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PERFORMANCE UPDATE AND FURTHER INQUIRY

WEST VIRGINIA BUREAU FOR MEDICAL SERVICES AND THE MEDICAID FRAUD CONTROL UNIT

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

AUDIT OVERVIEW

The Bureau of Medical Services and the Medicaid Fraud Control Unit Have Made Some Progress in Responding to Issues Raised in the Performance Review of 2007; However, Other Important Issues Have Not Been Adequately Addressed

The Medicaid Fraud Control Unit Does Not Adequately Communicate with Occupational Licensing Boards, and the Medicaid Fraud Control Unit Should Further Develop Its Case Prioritization Procedure

WEST VIRGINIA LEGISLATIVE AUDITOR
PERFORMANCE EVALUATION & RESEARCH DIVISION

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EXECUTIVE SUMMARY

As part of the 2012 Agency Review of the Department of Health and Human Resources (DHHR), pursuant to Chapter 4, Article 10, Section 8(b)(5) of the *West Virginia Code*, the Legislative Auditor conducted an update to the previous performance review issued in 2007 of the Bureau for Medical Services and the Medicaid Fraud Control Unit in order to determine the agency's response to the recommendations of the review.

Report Highlights:

Issue 1: The Bureau for Medical Services and the Medicaid Fraud Control Unit Have Made Some Progress in Responding to Issues Raised in the Performance Review of 2007; However, Other Important Issues Have Not Been Adequately Addressed.

- Out of the 10 recommendations in PERD's 2007 performance review, the Bureau for Medical Services (BMS) and the Medicaid Fraud Control Unit (MFCU) have responded with the following levels of compliance:
  - In Compliance with four recommendations,
  - Partial Compliance with three recommendations,
  - Planned Compliance with one recommendation, and
  - Non-Compliance with two recommendations.

- In order to increase the level of compliance with the 2007 performance review and increase the effectiveness and efficiency of West Virginia's Medicaid Fraud Control efforts, this update has provided new recommendations:

  1. The MFCU should hire and retain an appropriate level of staff in order to eliminate its backlog of referred cases and pursue civil fraud cases in state court.

  2. The MFCU should pursue civil cases regardless of potential provider bankruptcies.

  3. The BMS should develop a claims-based flagging system for the purpose of implementing pre-payment review on Medicaid claims.

  4. The BMS should develop a provider-based flagging system to identify providers with high billing error rates for the purpose of implementing pre-payment review on select Medicaid providers.

  5. The BMS should utilize the predictive modeling tool, once it is fully implemented, to establish criteria such as billing error rates for the claims-based and provider-based flagging systems recommended in this report.

  6. The BMS should coordinate with the MFCU to create written policies that establish objective criteria for employees to follow in distinguishing between overpayment cases that the BMS would handle and cases that should be referred to the MFCU.

7. Once the MFCU achieves an appropriate staffing level, it should develop a performance goal regarding the length of time in which cases can remain in "referred" status without being assigned and investigated.

8. The MFCU and the BMS should meet regularly in order to increase the level of communication between the two agencies.

Issue 2: The Medicaid Fraud Control Unit Does Not Adequately Communicate with Occupational Licensing Boards, and the Medicaid Fraud Control Unit Should Further Develop Its Case Prioritization Procedure.

- The Legislative Auditor finds the MFCU does not adequately communicate or coordinate with occupational licensing boards when it files a civil case or criminal charges against a Medicaid provider. Furthermore, the MFCU had not created a case prioritization document until the Legislative Auditor requested one. Therefore, this report has provided additional recommendations outside the scope of the 2007 performance review:

9. The MFCU should create objective criteria for the sliding scale questions in the "Referral Screening Report," which would ensure a standard and consistent "solvability weight" for all incoming referrals.

10. The MFCU should incorporate the "Referral Screening Report" into the Policies and Procedures Handbook as soon as possible.

11. The MFCU and the BMS should notify the relevant occupational licensing boards when filing a civil or criminal case against a Medicaid provider.

PERD's Evaluation of the Agency's Written Response

The Office of the Legislative Auditor's Performance Evaluation and Research Division received the Department of Health and Human Resource's response on September 12, 2013. The agency response can be found in Appendix F. The DHHR generally concurred with the findings and recommendations in this report. However, the agency disagreed with three of the recommendations.

a. **Recommendation 6:** *The BMS should coordinate with the MFCU to create written policies that establish objective criteria for employees to follow in distinguishing between suspected fraud and accidental overpayments.*

   Recommendation has been modified: This recommendation was modified to read as follows: "The BMS should coordinate with the MFCU to create written policies that establish objective criteria for employees to follow in distinguishing between overpayment cases that the BMS would handle, and cases that should be referred to the MFCU." The modification in language came as a direct result of the Exit Conference with PERD, BMS, and the MFCU. All parties agreed that the original language did not properly reflect the recommendation's intent. Therefore, the recommendation has been changed to better convey the intent of the recommendation. As a result, the BMS and the MFCU agree with the rewritten recommendation, though the agency noted that it will "need to develop criteria that is flexible enough to change with new schemes/scams as policies and technology progresses. An issue that is prevalent today may be very different from something new that may develop with a new service/new code/new delivery method, etc."

b. **Recommendation 9:** *The MFCU should create objective criteria for the sliding scale questions in the "Referral Screening Report," which would ensure a standard and consistent "solvability weight" for all incoming referrals.*

   An agency response: The MFCU disagrees that its case prioritization process is not objective. The Legislative Auditor denotes concern about utilization of the screening form due to the possibility of the solvability weight fluctuating from one employee to the next. It should be noted that this form is not utilized by random employees but by the investigative supervisors who have adequate training and experience to utilize the form appropriately. Investigations are rarely black and white, and the decision to pursue or not pursue a particular case must take many factors into consideration, not all of which are explicit. The investigative supervisors must use their training and experience to evaluate the evidence and assign a particular weight to certain issues. This form was developed pursuant to specific training offered by a respected, experienced consulting firm that specializes in the operations and management of criminal investigation units. It is the MFCU's position that those trained and experienced in investigative management are best qualified to determine the process for prioritizing criminal investigations, and the current process is adequate.

   PERD's evaluation: PERD agrees that fraud investigations are complicated, ever-evolving, and require considerable training and experience. PERD does not object to the

use of the Referral Screening Report document. However, as noted in the report, certain factors in the document depend on the investigative supervisor assigning points for specific items on a scale of 0-5. We believe the document can become an effective way for the MFCU to prioritize referrals, but the Unit must provide an additional document establishing objective criteria for the 0-5 point scale. For example, one of these categories is simply titled "Other considerations" and has a list of items including "management to decision to pursue," again with a 0-5 point scale. Without objective criteria, what one supervisor might consider a 2 on the scale, another could consider a 4. There is no supplementary document to explain the difference between these two numbers. If the MFCU created a supplementary document establishing objective criteria for these sliding scale numbers, the Referral Screening Report would provide an objective means for the Unit to prioritize incoming referrals.

c. **Recommendation 11:** *The MFCU and the BMS should notify the relevant occupational licensing boards when filing a civil or criminal case against a Medicaid provider.*

Agency response: The MFCU concurs with this recommendation in civil cases, but disagrees in criminal cases.

PERD's evaluation: Once the MFCU has filed a criminal case against a Medicaid provider, it should notify the relevant occupational licensing board. In making this recommendation, PERD is not suggesting the MFCU notify the relevant occupational licensing board during the investigation. PERD is also not suggesting that the MFCU make any judgment as to the provider's guilt, the severity of the case, the quality of the evidence, or recommend the board take any action. The recommendation only asks that the MFCU notify the licensing board so the board can determine whether or not to conduct its own investigation within the statute of limitations. As evidenced by the case PERD examined, if the occupational licensing board only learns of a case after the completion of court proceedings, the statute of limitations on the case could expire, thereby leaving the board with fewer legal options.

Recommendations

1. *The MFCU should hire and retain an appropriate level of staff in order to eliminate its backlog of referred cases and pursue civil fraud cases in state court.*

2. *The MFCU should pursue civil cases regardless of potential provider bankruptcies.*

3. *The BMS should develop a claims-based flagging system for the purpose of implementing pre-payment review on Medicaid claims.*

4. *The BMS should develop a provider-based flagging system to identify providers with high billing error rates for the purpose of implementing pre-payment review on select Medicaid providers.*

5. *The BMS should utilize the predictive modeling tool, once it is fully implemented, to establish criteria such as billing error rates for the claims-based and provider-based flagging systems recommended in this report.*

6. *The BMS should coordinate with the MFCU to create written policies that establish objective criteria for employees to follow in distinguishing between overpayment cases that the BMS would handle and cases that should be referred to the MFCU.*

7. *Once the MFCU achieves an appropriate staffing level, it should develop a performance goal regarding the length of time in which cases can remain in "referred" status without being assigned and investigated.*

8. *The MFCU and the BMS should meet regularly in order to increase the level of communication between the two agencies.*

9. *The MFCU should create objective criteria for the sliding scale questions in the "Referral Screening Report," which would ensure a standard and consistent "solvability weight" for all incoming referrals.*

10. *The MFCU should incorporate the "Referral Screening Report" into the Policies and Procedures Handbook as soon as possible.*

11. *The MFCU and the BMS should notify the relevant occupational licensing boards when filing a civil or criminal case against a Medicaid provider.*

Issue 1

The Bureau for Medical Services and the Medicaid Fraud Control Unit Have Made Some Progress in Responding to Issues Raised in the Performance Review of 2007; However, Other Important Issues Have Not Been Adequately Addressed.

This report evaluates the responses of the BMS and the MFCU to recommendations made in the performance review of January 2007. A total of 10 recommendations from that report are being updated in this current report.

Background

This report evaluates the responses of the BMS and the MFCU to recommendations made in the performance review of January 2007. A total of 10 recommendations from that report are being updated in this current report.

The BMS and the MFCU, within the Department of Health and Human Resources (DHHR) are responsible for detecting, investigating, and prosecuting Medicaid providers that commit fraud in West Virginia. Federal regulations define a Medicaid provider as either of the following:

(1) For the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency.

(2) For the managed care program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services.

The MFCU and the BMS are located in different branches of the DHHR to comply with the Social Security Act, which states that "MFCUs must be separate and distinct from the State's Medicaid agency."

The BMS and the MFCU, within the Department of Health and Human Resources (DHHR) are responsible for detecting, investigating, and prosecuting Medicaid providers that commit fraud in West Virginia.

The Office of Quality and Program Integrity (OQPI), within BMS, performs data analysis and other types of review to identify fraud, waste, and abuse cases within the West Virginia Medicaid program. If the OQPI finds evidence of suspected fraud, it refers the matter to the MFCU, located within the Office of the Inspector General (OIG). Upon receipt of the referral from the OQPI, the MFCU launches an investigation and determines if the matter should be pursued as a civil case or a criminal case. If the MFCU decides to pursue criminal charges, it refers the matter to a U.S. Attorney or County Prosecutor. Organizational charts of both the BMS and the OIG are provided in Appendix D.

Update of 2007 Recommendations

Recommendation 1

The Bureau for Medical Services should consider requiring surety bonds for high-risk providers.

