DMA-710 form (Credit Balance Report).
- On-site and desktop audits are conducted by the TPL vendor to determine if overpayments are due back to Medicaid.

Commercial Billings and Recoupments

- Commercial Billings and Recoupments recover funds from liable third parties and reduce costs for Medicaid.
- When Medicaid pays a TPL claim as primary, the TPL vendor recoups the funds by filing a claim in the amount paid by Medicaid to the commercial insurance carrier.
- Monthly claims and eligibility files are sent to the TPL vendor to identify which claims should be filed on the behalf of Medicaid.

TPL File Maintenance

- File maintenance is a process of verifying and updating the Medicaid Management Information System (MMIS) database with the most current and accurate information available regarding Medicaid members.
- The most common sources for TPL updates are:
  - DMA 285 (TPL Health Information form)- A form completed by Department of Family and Children Services (DFCS) and sent to the TPL vendor for verification and update.
  - TPL Vendor data matching- The TPL vendor does data matches with different commercial insurance carriers to identify Medicaid members who also have private insurance.
  - Medicaid claims submission- TPL is indicated on the Medicaid claim.

Trust Operations

- Miller Trust/Qualified Income Trust (QIT)– is an instrument used for applicants that have income over the limit. It involves a legal document and a QIT bank account. It is composed of the applicant's own income (Social Security, pension, etc.).
- Special Needs Trust (SNT) – A trust where the State receives funds remaining in the trust, up to the amount paid by Medicaid on behalf of the individual under the State Medicaid plan.
- Pooled Trust – A trust established and administered by a non-profit organization.

TPL Recovery Amounts for SFY14

TPL Programs	Recovery Amounts for SFY14
Casualty	$ 7,048,598.05
Estate Recovery	$ 4,571,149.51
Trusts- SNT, Miller and Pooled	$ 2,313,539.80
Credit Balance Audits	$ 1,467,683.15
Commercial Billings and Recoupments	$23,431,552.00
Totals	$38,832,522.51

TPL Cost Avoidance

- The TPL function provides the capability to manage the private health, Medicare, and other third party resources of Medicaid members, while ensuring that Medicaid is the payer of last resort. This function works with a combination of cost avoidance (claim denial) and the TPL vendor cost recovery (post-payment billing to insurers).
- The system utilizes edits to avoid cost for medical services when the member has a private insurance on file.
- These edits are used to calculate cost avoidance dollars. **These are funds that DCH does not have to pay out*

TPL Cost Avoidance

TPL Cost Avoidance Programs	Cost Avoidance Amounts for SFY14
Medicare Cost Avoidance	$704,351,523.83
Commercial Cost Avoidance	$165,128,544.69
Total	$869,480,068.52

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Operations Unit Responsibilities

- General OIG Inquiries
- General OIG Support
- Open Records Requests
- Project support
- Staff relocation
- New Hire – OIG Onboarding
- 5th Floor Facilities
- Secured Data media
- Equipment Support
- Work Orders

Questions and Answers

Questions?