WEST VIRGINIA LEGISLATIVE AUDITOR

PERFORMANCE EVALUATION & RESEARCH DIVISION

Full Performance Evaluation

Department of Health and Human Resources

The Bureau for Medical Services Should Implement Additional Fraud Prevention Initiatives

The Bureau for Medical Services Refers Few Cases to the Medicaid Fraud Control Unit

January 2007
PE 06-32-405

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January 8, 2007

The Honorable Edwin J. Bowman
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129 West Circle Drive
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The Honorable J.D. Beane
House of Delegates
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Dear Chairs:

Pursuant to the West Virginia Sunset Law, we are transmitting a Full Performance Evaluation on the Department of Health and Human Resources, which will be presented to the Joint Committee on Government Operations on Monday, January 8, 2007. The issues covered herein are "The Bureau for Medical Services Should Implement Additional Fraud Prevention Initiatives;" and "The Bureau for Medical Services Refers Few Cases to the Medicaid Fraud Control Unit Issue Title."

We transmitted a draft copy of the report to the Department of Health and Human Resources on December 22, 2006. We held an exit conference with the Department of Health and Human Resources on January 3, 2007. We did not receive a written response from the agency.

Let me know if you have any questions.

Sincerely,

John Sylvia

JS/jda

Joint Committee on Government and Finance

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Medicaid fraud may have accounted for between $105 million and $210 million of state and federal funds spent on the program during FY 2006. Of the funds lost to fraud, West Virginia may have lost somewhere between $26 million and $52 million in state funds.

West Virginia's annual Medicaid fee for provider services budget during FY 2006 was $2.1 billion and the largest single expenditure in the state budget. The federal portion of the Medicaid budget in 2006 was $1.6 billion with the state covering the remaining $525 million. Using U.S. Centers for Medicare and Medicaid Studies (CMS) and U.S. Government Accountability Office (GAO) estimates, Medicaid fraud may have accounted for between $105 million and $210 million of state and federal funds spent on the program during FY 2006. Of the funds lost to fraud, West Virginia may have lost somewhere between $26 million and $52 million in state funds.

The U.S. CMS recommends six measures to control fraud related to high-risk providers. Currently, West Virginia only provides provider education.

High-risk providers are Medicaid providers who pose the greatest potential fraud risk to the system. They include durable medical equipment providers (DME), private transportation companies, non-physician owned clinics, home health agencies and independent laboratories. The U.S. CMS recommends six measures to control fraud related to high-risk providers. These six methods are surety bonds, on-site inspections, criminal background checks, intensified claims reviews or auditing, provider education and time-limited enrollment. Currently, West Virginia only provides provider education. A total of 10 states apply no more than one measure to preserve program integrity with regard to high-risk providers. A total of 27 states apply three or more measures. When compared to actions taken by other states West Virginia is not engaging in enough proactive measures.

According to BMS staff, "BMS does not currently have information regarding the number of providers who have 'dropped out' of the Medicaid system in the past three to six years."

The BMS only recently began participating in this TAG during the course of this evaluation.

The Bureau for Medical Services (BMS) last conducted a review of DME suppliers in 2002 and another review has not been scheduled. The last full provider re-enrollment was conducted in 1999. According to BMS staff, *"BMS does not currently have information regarding the number of providers who have 'dropped out' of the Medicaid system in the past three to six years."* In an effort to better protect federal funds, the U.S. CMS has recently created the Medicaid Fraud and Abuse Technical Assistance Group (TAG) monthly teleconference. TAGs are joint state-U.S. CMS workgroups formed to discuss policy and procedures in various program areas. TAGs are a means for states and the federal government to discuss methods of fraud control and prevention. The BMS only recently began participating in this TAG during the course of this evaluation.

In order to discourage fraud, 24 states assess an administrative penalty against fraudulent behavior. Penalties range from $1,000 to as much as $10,000 *per incident*. West Virginia currently has no administrative penalties against Medicaid fraud. The state does have a process for pursuing civil action against providers via *WVC* §9-7-6 allowing for triple recovery of funds lost to Medicaid fraud but this option is rarely pursued.

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A representative of the BMS stated in communications with the Legislative Auditor's staff that BMS software has the capability to flag providers for pre-payment review. The BMS, however, does not use this option and does not have any providers flagged for review. During FY 2006, the BMS identified several providers as having received Medicaid overpayments who have been the target of fraud investigations in the recent past as discussed in the MFCU's annual reports.

Issue 2: The Bureau for Medical Services Refers Few Cases to the Medicaid Fraud Control Unit

Global recoveries accounted for more than 78% of the MFCU's total recoveries during the period from FY 2002-FY2006.