Level of Compliance: **Non-Compliance**

The Bureau for Medical Services (BMS) has not implemented this recommendation and has not provided any reason as to why it has not done so. As noted in PERD's 2007 report, high-risk providers pose the greatest potential for risk of fraud and include durable medical equipment providers, private transportation companies, non-physician owned clinics, home health agencies and independent laboratories. The Centers for Medicare & Medicaid Services (federal CMS), operating under the United States Department of Health and Human Services (DHHS), requires certain Medicare providers, but not Medicaid providers, to obtain a surety bond. The DHHS defined Medicare surety bonds as follows:

> *A surety bond is issued by an entity (the surety) guaranteeing that the surety will pay CMS the amount of any monetary obligations incurred during the term of the bond, and for which the supplier is responsible, up to the surety's maximum obligation.*

The Bureau for Medical Services (BMS) has not implemented this recommendation and has not provided any reason as to why it has not done so.

Though the federal CMS does not require surety bonds for Medicaid providers, states can enact laws to require surety bonds. When PERD issued the 2007 report, six states required surety bonds for certain Medicaid providers: California, Illinois, Louisiana, Florida, Texas, and Washington. Since then, Alabama and Minnesota have also started requiring surety bonds for certain Medicaid providers. As noted in the 2007 report, surety bonds provide a financial incentive to discourage fraudulent providers from enrolling in a state's Medicaid program and provide financial protection against provider fraud.

As noted in the 2007 report, surety bonds provide a financial incentive to discourage fraudulent providers from enrolling in a state's Medicaid program and provide financial protection against provider fraud.

Recommendation 2

> *The Bureau for Medical Services should consider conducting random on-site visits to high-risk providers.*

Level of Compliance: **In Compliance**

PERD's 2007 performance review noted that the federal CMS recommended six measures to control the risk presented by high-risk providers. One such measure was on-site review, which is designed to determine the legitimacy of provider businesses. At the time, 29 states conducted on-site visits to providers applying to participate in Medicaid, and most states focused their efforts on high-risk providers. These visits have proven effective in combating fraud. In Florida, one month of site visits to 85 provider applicants revealed that all of these applications were illegitimate. In Texas, the introduction of on-site visits decreased

the number of new applicants by 50 percent leaving only legitimate businesses, as confirmed by the visits. The Legislative Auditor therefore recommended West Virginia adopt this practice to verify the legitimacy of Medicaid providers and deter illegitimate applicants.

As of 2013, the Legislative Auditor finds the BMS conducts very few random on-site visits to high-risk providers. However, under federal regulations the BMS can accept the results of site visits conducted by Medicare contractors or a state licensing agency.

As of 2013, the Legislative Auditor finds the BMS conducts very few random on-site visits to high-risk providers. However, under federal regulations the BMS can accept the results of site visits conducted by Medicare contractors or a state licensing agency. Federal regulation 42 CFR 455.432, which was implemented as a result of the Affordable Care Act, requires the BMS to perform unannounced pre-enrollment and post-enrollment site visits to providers who are designated as "moderate" or "high" categorical risks to the Medicaid program. High-risk providers include the following providers:

- home health agencies, and
- suppliers of durable medical equipment, prosthetics, orthotics, and supplies

For high-risk providers, the BMS relies on site visits conducted by Medicare or a State licensing agency, a practice that is permitted under Federal regulation 42 CFR 455.410:

> *(c) The State Medicaid agency may rely on the results of the provider screening performed by any of the following:*
>
> *(1) Medicare contractors.*
>
> *(2) Medicaid agencies or Children's Health Insurance Programs of other States.*

Therefore, while the BMS is mainly relying on site inspections conducted by Medicare contractors, the intended purpose of the recommendation is being fulfilled.

The BMS's fiscal agent, Molina Healthcare, validates site visits from outside entities and conducts site visits to providers that have not already received a visit from a Medicare contractor. In 2012, Molina completed 2,399 enrollments and 886 re-enrollments, and only found five sites that required inspection. **Therefore, while the BMS is mainly relying on site inspections conducted by Medicare contractors, the intended purpose of the recommendation is being fulfilled.**

Recommendation 3

> *The Bureau for Medical Services should consider conducting provider re-enrollment and update provider information on a regularly-scheduled basis.*

Level of Compliance: **In Compliance**

PERD's 2007 performance review noted that 25 other states conducted time-limited enrollments, which helps track providers and removes providers who are no longer in business. These re-enrollments and the periodic update of provider information ensure that providers are still operating, and that they have not changed locations, contact information, ownership, or undergone other major changes. As such, the review found the BMS could not provide information regarding the number of providers who had "dropped out" of the Medicaid program system in the previous three to six years.

These re-enrollments and the periodic update of provider information ensure that providers are still operating, and that they have not changed locations, contact information, ownership, or underwent other major changes.

As of 2013, the Legislative Auditor finds the BMS conducts provider re-enrollment and updates provider information on a regularly-scheduled basis. The new federal regulations, mentioned in Recommendation 2, also established requirements for regularly-scheduled provider re-enrollment. Federal regulation 42 CFR 455.414 stipulates that the state Medicaid agency must revalidate the re-enrollment of all providers regardless of provider type at least every five years. The BMS has stated that it will follow these regulations and require a five-year re-enrollment of all providers on an ongoing basis.

Federal regulation 42 CFR 455.414 stipulates that the state Medicaid agency must revalidate the re-enrollment of all providers regardless of provider type at least every five years. The BMS has stated that it will follow these regulations and require a five-year re-enrollment of all providers on an ongoing basis.

In addition, the BMS states that it conducts provider re-enrollments under the following circumstances:

- *a change of ownership occurs;*
- *upon request of an out-of-state provider dis-enrolled due to expiration of a limited enrollment period;*
- *upon request of a provider that was dis-enrolled due to no claims being submitted for two years; or*
- *upon request of a provider dis-enrolled for other reasons, such as moving out of West Virginia, license revocation, etc.*

This year, the BMS will also begin re-enrollment of all West Virginia Medicaid providers. The Bureau anticipates this process will last 12 to 18 months.

This year, the BMS will also begin re-enrollment of all West Virginia Medicaid providers. The Bureau anticipates this process will last 12 to 18 months.

Recommendation 4

The Legislature should consider amending the West Virginia Code to require the Bureau for Medical Services to conduct FBI criminal background checks on all Medicaid provider applicants as well as existing providers.

Level of Compliance: **Planned Compliance**

PERD's 2007 performance review noted that 13 other states require criminal background checks of high-risk providers. In order for the BMS to conduct FBI criminal history background checks, federal law required the state to have legislation in place authorizing criminal background checks through the FBI. While the BMS relied on licensing boards to ensure providers possessed the necessary qualifications and standards to legally operate, very few of these licensing boards conducted criminal background checks. Therefore, the review recommended the Legislature amend Code to allow, and require, the BMS to conduct criminal background checks on providers.

As of 2013, the Legislature did not amend West Virginia Code to require the BMS to conduct FBI criminal background checks on all Medicaid provider applicants as well as existing providers.

As of 2013, the Legislature did not amend West Virginia Code to require the BMS to conduct FBI criminal background checks on all Medicaid provider applicants as well as existing providers. However, in February 2011 federal regulation 42 CFR 455.434 was implemented allowing, and requiring, the BMS to conduct criminal background checks of providers upon enrollment. The BMS is awaiting federal guidance regarding criminal background checks, which the federal CMS is still developing.

In February 2011 federal regulation 42 CFR 455.434 was implemented allowing, and requiring, the BMS to conduct criminal background checks of providers upon enrollment.

In the meantime, the BMS has begun developing procedures to require long-term care facilities perform background checks on all prospective patient/resident access employees. In October 2011, the BMS was awarded a federal grant that it says will used to "develop and implement a statewide background check process for all Long Term Care direct-care employees."

Recommendation 5

> *The Bureau for Medical Services should develop an online pre-approval system for prescriptions as soon as possible.*

Level of Compliance: **In Compliance**

As of 2013, the Legislative Auditor finds the BMS has a fully-functional pre-approval system for prescriptions.

PERD's 2007 performance review found the BMS planned to pursue online pre-approvals for prescriptions, but did not currently have a fully functioning system in place. As noted in the 2007 report, online pre-approval of prescription drugs would allow the BMS to examine pharmaceutical and medical claims history, the patient's diagnoses, as well as history of prior drug use.

As of 2013, the Legislative Auditor finds the BMS has a fully-functional pre-approval system for prescriptions. On November 18,

2008, the BMS implemented the Automated Prior Authorization System. The system can be modified as new medicines and clinical information becomes available, provides the ability to issue or deny drugs that should be controlled, and contains a telephone Help Line for pharmacists.

Recommendation 6

The Medicaid Fraud Control Unit and the Bureau for Medical Services should begin coordinating efforts to pursue action against providers via the provisions in WVC §9-7-6, rather than relying solely on post-payment reviews to recover funds overpaid to Medicaid providers.

The review found the DHHR only filed five civil suits against suspected providers from 2002 to 2005. It therefore recommended the DHHR increase the number of civil actions against suspected providers to increase recoveries and serve as a deterrent against fraud.

Level of Compliance: **Partial Compliance**

PERD's 2007 performance review noted that West Virginia had a process for pursuing civil action against providers, WVC §9-7-6, but the DHHR rarely pursued this option. The provisions of WVC §9-7-6 state the following:

Any person, firm, corporation or other entity which willfully, by means of a false statement or representation, or by concealment of any material fact, or by other fraudulent scheme, devise or artifice on behalf of himself, herself, itself, or others, obtains or attempts to obtain benefits or payments or allowances under the medical programs of the Department of Health and Human Resources to which he or she or it is not entitled, or, in a greater amount than that to which he or she or it is entitled, shall be liable to the Department of Health and Human Resources in an amount equal to three times the amount of such benefits, payments or allowances to which he or she or it is not entitled, and shall be liable for the payment of reasonable attorney fees and all other fees and costs of litigation.

As of 2013, there are several issues that prevent the Legislative Auditor from finding the MFCU fully "In Compliance" with this recommendation.

The review found the DHHR only filed five civil suits against suspected providers from 2002 to 2005. It therefore recommended the DHHR increase the number of civil actions against suspected providers to increase recoveries and serve as a deterrent against fraud.

As of 2013, there are several issues that prevent the Legislative Auditor from finding the MFCU fully "In Compliance" with this recommendation.

Due to Staffing Issues, the MFCU has a Backlog of Referrals and Does Not Pursue Civil Fraud in State Court

Due to a lack of staffing, the MFCU has accumulated a significant backlog of fraud referrals, meaning fraud referrals are not investigated in a timely manner. For example, as of February 2013, the MFCU had yet to assign an investigator or launch an investigation on 5 referrals from 2008 and 18 referrals from 2009 (see Table 1). In total, the MFCU had 171 referrals from September 2008 to February 2013 that had yet to be assigned or investigated (see Table 1 and Appendix C). **As a result, many cases of suspected fraud remain uninvestigated for several years.**

Due to a lack of staffing, the MFCU has accumulated a significant backlog of fraud referrals, meaning fraud referrals are not investigated in a timely manner.

Table 1

Referrals to the MFCU That Have Not Been Investigated as of February 2013

Year of Referral	Number of Referrals
2008	5
2009	18
2010	26
2011	45
2012	72
2013	5
Total	**171**

Source: Medicaid Fraud Control Unit, Referrals Accepted But Unassigned, 2008-2013

As a result, many cases of suspected fraud remain uninvestigated for several years.

To address this issue, the MFCU is in the process of hiring eight new staff members, which would allow the MFCU to increase caseload, thereby increasing the number of criminal convictions and the amount of recoveries in civil cases. However, the MFCU emphasizes that even with eight new employees it expects referrals will continue to exceed capacity. As a result, there are cases of potential fraud that are not being addressed in a timely manner. The MFCU also reports that it made a Request for Quotation to upgrade its case management software, but the process has been ongoing for over a year as the upgrade must be approved by five separate state offices: DHHR Management Information Services, the West Virginia Office of Technology, DHHR Purchasing, DHHR Finance, and the West Virginia Department of Administration.

Due to staffing issues the MFCU only pursues civil cases in federal court, wherein the MFCU turns prosecution over to a federal prosecutor who directs the litigation.

Furthermore, due to staffing issues the MFCU only pursues civil cases in federal court, wherein the MFCU turns prosecution over to a federal prosecutor who directs the litigation. According to the MFCU, federal prosecutors will sometimes impose thresholds and other criteria when deciding whether to accept an MFCU case. As such, from 2007 to 2011 the MFCU pursued a total of seven cases in federal court (U.S.

District Court). The MFCU does not currently pursue civil fraud cases in state court due to lack of staffing, but plans to develop state civil fraud procedures once it hires a second attorney: "Pursuing civil actions by MFCU attorneys in state court under §9-7-6 remains a goal of the unit based on the 2007 PERD report."

Since the MFCU is not pursuing fraud cases in state court, there is a potential loss of collectible funds, as cases that do not meet the federal prosecutors' criteria for acceptance are not prosecuted in federal court. As a result, West Virginia does not have adequate disincentive to prevent Medicaid providers from committing fraud. While it was beyond the scope of this performance update to examine staffing levels, **the Legislative Auditor recommends the MFCU hire and retain an appropriate level of staff in order to eliminate its backlog of referred cases and pursue civil fraud cases in state court.**

Since the MFCU is not pursuing fraud cases in state court, there is a potential loss of collectible funds, as cases that do not meet the federal prosecutors' criteria for acceptance are not prosecuted in federal court.

Due to Unfounded Concerns Regarding Federal CMS Policy, the MFCU Does Not Pursue Civil Cases in Which There Is a Risk of Bankruptcy

The MFCU is concerned about the potential loss of state funds due to provider bankruptcies and therefore is not pursuing civil cases that have a risk of the provider declaring bankruptcy. The MFCU states this concern as such:

> *When a settlement is reached, the Centers for Medicaid and Medicaid Services (CMS) takes back the federal matching portion of the Medicaid recovery (for WV around 75%). CMS has taken the position that all recoveries are subject to federal reimbursement upon the court finding. So if a provider is ordered to pay $1 million in restitution and damages to West Virginia for losses to the Medicaid program, CMS has taken the position that West Virginia should pay back the matching share of the entire ordered amount (in this case around $750,000) even if the provider can't pay the ordered amount. Therefore, MFCU takes into consideration the collect ability of a judgment before pursuing civil action. Collectability plays no factor in determining whether to pursue criminal charges against a provider.*

The MFCU is concerned about the potential loss of state funds due to provider bankruptcies and therefore is not pursuing civil cases that have a risk of the provider declaring bankruptcy.

The Legislative Auditor finds these concerns are unfounded because the evidence shows the federal CMS does not require state Medicaid programs to pay back the federal matching portion of the Medicaid recovery in the event of a provider bankruptcy.

The Legislative Auditor finds these concerns are unfounded because the evidence shows the federal CMS does not require state Medicaid programs to pay back the federal matching portion of the Medicaid recovery in the event of a provider bankruptcy. According to 42 USC §1396b(d)(2)(D)(i), the State is not required to pay the FMAP rate to the federal CMS when the State is unable, due to bankruptcy,

to recover a debt which represents an overpayment:

> ***(i)*** *In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).*

In May 2012, the federal CMS reasserted this policy in the Federal Register:

> *Under §411.318, a State Medicaid agency will not be required to repay the Federal share of a discovered overpayment if a provider is determined to be bankrupt or out of business in accordance with §433.318.*

Furthermore, the BMS does not agree with the MFCU on its perception of the federal government's policies towards bankruptcies: "CMS does not require states to return the FMAP portion of a settlement or Default Judgment Order if the provider declares bankruptcy."

Since the MFCU is not pursuing certain civil cases due to "collectability considerations," West Virginia again does not have adequate disincentive to prevent Medicaid providers from committing fraud. This practice undermines the integrity of the state Medicaid program and is based on unfounded concerns regarding federal policy. **Therefore, the Legislative Auditor recommends the MFCU pursue civil cases regardless of potential provider bankruptcies.**

The Legislative Auditor finds the MFCU is pursuing triple recoveries in federal court according to the provisions in WVC §9-7-6. However, the MFCU's lack of staffing, lack of state civil prosecutions, unfounded concerns over federal CMS policies, lack of communication with the BMS, and dependence on global cases demonstrate areas that still require improvement.

The Legislative Auditor finds the MFCU is pursuing triple recoveries in federal court according to the provisions in WVC §9-7-6. However, the MFCU's lack of staffing, lack of state civil prosecutions, unfounded concerns over federal CMS policies, lack of communication with the BMS, and dependence on global cases demonstrate areas that still require improvement.

Recommendation 7

> *The Bureau for Medical Services should conduct prepayment review of claims filed by providers who have been the object of fraud investigations or litigations in the recent past.*

Level of Compliance: **Non-Compliance**

PERD's 2007 performance review made the following finding regarding BMS pre-payment review:

> *A representative of the BMS stated in communications with the Legislative Auditor's staff that BMS software has the capability to flag providers for prepayment review. The BMS, however, does not use this option and has never flagged providers for review…. Medicaid claims filed by providers who have a suspect past should receive added scrutiny in the form of pre-payment review.*

The 2007 review found several providers who had been the target of recent fraud investigation and owed overpayments to the BMS. One such provider, a major pharmacy chain, paid West Virginia a $406,000 settlement in 2004, yet by 2007 the pharmacy owed several overpayments to the State, totaling $17,000.

The 2007 review found several providers who had been the target of recent fraud investigation and owed overpayments to the BMS. One such provider, a major pharmacy chain, paid West Virginia a $406,000 settlement in 2004, yet by 2007 the pharmacy owed several overpayments to the State, totaling $17,000. Therefore, the 2007 review recommended the BMS conduct pre-payment review on once-suspected providers to help prevent unnecessary payments.

As of 2013, the Legislative Auditor finds the BMS is not conducting pre-payment review of claims filed by providers who have been the object of prior fraud investigations or litigations. In fact, the BMS has never placed any provider on prepayment review. To clarify, pre-payment review refers to the medical review, performed by the state Medicaid agency or its contractor, of a claim submitted by a Medicaid provider prior to the state Medicaid agency making payment to the provider for that claim. The federal CMS currently conducts pre-payment review for Medicare, but no federal or state entity is conducting pre-payment review in West Virginia's Medicaid program.

As of 2013, the Legislative Auditor finds the BMS is not conducting pre-payment review of claims filed by providers who have been the object of prior fraud investigations or litigations.

Prepayment Review Strategy Suggestions for the BMS

There are a considerable number of strategies and techniques available for states to utilize in conducting pre-payment review. For West Virginia, the Legislative Auditor examined prepayment strategies utilized by neighboring states (for Medicaid) and the federal CMS (for Medicare). As a result, the Legislative Auditor identified three types of prepayment review strategies the BMS could implement in West Virginia's Medicaid program to help prevent losses due to improper payments.

First, the BMS could benefit from the more extensive and detailed *non-random prepayment medical review,* which the federal CMS defines as follows:

> *Non-random prepayment medical review means the prepayment medical review of claim information and medical documentation, by nonclinical or clinical medical review staff, for a billed item or service identified by data analysis techniques or probe review to have a likelihood of sustained or high level of payment error.*

This type of review would allow the BMS to determine, before paying a claim, whether an item or medical service is reasonable and necessary given the patient's condition.

This type of review would allow the BMS to determine, before paying a claim, whether an item or medical service is reasonable and necessary given the patient's condition. For Medicare, the federal CMS determines the types of claims that deserve prepayment review by examining national and local claims data, recipient complaints, and alerts from federal organizations such as the DHHS and the U.S. Government Accountability Office. For Medicaid, Ohio and Pennsylvania also operate a claims-based *non-random pre-payment medical review*. Ohio flags certain types of claims, such as hysterectomies, and a doctor or nurse will perform a medical review of supporting documentation *before* the state makes any payment. Pennsylvania utilizes predictive modeling to attach a score to all outpatient and professional claims prior to payment. Staff then review the highest-rated claims and determine whether to pay, deny, or flag the claim for detailed medical review.

Through data analytics capabilities, such as those provided to the BMS by Truven Health Analytics, the BMS could use the national and local claims data to determine the types of claims that have a high level of payment error. This would allow the BMS to create a claims-based flagging system that automatically identifies types of claims that require *non-random pre-payment medical review.* **Therefore, the Legislative Auditor recommends the BMS develop a claims-based flagging system for the purpose of implementing pre-payment review on Medicaid claims.**

One method for identifying providers to place on pre-payment review is to determine, through predictive modeling or a probe review, that a provider has a high billing error rate.

Second, the BMS could also utilize pre-payment review to add an additional layer of scrutiny on the providers themselves. In contrast to claims-based flagging wherein the BMS identifies certain types of claims for prepayment review, a provider-based flagging system would require specific providers to undergo pre-payment review for all of their claims. One method for identifying providers to place on pre-payment review is to determine, through predictive modeling or a probe review, that a provider has a high billing error rate.

In determining what action the BMS takes when providers have a high billing error rate, the Legislative Auditor's staff asked the BMS the following question:

> *If a provider has a higher billing error rate compared to other providers in that category, would the BMS suspend payments and conduct pre-payment review on every claim that provider files?*

The BMS responded with the following:

> *The rate turnover for physician office staff filing Medicaid claims is very high. There are very complex rules in what can and cannot be billed. What constitutes a high billing error rate? There is not a national standard for billing error rates.*

The answer to the BMS's response lies in the federal CMS's current practices for Medicare prepayment review. The federal CMS explains the process in the following statement:

> *When a probe confirms or determines whether a provider or supplier is billing the program in error, and those billing errors present a likelihood of sustained or high level of payment error (for example, a high billing error rate or errors on claims representing high dollar value) this may result in the provider or supplier being placed by the contractor on non-random prepayment complex medical review.*

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The federal CMS states that Medicare contractors establish appropriate billing error rates and determine when a provider exceeds that level. When a provider who has been placed on pre-payment review returns to an appropriate billing error rate, the contractor removes that provider from pre-payment review. While this type of review can present an administrative burden on innocent providers, the federal CMS explains how a probe review can better target providers and prevent improper payments:

> *Performing medical review on a sample of claims for a specific billing code before placing the provider or supplier on non-random prepayment complex medical review allows for a determination as to whether a problem exists, ensures that contractor medical review resources are targeted appropriately, and ensures that providers and suppliers are not unnecessarily burdened.*

Performing medical review on a sample of claims for a specific billing code before placing the provider or supplier on non-random prepayment complex medical review allows for a determination as to whether a problem exists, ensures that contractor medical review resources are targeted appropriately, and ensures that providers and suppliers are not unnecessarily burdened.