The MFCU has benefitted greatly from the efforts of other states and the federal government. Fraud investigations begun in other states or by the federal government are referred to as global cases by the MFCU. Global recoveries accounted for more than 78% of the MFCU's total recoveries during the period from FY 2002-FY2006. The relatively low amount of recoveries from West Virginia sources was the result of a lack of referrals from the BMS. FY 2005, the BMS reviewed payments made to 1,608 providers and referred two providers to the MFCU. The BMS OQPI referred only one provider to the MFCU during FY 2006. The combined total referrals for the period from FY 2002 to FY 2005 (16) resulted in fewer referrals from the BMS than the single year total from FY 2001 (17).

For the purposes of recovering overpayments, the BMS considers most over billing cases to be mistakes and not fraud. During FY 2006, the BMS identified approximately 400 cases with $7.9 million in overpayments. The Legislative Auditor's staff identified 29 cases they felt to be suspect. These 29 cases total $5.4 million in overpayments and account for 87% of total overpayments identified by the BMS.

For the purposes of recovering overpayments, the BMS considers most over billing cases to be mistakes and not fraud. During FY 2006, the BMS identified approximately 400 cases with $7.9 million in overpayments. The Legislative Auditor's staff identified 29 cases they felt to be suspect. These 29 cases total $5.4 million in overpayments and account for 87% of total overpayments identified by the BMS. A hospital received $1.17 million in overpayments and has yet to repay any. Another hospital currently owes $200,000 and an ambulance company owes $407,458. Another ambulance company received $420,000 in overpayments and, as of December 1, 2006, has currently repaid $204,000.

Eighteen (18) providers repaid the identified funds to the BMS and the BMS took no further action. **It appears that the BMS OQPI does not actively pursue potential fraud against those providers who cooperate in refunding overpayments**. While not all of these cases may be the result of fraudulent billing practices, the overpayment amounts are substantial and these cases should at least be reviewed by the MFCU's trained fraud investigators.

The BMS and the MFCU also have not had regular meetings as previously agreed upon by the agencies in a "memorandum of understanding" between the agencies.

There is a communication problem between the BMS and the MFCU. This problem stems from the MFCU not keeping the BMS fully informed of the status of its investigations. As a result the BMS began to conduct its own investigations and refer fewer cases to the MFCU. The BMS and the MFCU also have not had regular meetings as previously agreed upon by the agencies in a "memorandum of understanding" between the agencies. A provider pays no additional financial penalties if it simply refunds excess payments after the BMS identifies them. This has led to fewer referrals to the MFCU and more recoveries by the BMS, in some cases, when fraud investigations would have been more appropriate. Communications between the BMS OQPI and the MFCU must be improved as the MFCU lacks the data to review all overpayments made to providers and the OQPI does not have the training to conduct fraud investigations. Without a fraud investigation by the MFCU and the resulting legal *WVC* §9-7-6, allowing for triple recoveries in legal judgements involving fraud, may not come into play. The BMS is legally allowed to file a civil suit against providers but the BMS was unable to provid the Legislative Auditor with any information detailing when, if ever, this option has been pursued without a fraud investigation by the MFCU. Given the level of research involved in a legal case it is unlikely the BMS could adequately take legal action itself. In addition, there is no deterrence to committing fraud.

The BMS is legally allowed to file a civil suit against providers but the BMS was unable to provid the Legislative Auditor with any information detailing when, if ever, this option has been pursued without a fraud investigation by the MFCU.

Recommendations

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

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

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

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.*

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

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.*

7. *The Bureau for Medical Services should conduct pre-payment review of claims filed by providers who have been the object of fraud investigations or litigation in the recent past.*

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

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.*

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

Review Objective, Scope and Methodology

Objective

The objective of the Full Performance Evaluation of the Department of Health and Human Resources (DHHR) is to identify methods for the Department of Health and Human Resources Bureau, for Medical Services Office of Quality and Program Integrity, and the Office of the Inspector General Medicaid Fraud Control Unit to better detect and prevent fraudulent billings from medical providers participating in the Medicaid Program, and to recover funds lost to these overpayments.

Scope

The scope of this report is from FY 2001 to December 1, 2006.