Pennsylvania also has a system in place wherein the state can select certain providers for pre-payment review based on high billing error rates, high number of complaints or other reasons. When the agency conducts pre-payment review on these providers, it notifies the provider that all their claims will be subject to pre-payment review, though the agency may choose to only examine certain types of claims from the flagged provider. However, due to lack of resources, Pennsylvania does not utilize this method very often.

Conducting pre-payment review on providers with high billing error would strengthen the integrity of West Virginia's Medicaid program

by allowing the state to better prevent incorrect payments rather than issuing payments to providers up-front and then launching post-payment investigations. **Therefore, the Legislative Auditor recommends the BMS develop a provider-based flagging system to identify providers with high billing error rates for the purpose of implementing pre-payment review on select Medicaid providers.**

Conducting pre-payment review on providers with high billing error would strengthen the integrity of West Virginia's Medicaid program by allowing the state to better prevent incorrect payments rather than issuing payments to providers up-front and then launching post-payment investigations.

Lastly, the BMS could comply with the 2007 recommendation by utilizing pre-payment review to add an additional layer of scrutiny on providers who have been the object of fraud investigations or litigations in the recent past. This strategy would be similar to the provider-based flagging system since the BMS would still review all claims submitted by select providers. However, this strategy would not be based on current levels of billing error rates, but on the provider's recent history. If a provider's behavior in the past was suspicious enough to warrant several investigations and/or litigations, the BMS should place the provider on a probationary period in which the BMS will conduct pre-payment review on all claims the provider submits.

If a provider's behavior in the past was suspicious enough to warrant several investigations and/or litigations, the BMS should place the provider on a probationary period in which the BMS will conduct pre-payment review on all claims the provider submits.

Pennsylvania and Kentucky have established similar practices for providers with a suspect past. Pennsylvania currently utilizes pre-payment review based on provider history, but this practice is not used as often as post-payment review and on-site review of repeat offenders. According to Pennsylvania staff, the main issue in conducting this type of pre-payment review is, again, lack of resources. Kentucky does not automatically subject providers to pre-payment review after a fraud investigation or litigation, but staff reported that "[e]ach case would be weighed on the specific facts and circumstances when determining whether a provider should be placed on pre-payment review."

By creating a provider-based flagging system to temporarily place once-suspected Medicaid providers on pre-payment review, the BMS could prevent improper payments, discourage fraudulent behavior, and comply with the pre-payment review recommendation from PERD's 2007 performance review.

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The BMS Is Concerned About Possible Issues Involved in Implementing Pre-payment Review

In communications with the Legislative Auditor, the BMS stated the following regarding its process for what is, in effect, claims-based pre-payment review:

> *The fiscal agent's claims processing system has edits capabilities that allows suspension of payments on specific types of claims (for example, a sterilization/hysterectomy*

> *procedure that requires consent form) until BMS staff has examined the supporting medical documentation from that provider. This functionality is currently in use.*

As such, the Legislative Auditor requested the number of claims the BMS flagged for prepayment review in 2012 (i.e. the number the BMS identified as requiring additional medical documentation prior to the BMS issuing payment). In the following response, the BMS stated it does not conduct this type of prepayment review:

> *If you are wanting cases in which we suspended claim adjudication because additional medical documentation was required to ensure the service billed was appropriate, the Bureau has already disclosed that we have not performed any of those type of prepayment reviews*.

Given the latter statement from the BMS, the Legislative Auditor must conclude that the BMS does not perform claims-based pre-payment review.

These statements are contradictory, and the Legislative Auditor made several attempts to determine whether the BMS conducts claims-based pre-payment review. Given the latter statement from the BMS, the Legislative Auditor must conclude that the BMS does not perform claims-based pre-payment review.

The BMS also does not perform provider-based pre-payment review. The agency listed the following concerns in implementing provider-based prepayment review:

- *alerting providers of a review which may impede court action,*
- *federal prompt-pay regulations,*
- *staffing required to perform manual review of claims,*
- *legal implications that may result in conducting pre-payment review if the provider is found not guilty or further review determined the suspected activity was not fraudulent, and*
- *the cost associated with additional contractor staffing that would be required verses the benefit or savings that would result from such review and assurance for continued compliance with federal prompt pay standards.*

The BMS also does not perform provider-based pre-payment review.

The Bureau explained the concern for possible legal implications, as noted in the fourth bullet above, by stating that it would seek legal advice if

- the provider's billings were appropriate, and
- the continued use of pre-payment review could be interpreted as retaliatory.

To clarify, the recommendations in these reports are not designed for use on providers who are currently the focus of an MFCU fraud investigation, especially if the MFCU is building a criminal case against the provider. The pre-payment review strategies identified in this report and PERD's 2007 performance review are designed to prevent the BMS from making improper and unnecessary payments to high-risk providers and on high-risk claims.

To clarify, the recommendations in these reports are not designed for use on providers who are currently the focus of an MFCU fraud investigation, especially if the MFCU is building a criminal case against the provider.

Regarding the BMS's concern about legal implications, the BMS would be conducting pre-payment review to prevent improper payments on claims with a high billing error rate, providers with a high billing error rate, and providers who have demonstrated suspicious behavior *in the past.* This strategy is designed to help prevent the BMS from making improper payments on the claims and providers that represent the highest risk of error and fraud. This strategy is focused on prevention, rather than the detection and investigation of fraud. Like other states, the BMS detects fraud through a strategy known as "pay-and-chase" wherein the BMS pays provider claims up-front and then conducts *post-payment* data mining operations to determine the validity of those claims. If the BMS detects fraudulent activity during the course of this data mining, it should then refer the matter to the MFCU for a thorough investigation. As noted in Recommendation 6, it is likely the MFCU would not launch or complete such an investigation in a timely manner. Therefore, it is essential that the BMS conduct pre-payment review to ensure the State is not making improper payments to providers and on claims that pose the greatest risk to the Medicaid program.

This strategy is designed to help prevent the BMS from making improper payments on the claims and providers that represent the highest risk of error and fraud. This strategy is focused on prevention, rather than the detection and investigation of fraud.

Regarding staffing levels and federal prompt pay regulations, the Legislative Auditor's staff asked the OQPI if, with appropriate staffing levels, it could perform pre-payment claim reviews of providers while still adhering to federal prompt pay regulations. The OQPI responded with the following:

> *At this time the Bureau would not be able to respond to staffing levels or whether it would be appropriate to utilize OQPI staff to perform these types of review*s…. *It may be more appropriate for BMS to define prepayment criteria and utilize the fiscal agent contract staff to implement such review if that approach is deemed appropriate and cost effective.*

The Legislative Auditor will address the issue of OQPI staffing in greater detail in an upcoming report.

The Legislative Auditor does not believe these concerns should prevent the BMS from implementing pre-payment review. The three strategies outlined in this section will strengthen the integrity of West

Virginia's Medicaid program by placing more emphasis on prevention, rather than the traditional "pay-and-chase" strategy. In a statement to the Legislative Auditor, the federal CMS emphasized the importance of new preventive and prepayment approaches to "avoid improper payments and costly efforts to recoup monies that have already gone out the door." To that end, the BMS should consider implementing the pre-payment review strategies as recommended in this report.

In a statement to the Legislative Auditor, the federal CMS emphasized the importance of new preventive and prepayment approaches to "avoid improper payments and costly efforts to recoup monies that have already gone out the door." To that end, the BMS should consider implementing the pre-payment review strategies as recommended in this report.

The BMS Plans to Implement Predictive Modeling

While the BMS has not implemented pre-payment review, it is currently working towards implementing a predictive modeling tool, "a modeling system in which information extrapolated from historical data is applied to the projection of future outcomes." The Small Business Jobs Act of 2010 requires states to implement predictive analytic technologies in their Medicaid program by 2015. In the following description, the federal CMS explains why it recommends the utilization of predictive modeling in prepayment reviews:

> *While recognizing that some pay-and-chase activities will always be necessary, the Center for Program Integrity has implemented powerful new anti-fraud tools provided by Congress, as well as designed and implemented large-scale, innovative improvements to our Medicare and Medicaid program integrity strategy to shift beyond a "pay and chase" approach by focusing new attention on preventing fraud. One of the core elements of this strategy is a new Fraud Prevention System (FPS), which applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing patterns.*

While the BMS has not implemented pre-payment review, it is currently working towards implementing a predictive modeling tool, "a modeling system in which information extrapolated from historical data is applied to the projection of future outcomes."

Currently, however, the BMS's system is not yet fully functional. The predictive modeling tool was included in the scope of a contract awarded in December 2011 to Truven Health Analytics, and the BMS expects this will be fully implemented in March 2014. **Therefore, the Legislative Auditor recommends the BMS utilize the predictive modeling tool, once it is fully implemented, to establish criteria such as appropriate billing error rates for the claims-based and provider-based flagging systems recommended in this report.**

Currently, however, the BMS's system is not yet fully functional.

Recommendation 8

The Bureau for Medical Services should refer any cases involving a question of fraud to the Medicaid Fraud Control Unit.

Level of Compliance: **Partial Compliance**

PERD's 2007 performance review found the BMS was not referring an adequate number of suspected fraud cases to the MFCU.

PERD's 2007 performance review found the BMS was not referring an adequate number of suspected fraud cases to the MFCU. The BMS made a total of 33 referrals from 2001 to 2006, with only two referrals in both 2004 and 2005. These referrals account for only 13% of all referrals made from 2001 to 2006, while "global" cases comprised a substantial portion of the remainder. For 2002, 2004, and 2005, the MFCU was not able to recover any money from any BMS referral. As the review noted, BMS referrals are vital to the MFCU's fund recoveries and are typically of a higher quality than referrals from other sources.

As of 2013, the OQPI has developed a new Medicaid Fraud Referral Form to better facilitate the referral process.

As of 2013, the OQPI has developed a new Medicaid Fraud Referral Form to better facilitate the referral process. On the front cover of the form is a "Recommended Standard for Determining Whether a Case Should be Referred to MFCU." This is followed by the definition of fraud as established by 42 CFR 455.2. The form itself is comprehensive and includes such information as

- provider information,
- source of referral,
- Factual Explanation of Allegation,
- OQPI referring staff member, and
- a list of actions to be taken.

Unfortunately, the BMS states that there are no written policies for employees to follow in distinguishing between suspected fraud and accidental overpayment.

Unfortunately, the BMS states that there are no written policies for employees to follow in distinguishing between suspected fraud and accidental overpayment. Federal regulation 42 CFR 433.304 defines "fraud" and "overpayment" as follows:

> *Fraud (in accordance with §455.2) means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.*
>
> *Overpayment means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.*

According to the OQPI, its staff regularly participates in external training at the Medicaid Integrity Institute, funded by the federal government, "… to instruct program integrity Medicaid staff in all states on the identification of potential issues via data mining or data reviews specific to Medicaid." While this training will surely help OQPI staff better determine if any specific overpayment can be qualified as suspected fraud, the information gathered at these external training sessions should be developed into a standard manual for current and future employees to follow. Since the BMS is responsible for overpayments and the MFCU is responsible for cases involving fraud, it is essential that OQPI employees can consistently and objectively distinguish between overpayments and suspected fraud so it can send referrals to the appropriate office.