Methodology

The Legislative Auditor obtained information from multiple offices of the DHHR, including the Bureau for Medical Services (BMS) and the Office of the Inspector General Medicaid Fraud Control Unit (MFCU). The information included year end reports, budget information and information on policies and procedures followed by the BMS and the MFCU. The BMS provided information on payments to Medicaid providers and the MFCU provided information relating to fraud control investigations. Information from the DHHR was compared to reports on Medicaid agencies in other states as well as reports issued by the U.S. Government Accountability Office, Centers for Medicare and Medicaid Services and the U.S. Department of Health and Human Services Office Of the Inspector General. Various reports from both federal and state government auditing agencies were reviewed in an effort to determine which methods of fraud control and prevention are used in other states, as well as their relative costs and effectiveness.

Issue 1

The Bureau for Medical Services Should Implement Additional Fraud Prevention Initiatives

Issue Summary

The Legislative Auditor found that, when compared to other states, the Bureau for Medical Services (BMS) does utilize many available controls to identify and prevent Medicaid fraud. The U.S. Centers for Medicare and Medicaid Services (CMS) recommends six measures to control fraud related to high-risk providers. West Virginia only employs one of these measures. The BMS predominately relies on post-payment review in detecting Medicaid fraud. This method has proven to be ineffective in investigating and deterring Medicaid fraud. As a result, West Virginia could be losing millions of dollars in state funds annually due to the lack of sufficient fraud controls.

Medicaid fraud may have accounted for between $105 million and $210 million of state and federal funds spent on the program during FY 2006. Of the funds lost to fraud, West Virginia may have lost somewhere between $26 million and $52 million in state funds.

West Virginia Could Be Losing Millions To Medicaid Fraud

West Virginia's annual Medicaid fee for provider services budget during FY 2006 was $2.1 billion and the largest single expenditure in the state budget. The federal portion of the Medicaid budget in 2006 was $1.6 billion with the state covering the remaining $525 million. The U.S. CMS, the federal agency responsible for oversight of the state Medicaid programs, estimates that approximately 10% of Medicaid payments are fraudulent. The U.S. Government Accountability Office (GAO) suggests that the rate of fraud is approximately 5%. Using these percentages, Medicaid fraud may have accounted for between $105 million and $210 million of state and federal funds spent on the program during FY 2006. Of the funds lost to fraud, West Virginia may have lost somewhere between $26 million and $52 million in state funds. Table 1 illustrates Medicaid expenditures for the top 10 provider types. Appendix B provides a complete list of Medicaid expenditures for all provider types during FY 2006.

Table 1 Top 10 BMS Expenditures By Provider Type and Total Expenditures FY 2006	
Nursing Facility Services	$402,903,863
Prescribed Drugs	$378,095,030
Medicaid Health Insurance Payments: Managed Care Organizations (MCO)	$213,950,846
Inpatient Hospital Services	$209,860,932
Home and Community-Based Services (Mental Retardation or Developmental Disabilities)	$185,607,767
Physicians Services	$126,950,184
Other Care Services	$117,082,516
Outpatient Hospital Services	$93,921,521
Medicare Health Insurance Payments- Part B Premiums	$61,584,326
Home and Community-Based(Aged/Disabled)	$60,658,000
Total Medicaid Program Expenditures	**$2,127,085,832**
Source: BMS Medicaid Report November 2006	

West Virginia may lose between $33 million to $67 million in state funds during FY 2007.

Some notable expenditure items during FY 2006 were $403 million for nursing facility services and $210 million for inpatient hospital services. During FY 2006 Medicaid spent $378 million on prescription drugs and $214 million on managed care organizations. Total expenditures for home and community based services for mental retardation or developmental disabilities were $186 million. During FY 2006, these were the five most costly expenditures for the Medicaid Program, accounting for $1.4 billion, or 66% of total Medicaid expenditures.

The Medicaid fee for provider services budget for FY 2007 is projected to be $2.26 billion with the state supplying $678 million of the budget. Using the CMS and GAO estimates, West Virginia may lose between $33 million to $67 million in state funds during FY 2007.

The BMS Does Not Closely Monitor High-Risk Providers

High-risk providers are Medicaid providers who pose the greatest potential fraud risk to the system. They include durable medical equipment providers, private transportation companies, non-physician owned clinics, home health agencies and independent laboratories. The U.S. CMS recommends six measures to control fraud related to high-risk providers. These six methods are surety bonds, on-site inspections, criminal background checks, intensified claims reviews or

auditing, provider education and time-limited enrollment. Every technique for detecting potential fraud also has limitations. According to a report issued by the U.S. GAO "*...effective detection of potential fraud and abuse necessarily involves the application of several of these techniques and considerable analysis....*". Currently, West Virginia only provides provider education. A total of 10 states apply no more than one measure to preserve program integrity with regard to high-risk providers. A total of 27 states apply three or more measures. When compared to actions taken by other states West Virginia is not engaging in enough proactive measures.