Since the BMS is responsible for overpayments and the MFCU is responsible for cases involving fraud, it is essential that OQPI employees can consistently and objectively distinguish between overpayments and suspected fraud so it can send referrals to the appropriate office.

This is especially important given the low number of referrals the BMS sent to the MFCU from 2007-2009 (see Table 2). According to the BMS, there are more than 25,000 Medicaid providers operating in West Virginia. With 25,000 providers, and the national rate of Medicaid fraud estimated at 10 percent, it seems unlikely that the number of suspicious Medicaid filings in West Virginia could be far less than 1 percent. The Legislative Auditor commends the BMS for developing a standardized fraud referral form and increasing the number of referrals from the BMS to the MFCU in recent years. **However, the Legislative Auditor recommends the BMS coordinate with the MFCU to create written policies that establish objective criteria for employees to follow in distinguishing between overpayment cases that the BMS would handle and cases that should be referred to the MFCU.**

This is especially important given the low number of referrals the BMS sent to the MFCU from 2007-2009.

Table 2
Number of Cases the BMS Referred to the MFCU
2007-2011

Year	Number of referrals
2007	10
2008	7
2009	11
2010	50
2011	84

Source: The Bureau for Medical Services, Referral Data, 2007-2011

The MFCU Is Not Launching Investigations in a Timely Manner

While referrals from the BMS to the MFCU await investigation, suspected providers are allowed to continue operation, because, according to both the MFCU and the BMS, suspending payments could likely compromise a criminal investigation. However, Chapter 800.6 of the West Virginia Medicaid Provider Manual states the following in regard to suspension of payment: "A suspension of payment to a provider *shall* [emphasis added] be performed when there is a credible allegation of fraud." The Legislative Auditor will address this issue in greater detail in an upcoming report.

While referrals from the BMS to the MFCU await investigation, suspected providers are allowed to continue operation, because, according to both the MFCU and the BMS, suspending payments could likely compromise a criminal investigation.

Suspending payments prior to conducting an investigation could seriously disrupt a provider's practice, which is especially harmful to the provider and patients if the investigation ultimately finds the provider innocent of any wrongdoing. On the other hand, providers that are allowed to operate prior to and during an MFCU investigation could possibly continue to commit fraud against the government, risk the health of their patients and potentially cost millions of dollars in taxpayer money. Therefore, it is essential that the MFCU launch investigations in a timely manner to maintain an appropriate balance between West Virginia's anti-fraud efforts and the needs of Medicaid providers and recipients.

Therefore, it is essential that the MFCU launch investigations in a timely manner to maintain an appropriate balance between West Virginia's anti-fraud efforts and the needs of Medicaid providers and recipients.

As noted in Recommendation 6, however, the MFCU currently operates with a significant lapse of time between the original referral to the MFCU and start of an investigation. To address this issue, the MFCU states that it is in the process of hiring staff and upgrading its case management software. In addition to having a lack of staff, the MFCU does not have a performance goal regarding the length of time in which cases can remain in "referred" status without being "opened." If the agency is successful in increasing staff to an appropriate level, it should combine its staff with performance goals and performance measures to decrease the time between receiving a referral and launching an investigation. **Therefore, once the MFCU achieves an appropriate staffing level, the Legislative Auditor recommends the MFCU develop a performance goal regarding the length of time in which cases can remain in "referred" status without being assigned and investigated.**

If the agency is successful in increasing staff to an appropriate level, it should combine its staff with performance goals and performance measures to decrease the time between receiving a referral and launching an investigation.

Recommendation 9

The Medicaid Fraud Control Unit should keep the Bureau for Medical Services better informed of the progress of investigations and both agencies should take steps to improve communications.

Level of Compliance: **Partial Compliance**

In PERD's 2007 performance review, the Director of the MFCU acknowledged that the MFCU did not routinely keep the BMS informed of the progress of Medicaid fraud investigations. In addition, the BMS and the MFCU had not conducted regular meetings as previously agreed upon in a "memorandum of understanding" between the two agencies. As a result, the BMS sent fewer referrals to the MFCU and, in some cases, initiated overpayment recoveries from providers when a fraud investigation would have been more appropriate.

In PERD's 2007 performance review, the Director of the MFCU acknowledged that the MFCU did not routinely keep the BMS informed of the progress of Medicaid fraud investigations.

As of 2013, the Legislative Auditor finds both agencies have made some progress in improving communications. According to the BMS, the creation of the aforementioned Medicaid Fraud Referral Form has greatly standardized fraud referrals and improved communication by clarifying the information the MFCU needs for its investigations. In addition, the MFCU and OQPI have conducted annual joint training for all staff to discuss fraud and program integrity issues. Since 2010, the MFCU and the OQPI have also scheduled monthly meetings in which they discuss referral updates and specific fraud schemes.

As of 2013, the Legislative Auditor finds both agencies have made some progress in improving communications.

There are two issues, however, that negatively impact effective communication between the MFCU and the BMS. First, as noted in Recommendation 8, the Medicaid Fraud Referral Form lacks written policies establishing objective criteria for employees to follow in distinguishing between suspected fraud and accidental overpayments. The referral process could be impacted by subjective opinions on what constitutes "suspected fraud." Thus, while the BMS is responsible for overpayments, the MFCU notes sometimes there is a fine line between overpayments and potential fraud, and as such, the MFCU notes "it would be beneficial for BMS to coordinate with MFCU on significant overpayment cases."

There are two issues, however, that negatively impact effective communication between the MFCU and the BMS.

Second, the scheduled monthly meetings between the MFCU and the BMS are not occurring on a consistent basis as scheduled. According to the meeting minutes, during 2010 the MFCU and the OQPI only met five times with no monthly meetings between June 2010 and November 2010. In 2011, the MFCU and the OQPI held only six monthly meetings. **Therefore, the Legislative Auditor recommends the MFCU and the BMS meet regularly in order to increase the level of communication between the two agencies.**

Recommendation 10

The Bureau for Medical Services, or its contractor, should perform data mining operations on targeted providers on a regular basis and provide that information to the Medicaid Fraud Control Unit.

Level of Compliance: **In Compliance**

PERD's 2007 performance review noted that the MFCU was legally prohibited from conducting data mining operations. It must therefore rely on the BMS to examine claims data for instances of suspected fraud, and then refer any such cases to the MFCU. The MFCU does not have access to these data, and the OQPI does not have the training to conduct fraud investigations. As a result, the 2007 review recommended the BMS regularly perform data mining operations on targeted providers.

PERD's 2007 performance review noted that the MFCU was legally prohibited from conducting data mining operations. It must therefore rely on the BMS to examine claims data for instances of suspected fraud, and then refer any such cases to the MFCU.

As of 2013, the Legislative Auditor finds that the BMS is conducting data mining operations on all providers on a regular basis. As noted earlier in the report, the OQPI is the specific office within the BMS responsible for identifying fraud, waste, and abuse cases. To execute this role, the OQPI performs data mining reviews on areas such as program affiliation, service categories, and service codes to identify possible billing aberrations. This involves the use of the Java Surveillance and Utilization Review Subsystem (J-SURS) software, developed and maintained by Truven Health Analytics to run "spike" reports that identify provider payments that fall outside the norm of similar provider types, categories, services, and codes. As the BMS explains it:

As of 2013, the Legislative Auditor finds that the BMS is conducting data mining operations on all providers on a regular basis.

> *For example, we probe the type and the number of services ordered by the provider, how many beneficiaries are seen in a day or over the course of a specified time, and for example compare it to peers of the same provider type and specialty as well as the appropriate manual chapter for the established service limits, medically necessary requirements and/or billing patterns and practices.*

Therefore, the Legislative Auditor finds the BMS "In Compliance" with this recommendation.

Conclusion

The BMS and the MFCU have made progress in responding to the 2007 recommendations. Some of the progress from the BMS, however, came as the direct result of federal regulations enacted since 2007. Those regulations reflect the recommendations made by the Legislative Auditor in the 2007 performance review.

The BMS and the MFCU have made progress in responding to the 2007 recommendations. Some of the progress from the BMS, however, came as the direct result of federal regulations enacted since 2007. Those regulations reflect the recommendations made by the Legislative Auditor in the 2007 performance review. This review also indicates some areas that require improvement, and those have been compiled into new recommendations designed to improve the effectiveness, efficiency, and integrity of the West Virginia Medicaid program. Based on the data provided in the MFCU Annual Reports, the MFCU's recoveries on criminal and civil cases from 2008-2011 showed a return on investment

of $13.10 for every $1 spent. By comparison, in 2012 the 50 MFCUs across the country showed a return on investment of $13.48 for every $1 spent. While this demonstrates that West Virginia is near the national average for return on investment, the BMS and the MFCU can still increase recoveries and better protect the financial resources of the Medicaid program by working together to strengthen detection and prevention strategies against wasteful spending and fraud; implement new deterrents against providers who seek to commit fraud; reduce the length of time between the detection, investigation, and prosecution of fraud; and improve inter-agency communications.

While this demonstrates that West Virginia is near the national average for return on investment, the BMS and the MFCU can still increase recoveries and better protect the financial resources of the Medicaid program by working together to strengthen detection and prevention strategies against wasteful spending and fraud; implement new deterrents against providers who seek to commit fraud; reduce the length of time between the detection, investigation, and prosecution of fraud; and improve inter-agency communications.

Recommendations

1. *The MFCU should hire and retain an appropriate level of staff in order to eliminate its backlog of referred cases and pursue civil fraud cases in state court.*

2. *The MFCU should pursue civil cases regardless of potential provider bankruptcies.*

3. *The BMS should develop a claims-based flagging system for the purpose of implementing pre-payment review on Medicaid claims.*

4. *The BMS should develop a provider-based flagging system to identify providers with high billing error rates for the purpose of implementing pre-payment review on select Medicaid providers.*

5. *The BMS should utilize the predictive modeling tool, once it is fully implemented, to establish criteria such as billing error rates for the claims-based and provider-based flagging systems recommended in this report.*

6. *The BMS should coordinate with the MFCU to create written policies that establish objective criteria for employees to follow in distinguishing between overpayment cases that the BMS would handle and cases that should be referred to the MFCU.*

7. *Once the MFCU achieves an appropriate staffing level, it should develop a performance goal regarding the length of time in which cases can remain in "referred" status without being assigned and investigated.*

8. *The MFCU and the BMS should meet regularly in order to increase the level of communication between the two agencies.*

ISSUE 2

The Medicaid Fraud Control Unit Does Not Adequately Communicate with Occupational Licensing Boards, and the Medicaid Fraud Control Unit Should Further Develop Its Case Prioritization Procedure.

Issue Summary

As indicated in Issue 1, the MFCU and the BMS do not communicate adequately between themselves. In addition, we found the MFCU does not adequately communicate with occupational licensing boards when pursuing a civil or criminal case against a Medicaid provider. We also found the MFCU had not created a case prioritization document until the Legislative Auditor requested evidence of one. By not communicating effectively with the occupational licensing boards the MFCU could prevent the board from filing disciplinary measures against providers within the statute of limitations. By not developing an objective, written case prioritization procedure, the MFCU risks selecting cases for investigation based on subjective criteria.

By not communicating effectively with the occupational licensing boards the MFCU could prevent the board from filing disciplinary measures against providers within the statute of limitations. By not developing an objective, written case prioritization procedure, the MFCU risks selecting cases for investigation based on subjective criteria.

The MFCU's Case Prioritization Procedure Is Relatively New and Has Not Been Incorporated Into the Policies and Procedures Handbook

During the course of this review, the MFCU created a document titled "Referral Screening Report" document on February 15, 2013 as a result of the Legislative Auditor requesting all policy documents regarding case prioritization. The document is based on a points system designed to assign each referral a "solvability weight," which determines how quickly the MFCU will assign the referral to an investigator and launch an investigation. Some questions fall under a binary yes or no, and points are assigned accordingly, while other questions are on a sliding scale and are assigned points based on the strength of the answer.

During the course of this review, the MFCU created a document titled "Referral Screening Report" document on February 15, 2013 as a result of the Legislative Auditor requesting all policy documents regarding case prioritization. The document is based on a points system designed to assign each referral a "solvability weight," which determines how quickly the MFCU will assign the referral to an investigator and launch an investigation.

Unfortunately, the document does not provide objective criteria for employees to utilize in assigning points on the sliding scale. As a result, the "solvability weight" assigned to each case is subjective and can greatly fluctuate from employee to employee. **Therefore, the Legislative Auditor recommends the MFCU develop objective criteria for the sliding scale questions in the "Referral Screening Report," which would facilitate a standard and consistent "solvability weight" for all incoming referrals.** In addition, the MFCU states that the document has not yet been incorporated into the Policies and Procedures Handbook. **Therefore, the Legislative Auditor recommends the MFCU incorporate the "Referral Screening Report" into the Policies**

and Procedures Handbook as soon as possible. While we commend the MFCU for creating a potentially objective and efficient method for prioritizing referrals, in its current state cases are not being prioritized according to objective criteria.

Neither the BMS nor the MFCU Contacts State Occupational Licensing Boards Regarding Ongoing Court Cases

In the case the Legislative Auditor examined as part of Recommendation 6, the Board of Medicine was not aware of a civil court case, investigated and assisted by the MFCU, against a provider operating in West Virginia until three months after the case was closed. This case began as a joint investigation with the federal DHHS and the MFCU, ending in a U.S. District Court three and a half years later. During that time, neither the BMS nor the MFCU contacted the Board regarding the case. In fact, the Board states it has little to no communication with the BMS, and must always rely on the federal entities such as the DHHS, the federal CMS, or the courts for issues regarding Medicaid and West Virginia physicians. Furthermore, the MFCU stated it does not contact state occupational licensing boards when filing a civil or criminal case.

In fact, the Board states it has little to no communication with the BMS, and must always rely on the federal entities such as the DHHS, the federal CMS, or the courts for issues regarding Medicaid and West Virginia physicians. Furthermore, the MFCU stated it does not contact state occupational licensing boards when filing a civil or criminal case.

There is no legal requirement in either the West Virginia Code or state rules that requires the DHHR to notify the relevant occupational licensing board when filing a civil or criminal case against a Medicaid provider. However, Chapter 800.6 of the West Virginia Medicaid Provider Manual states that when the BMS has identified "unnecessary and/or inappropriate practices" through conducting reviews, the BMS *may* refer the matter to "the provider's licensing and/or certifying body(ies)" for appropriate action. In the case mentioned in Recommendation 6, when the court notified the Board about the case, the Board launched an investigation and revoked the provider's license. The provider, however, appealed the revocation and won on the grounds that the statute of limitations had expired. Therefore, had either the BMS or the MFCU notified the Board regarding this case, the Board could have taken appropriate action within the required time limit.

The Legislative Auditor understands that releasing information to the Board too soon can compromise and investigation. However, the MFCU or the BMS should have contacted the Board at some point regarding this case. As a result, when the Board attempted to implement disciplinary measures, the statute of limitations had expired.

The Legislative Auditor understands that releasing information to the Board too soon can compromise an investigation. However, the MFCU or the BMS should have contacted the Board at some point regarding this case. As a result, when the Board attempted to implement disciplinary measures, the statute of limitations had expired. As a result, the provider is still operating in West Virginia. **Therefore, the Legislative Auditor recommends the MFCU and the BMS notify the relevant occupational licensing boards when filing a civil or criminal case against a Medicaid provider.**

Conclusion

If the BMS and the MFCU address the problems identified above, West Virginia will have a uniform system of case prioritization and increased communication between the DHHR and occupational licensing boards. Improvements in these areas ensure a more comprehensive and thorough approach to combating Medicaid fraud across the state. In combination with the recommendations from Issue 1, the recommendations listed below provide a framework for both the BMS and the MFCU to create a more effective and efficient Medicaid program for West Virginia.

If the BMS and the MFCU address the problems identified above, West Virginia will have a uniform system of case prioritization and increased communication between the DHHR and occupational licensing boards.

Recommendations

9. *The MFCU should create objective criteria for the sliding scale questions in the "Referral Screening Report", which would ensure a standard and consistent "solvability weight" for all incoming referrals.*

10. *The MFCU should incorporate the "Referral Screening Report" into the Policies and Procedures Handbook as soon as possible.*

11. *The MFCU and the BMS should notify the relevant occupational licensing boards when filing a civil or criminal case against a Medicaid provider.*

Appendix A
Transmittal Letter

WEST VIRGINIA LEGISLATURE
Performance Evaluation and Research Division

Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610
(304) 347-4890
(304) 347-4939 FAX

John Sylvia
Director

September 5, 2013

Karen L. Bowling, Cabinet Secretary
West Virginia Department of Health & Human Resources
One Davis Square, Suite 100 East
Charleston, West Virginia 25301

Dear Secretary Bowling:

This is to transmit a draft copy of the Medicaid Fraud Performance Update for the Bureau for Medical Services and the Medicaid Fraud Control Unit. This report is scheduled to be presented during the September 23-25 interim meeting of the Joint Committee on Government Operations, and the Joint Committee on Government Organization. We will inform you of the exact time and location once the information becomes available. It is expected that a representative from your agency be present at the meeting to orally respond to the report and answer any questions the committees may have.

We need to schedule an exit conference to discuss any concerns you may have with the report. We would like to have the meeting between September 10-12th. Please notify us to schedule an exact time. In addition, we need your written response by noon on September 12th in order for it to be included in the final report. If your agency intends to distribute additional material to committee members at the meeting, please contact the House Government Organization staff at 340-3192 by Thursday, September 19th to make arrangements.

We request that your personnel not disclose the report to anyone not affiliated with your agency. Thank you for your cooperation.

Sincerely,

John Sylvia

John Sylvia

Enclosure

Joint Committee on Government and Finance

Appendix B
Objective, Scope and Methodolgy

This Compliance and Further Monitoring of the Department of Health and Human Resources is required and authorized by the West Virginia Performance Review Act, Chapter 4, Article 10, Section 8(b)(5).

Objective

The objective of this review is to determine the extent to which the Bureau for Medical Services (BMS) and the Medicaid Fraud Control Unit (MFCU) have responded to recommendations from the January 2007 performance review.

Scope

The scope of this review focuses on the recommendations made in the 2007 performance review, and to what extent the agency has responded to these recommendations. The scope also incorporates a case brought to the Legislative Auditor's attention by the Department of Health and Human Resources (DHHR), which required a detailed examination and resulted in additional recommendations beyond those included in the 2007 performance review.

Methodology

This report contains information provided to the Legislative Auditor from both the BMS and the MFCU regarding their response to recommendations made in the January 2007 performance review. This review also required communication with and receipt of information from the Centers for Medicare and Medicaid Services within the U.S. Department of Health & Human Services, as well as the DHHR's Inspector General, the West Virginia Board of Medicine, the West Virginia Attorney General's Office, the United States District Court for the Northern District of West Virginia, the United States Bankruptcy Court for the Northern District of West Virginia, and the Brooke County Circuit Court. All interviews and verbal comments were confirmed by written statements and in many cases were confirmed by corroborating evidence. The Performance Evaluation and Research Division (PERD) staff then determined what level of compliance should be provided to the BMS and/or the MFCU on each recommendation.

In addition, during the course of this review, the Legislative Auditor identified $12,000 the BMS paid to the federal government unnecessarily. We found this issue to be material, but not specifically related to the objectives of this update. Therefore, the Legislative Auditor sent the BMS a management letter notifying the Bureau of the error and recommended it attempt to recoup the $12,000 from the federal government.

This performance review was conducted in accordance with generally accepted government auditing standards (GAGAS). GAGAS requires that the audit is planned and performed to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. The Legislative Auditor believes that the evidence obtained provides a reasonable basis for the report's findings and conclusions based on the audit objectives.

Levels of Compliance	
In Compliance	The Department of Health and Human Resources has corrected the problem(s) identified in the Legislative Auditor's 2007 report.
Partial Compliance	The Department of Health and Human Resources has partially corrected the problem(s) identified in the Legislative Auditor's 2007 report.
Planned Compliance	The Department of Health and Human Resources has not corrected the problem but has provided sufficient documentary evidence to find that the agency will do so in the future.
In Dispute	The Department of Health and Human Resources does not agree with either the problem identified or the proposed solution.
Non-Compliance	The Department of Health and Human Resources has not corrected the problem(s) identified in the Legislative Auditor's 2007 report.
Requires Legislative Action	The recommendation was intended to call the attention of the Legislature to one or more issues that may or may not require statutory changes.
Legislation Enacted	Legislature responded to issues raised in the Legislative Auditor's 2007 report.

Appendix C
Referrals to the MFC That Have Been Accepted but Remain Unassigned (As of February 2013)

Case Number	Date of Referral to the MFCU
08-0254R	9/16/2008
08-0255R	9/16/2008
08-0259R	9/16/2008
08-0266R	10/8/2008
08-0267R	9/16/2008
09-0086R	2/19/2009
09-0088R	4/20/2009
09-0089R	4/14/2009
09-0132R	5/5/2009
09-0181R	5/11/2009
09-0196R	6/22/2009
09-0211R	7/14/2009
09-0222R	9/18/2009
09-0242R	11/16/2009
09-0248R	10/1/2009
09-0251R	12/30/2009
09-0255R	9/14/2009
09-0258R	8/11/2009
09-0262R	8/29/2009
09-0264R	9/15/2009
09-0277R	6/16/2009
09-0278R	7/16/2009
09-0280R	10/13/2009
10-0079R	3/25/2010
10-0080R	2/23/2010
10-0098R	4/13/2010
10-0101R	4/13/2010
10-0123R	5/6/2010
10-0142R	5/20/2010
10-0144R	5/3/2010
10-0146R	6/1/2010
10-0159R	6/9/2010
10-0176R	6/10/2010
10-0237R	8/17/2010
10-0246R	9/16/2010
10-0258R	10/19/2010
10-0260R	10/22/2010
10-0265R	11/3/2010
10-0296R	12/14/2010

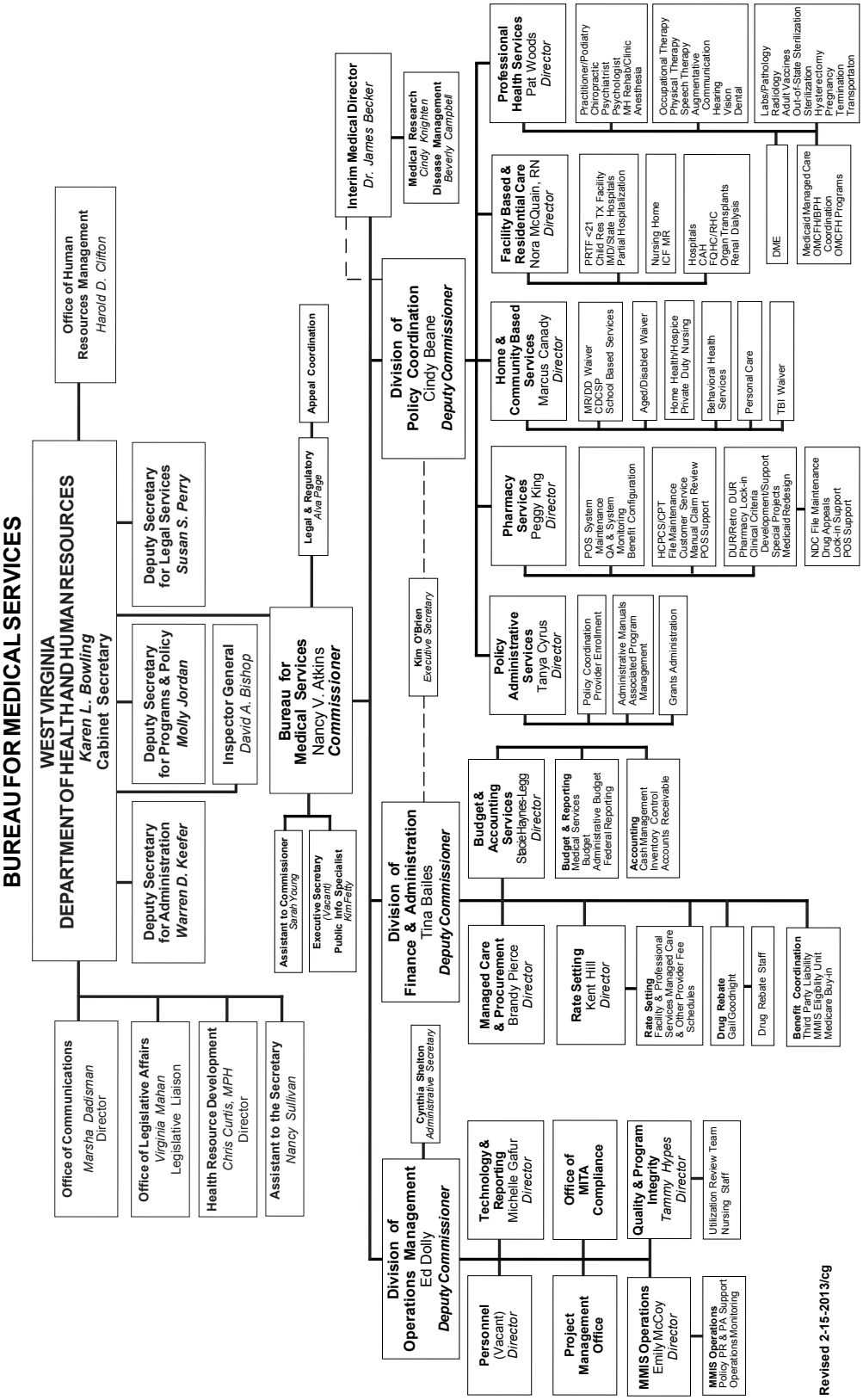
Case Number	Date of Referral to the MFCU
10-0298R	12/20/2010
10-0300R	12/30/2010
10-0303R	12/30/2010
10-0307R	8/16/2010
10-0308R	8/5/2010
10-0309R	8/23/2010
10-0310R	8/25/2010
10-0311R	3/11/2010
10-0312R	8/6/2010
10-0314R	8/23/2010
11-0002R	1/18/2011
11-0003R	1/18/2011
11-0007R	1/18/2011
11-0012	1/27/2011
11-0013R	1/28/2011
11-0016R	2/22/2011
11-0019R	3/15/2011
11-0020R	3/15/2011
11-0021R	3/15/2011
11-0022R	3/15/2011
11-0023R	3/15/2011
11-0024R	3/16/2011
11-0026R	3/16/2011
11-0027R	3/17/2011
11-0030R	3/21/2011
11-0031R	3/21/2011
11-0043R	4/15/2011
11-0045R	4/15/2011
11-0046R	4/15/2011
11-0051R	2/17/2011
11-0053R	3/25/2011
11-0061R	4/28/2011
11-0071R	5/9/2011
11-0077R	5/20/2011
11-0078R	5/20/2011
11-0080R	5/20/2011
11-0086R	5/19/2011
11-0089R	5/23/2011
11-0096R	6/5/2011

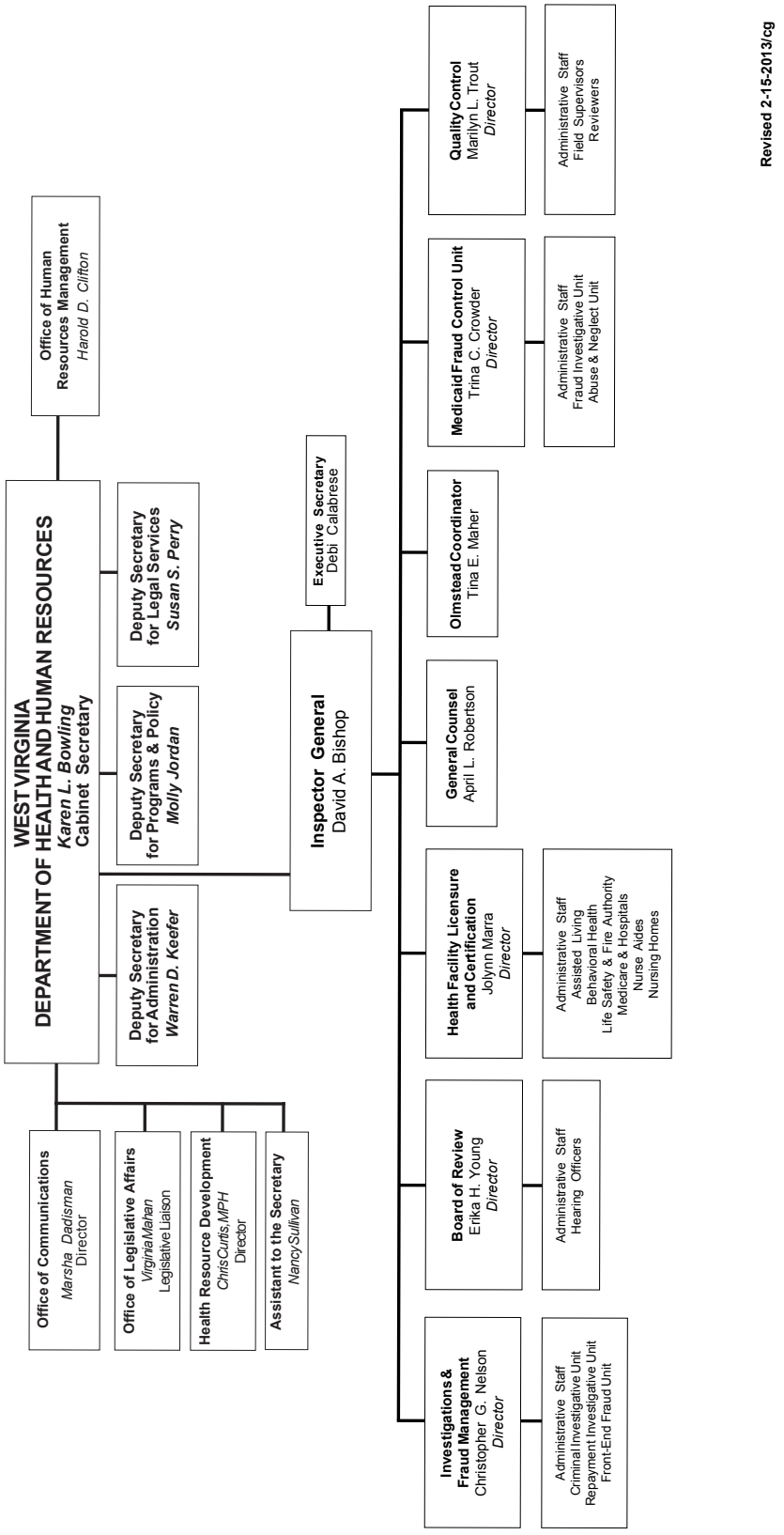
Case Number	Date of Referral to the MFCU
11-0099R	7/8/2011
11-0105R	6/27/2011
11-0142R	8/15/2011
11-0157R	4/15/2011
11-0184R	4/15/2011
11-0235R	9/22/2011
11-0245R	11/8/2011
11-0246R	10/19/2011
11-0247R	10/19/2011
11-0251R	9/26/2011
11-0254R	11/4/2011
11-0261R	10/21/2011
11-0263R	11/7/2011
11-0270R	11/2/2011
11-0271R	12/1/2011
11-0278R	5/19/2011
12-0005R	1/3/2012
12-0008R	1/17/2012
12-0016R	1/27/2012
12-0017R	1/27/2012
12-0019R	1/27/2012
12-0023R	2/10/2012
12-0029R	1/10/2012
12-0030R	1/27/2012
12-0031R	2/21/2012
12-0038R	3/7/2012
12-0046R	3/20/2012
12-0053R	3/21/2012
12-0056R	2/13/2012
12-0057R	1/30/2012
12-0059R	4/23/2012
12-0060R	4/23/2012
12-0078R	4/27/2012
12-0079R	4/9/2012
12-0090R	5/2/2012
12-0091R	5/18/2012
12-0092R	5/17/2012
12-0093R	5/17/2012
12-0095R	6/7/2012

Case Number	Date of Referral to the MFCU
12-0096R	5/18/2012
12-0108R	6/1/2012
12-0110R	5/30/2012
12-0112R	5/14/2012
12-0114R	5/1/2012
12-0118R	6/4/2012
12-0122R	5/16/2012
12-0124R	6/18/2012
12-0133R	6/18/2012
12-0135R	8/2/2012
12-0136R	8/3/2012
12-0137R	8/3/2012
12-0138R	8/9/2012
12-0140R	1/26/2012
12-0142R	8/3/2012
12-0150R	8/16/2012
12-0152R	7/17/2012
12-0158R	8/15/2012
12-0171R	9/25/2012
12-0172R	9/27/2012
12-0173R	9/27/2012
12-0175R	9/18/2012
12-0178R	9/18/2012
12-0180R	6/22/2012
12-0181R	9/28/2012
12-0182R	10/22/2012
12-0188R	8/20/2012
12-0189R	10/19/2012
12-0190R	10/15/2012
12-0191R	10/10/2012
12-0192R	10/23/2012
12-0193R	10/26/2012
12-0194R	10/26/2012
12-0196R	8/2/2012
12-0202R	12/7/2012
12-0203R	11/9/2012
12-0204R	10/29/2012
12-0205R	10/10/2012
12-0206R	8/9/2012

Case Number	Date of Referral to the MFCU
12-0207R	12/20/2012
12-0209R	7/20/2012
12-0210R	10/1/2012
12-0211R	8/1/2012
12-0212R	8/13/2012
12-0213R	8/13/2012
12-0214R	8/3/2012
12-0215R	1/24/2012
12-0216R	9/3/2012
12-0219R	10/1/2012
13-0001R	1/8/2013
13-0004R	1/4/2013
13-0005R	1/7/2013
13-0007R	1/14/2013
13-0010R	2/4/2013

Appendix D
Organizational Charts for the BMS and the OIG




WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Karen L. Bowling
Cabinet Secretary
Office of Human Resources Management
Harold D. Clifton
Deputy Secretary for Legal Services
Susan S. Perry
Deputy Secretary for Programs & Policy
Molly Jordan
Deputy Secretary for Administration
Warren D. Keefer
Executive Secretary
Debi Calabrese
Inspector General
David A. Bishop
Office of Communications
Marsha Dadisman
Director
Office of Legislative Affairs
Virginia Mahan
Legislative Liaison
Health Resource Development
Chris Curtis, MPH
Director
Assistant to the Secretary
Nancy Sullivan
Investigations & Fraud Management
Christopher G. Nelson
Director
Administrative Staff
Criminal Investigative Unit
Repayment Investigative Unit
Front-End Fraud Unit
Board of Review
Erika H. Young
Director
Administrative Staff
Hearing Officers
Health Facility Licensure and Certification
Jolynn Marra
Director
Administrative Staff
Assisted Living
Behavioral Health
Life Safety & Fire Authority
Medicare & Hospitals
Nurse Aides
Nursing Homes
General Counsel
April L. Robertson
Olmstead Coordinator
Tina E. Maher
Medicaid Fraud Control Unit
Trina C. Crowder
Director
Administrative Staff
Fraud Investigative Unit
Abuse & Neglect Unit
Quality Control
Marilyn L. Trout
Director
Administrative Staff
Field Supervisors
Reviewers
Revised 2-15-2013/cg

Appendix E
Agency Response

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

Bureau for Medical Services
Commissioner's Office
350 Capitol Street – Room 251
Charleston, West Virginia 25301-3706
Telephone: (304) 558-1700 Fax: (304) 558-1451

Karen L. Bowling
Cabinet Secretary

September 10, 2013

Mr. John Sylvia, Director
West Virginia Performance Evaluation and Research Division
Office of the Legislative Auditor
Building 1, Room W-314, State Capitol Complex
Charleston, West Virginia 25305-0610

Dear Mr. Sylvia:

The West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) and Office of Inspector General (OIG), has received and reviewed the draft report of the Medicaid Fraud Performance Update for the Bureau for Medical Services and the Medicaid Fraud Control Unit (MFCU) submitted to our office on September 5, 2013. The BMS and OIG offer the following as formal responses to the Issue 1 recommendations contained within the draft report:

1. The MFCU should hire and retain an appropriate level of staff in order to eliminate its backlog of referred cases and pursue civil fraud cases in state court.

   The MFCU concurs with this recommendation.

2. The MFCU should pursue civil cases regardless of potential provider bankruptcies.

   The MFCU will pursue civil cases as appropriate where there is a likelihood of collecting the judgment.

3. The MFCU should continue to pursue an increasing percentage of recoveries that derive from state cases.

The MFCU will continue to strive to increase investigations, convictions and recoveries. The hiring and training of additional staff will aid in the attainment of this goal.

4. The BMS should develop a claims-based flagging system for the purpose of implementing pre-payment review on Medicaid claims.

   In order for the Bureau for Medical Services to fully evaluate the legislative auditor's recommendation to implement prepayment review standards, the Bureau will need to complete a full assessment of funding and resource opportunities as well as fully develop advanced data analytic reporting capabilities to establish a base line for determining claims that present a high probability of improper billing. BMS expects the enhanced data analytics tools available through the data warehouse to be operational during the first quarter of calendar year 2014. A review of staffing needs has already been completed and additional positions and funding have been requested. With expanded data analytic capabilities, the Bureau's staff will be able to examine claims identified as potential problems through data analysis, to take the interim step of selecting a small "probe" samples of generally 20-40 potential problem claims (either on a pre-payment or post-payment basis) and validate that the hypothesis that such claims are being billed in error before deploying significant medical review resources to perform prepayment review. In absence of deployment of prepayment review standards, the Bureau continues to review abhorrent billing practices or suspected fraudulent activity through the use of internal and contracted post payment reviews including the use of CMS mandated Recovery Audit Contractors. In addition to the post payment review activities currently in place, the Bureau has implemented the Affordable Care Act provider enrollment provisions that aid in strengthening overall program controls by establishing provider screening categories based on provider risk, conducting re-enrollment of providers, conducting unannounced on-site visits of high risk providers, and requiring ownership disclosures. The Bureau's claims system also supports front end editing of claims through the use of Correct Coding Initiative (CCI) editing as well as custom edits developed based on policy and post payment review findings.

5. The BMS should develop a provider –based flagging system to identify providers with high billing error rates for the purpose of implementing pre-payment review on select Medicaid providers.

   As discussed in the Bureau's response to recommendation #4 above, in order to fully evaluate the legislative auditor's recommendation to implement prepayment review standards, the Bureau will need to complete a full assessment of funding

and resource opportunities as well as fully develop advanced data analytic reporting capabilities to establish a base line for identifying providers that present a high probability or risk of improper billing and payment. BMS expects the enhanced data analytics through the data warehouse to be operational during the first quarter of calendar year 2014. A review of staffing needs has already been completed and additional positions and funding have been requested. With expanded data analytic capabilities, the Bureau's staff will be able to examine providers claims history and billing patterns through data analysis, to select a small "probe" sample of the providers claims (either on a pre-payment or post-payment basis) and validate that the hypothesis that such claims are being billed in error before deploying significant medical review resources to perform prepayment review. In absence of deployment of prepayment review standards, the Bureau continues to review abhorrent billing practices or suspected fraudulent activity through the use of internal and contracted post payment reviews including the use of CMS mandated Recovery Audit Contractors. In addition to the post payment review activities currently in place, the Bureau has implemented the Affordable Care Act provider enrollment provisions that aid in strengthening overall program controls by establishing provider screening categories based on provider risk, conducting re-enrollment of providers, conducting unannounced on-site visits of high risk providers, and requiring ownership disclosures. The Bureau's claims system also supports front end editing of claims through the use of Correct Coding Initiative (CCI) editing as well as custom edits developed based on policy and post payment review findings.

6. The BMS should utilize the predictive modeling tool, once it is fully implemented, to establish criteria such as billing error rates for the claim-based and provider-based flagging systems recommended in this report.

   BMS concurs that advanced data analytic capabilities, including the use of predictive modeling, will enable the Bureau to fully evaluate the opportunities to establish prepayment reviews as an additional tool in combating improper payments. BMS expects that these tools will be operational during the first quarter of calendar year 2014.

7. The BMS should coordinate with the MFCU to create written policies that establish objective criteria for employees to follow in distinguishing between suspected fraud and accidental overpayments.

   The MFCU disagrees with this recommendation. Potential fraud referrals must be evaluated on a case by case basis. Fraud is perpetrated in a multitude of ways and is always changing and evolving. Usually the single state agency will not have all the information and facts to make a fraud determination. To create artificial criteria may create the cracks through which fraud cases could fall. The

referral form currently being utilized by QPI meets the requirements set forth by CMS regarding Best Practices for Interaction between Program Integrity Units and Medicaid Fraud Control Units. The instructions on the form provide guidance as to when a referral should be made to MFCU. The form provides relevant definitions to provide further guidance. It is impossible to define every scenario that may indicate fraud, therefore, dictating a finite list or more detailed guidelines of what should be referred, would create significant possibility of relevant cases not being referred.

8. Once the MFCU achieves an appropriate staffing level, it should develop a performance goal regarding the length of time in which cases can remain in "referred" status without being assigned and investigated.

   The MFCU concurs with this recommendation. Once the MFCU is appropriately staffed and all staff is trained, performance goals will be developed.

9. The MFCU and the BMS should meet regularly in order to increase the level of communication between the two agencies.

   The OQPI and MFCU are committed to improving communications through joint staff participation in monthly, quarterly and annual meetings. The OQPI and MFCU staff attended 7 monthly meetings within the past year. Additionally, OQPI and MFCU conducted their annual combined training for all staff in July 2013 and held their first quarterly meeting in August 2013 with Medicaid Managed Care Organizations program integrity staff. The MFCU agrees that regular meetings between the MFCU and QPI are important. The level of communication between the MFCU and QPI is very good and was noted as a "Best Practice" by CMS during a recent review of BMS. The units meet regularly and have met nearly every month in all of calendar year 2012 and 2013. In addition to formal meetings, the directors of both units have frequent informal meetings on an as-needed basis. The MFCU will continue to keep the lines of communication open.

In regards to the Issue 2 recommendations, the BMS and OIG offer the following responses:

10. The MFCU should create objective criteria for the sliding scale questions in the "Referral Screening Report", which would ensure a standard and consistent "solvability weight" for all incoming referrals.

Mr. John Sylvia, Director
Page 5
September 10, 2013

The MFCU disagrees that its case prioritization process is not objective. The Legislative Auditor denotes concern about utilization of the screening form due to the possibility of the solvability weight fluctuating from one employee to the next. It should be noted that this form is not utilized by random employees but by the investigative supervisors who have adequate training and experience to utilize the form appropriately. Investigations are rarely black and white, and the decision to pursue or not pursue a particular case must take many factors into consideration, not all of which are explicit. The investigative supervisors must use their training and experience to evaluate the evidence and assign a particular weight to certain issues. This form was developed pursuant to specific training offered by a respected, experienced consulting firm that specializes in the operations and management of criminal investigation units. It is the MFCU's position that those trained and experienced in investigative management are best qualified to determine the process for prioritizing criminal investigations, and the current process is adequate.

11. The MFCU should incorporate the "Referral Screening Report" into the Policies and Procedures Handbook as soon as possible.

    The MFCU concurs with this recommendation, but would note that, while reference to the form was not immediately added to the Handbook, the form has been utilized since its inception.

12. The MFCU and the BMS should notify the relevant occupational licensing boards when filing a civil or criminal case against a Medicaid provider.

    The MFCU concurs with this recommendation in civil cases, but disagrees in criminal cases.

Mr. John Sylvia, Director
Page 6
September 10, 2013

The BMS and OIG would like to thank the Legislative Auditor's Performance Evaluation and Research Division for the opportunity to respond to the draft report of the Medicaid Fraud Performance Update for the Bureau for Medical Services and the Medicaid Fraud Control Unit (MFCU).

Sincerely,

Nancy Atkins, RN, MSN, NP-BC
Commissioner

David Bishop
Inspector General

NA:lbk

cc: Brian Cassis, Director, DHHR Office of Internal Control and Policy Development

WEST VIRGINIA LEGISLATIVE AUDITOR
PERFORMANCE EVALUATION & RESEARCH DIVISION

Building 1, Room W-314, State Capitol Complex, Charleston, West Virginia 25305

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