"...effective detection of potential fraud and abuse necessarily involves the application of several of these techniques and considerable analysis....".

Surety Bonds For High-Risk Providers

One method of maintaining program integrity employed by other states is to require high-risk providers to post surety bonds. The BMS does not require this. Currently, according to the U.S. GAO, six states require high-risk providers to post surety bonds. These six states are California, Illinois, Louisiana, Florida, Texas, and Washington. 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. In Florida, a surety bond of $50,000 is required from all new durable medical equipment (DME) providers, independent laboratories, home health agencies, and other high-risk providers. Bonding adds yet another level of investigation to the process of obtaining a Medicaid provider number, as most bonding companies conduct their own investigations before agreeing to bond an individual or company. The costs associated with bonding could be a problem for some providers and the subject is worthy of further investigation regarding its feasibility. The BMS should consider bonding as a measure to improve program integrity controls and attempt to determine if it is viable option in West Virginia, at least with respect to some providers.

The Bureau for Medical Services currently does not conduct onsite visits to providers to determine the legitimacy of their business. Twenty-nine (29) states conduct onsite visits to applicants for provider numbers to determine if they are operating a legitimate business.

Conduct Random Onsite Visits to Provider Applicants and High- Risk Providers

The Bureau for Medical Services currently does not conduct onsite visits to providers to determine the legitimacy of their business. Twenty-nine (29) states conduct onsite visits to applicants for provider numbers to determine if they are operating a legitimate business. Florida and Louisiana visit all providers while California and Illinois only visit providers they believe to be of the highest risk to the Medicaid Program. These states do not visit facilities which

must pass routine federal or state inspections such as hospitals and nursing homes. Most efforts are focused on high- risk provider groups.

The BMS's last review of DME suppliers occurred in 2002 and another review has not been scheduled. The review required providers to comply with three guidelines:

1. Providers must have a showroom;
2. Providers must have supplies on hand; and
3. Providers must be handicap accessible.

The BMS's last review of DME suppliers occurred in 2002 and another review has not been scheduled.

The BMS should regularly schedule reviews of DME suppliers and other high-risk Medicaid providers to ensure compliance with various state and federal laws and rules. Information from Florida, California, and Texas demonstrates the effectiveness of onsite visits in discouraging and preventing fraud. In one month, about 85 new provider applications were received in Dade County, Florida. Onsite visits revealed that all of these applications were illegitimate and denied. The State of Florida potentially saved a great deal that would have been paid in fraudulent Medicaid billings due to onsite visits. In Texas, the Legislature mandated that the Medicaid agency should conduct onsite reviews of all provider applicants during a specified time period. During this time period, the number of new provider applicants declined by more than 50%. In addition, all provider applicants were judged to be legitimate businesses

The cost of sending staff from the home office out to conduct onsite visits to providers is substantial and more than some state Medicaid agencies may be able to afford. Onsite visits create travel expenses and may also require additional staff. Other states, such as Florida and Louisiana, use local welfare field offices and Medicaid staff not stationed in the home office to conduct visits to ensure that every new provider is visited before a provider number is issued. The Medicaid agency in these states also provides guidance to the welfare office on how to conduct each onsite visit. Using local welfare offices and out-stationed Medicaid staff to conduct on-site visits to high-risk Medicaid provider applicants is a viable option for West Virginia and one that should be considered by the BMS.

The BMS Verifies Physician Licensure But Rarely Conducts Full Provider Re-enrollment and Does Not Have Time-Limited Enrollment

West Virginia has not conducted a full provider re-enrollment since 1999. Twenty-five (25) other states allow for time-limited enrollment which requires providers to re-enroll in the Medicaid system periodically, usually every three years. Provider re-enrollments not only assist states in tracking providers but also helps to remove providers who are no longer operating from the system. Re-enrollment and updated provider information ensures that providers are still operating, have not changed location, telephone numbers or ownership, or experienced any other major change that could affect eligibility to participate in the system. The BMS updates provider information annually by reviewing physician licensure status. In 16 other states the re-enrollment process also involves verifying the ownership and legitimacy of all provider businesses as well as medical credentials. In these states re-enrollment may include on-site visitations to the business. The BMS currently does not verify if a licensed physician is operating through a legitimate business. A medical license does not guarantee that an actual business exists. In addition, some providers such as DME providers and laboratories do not have medical licenses, only business licenses if they are properly licensed by the State.

The BMS updates provider information annually by reviewing physician licensure status. The BMS currently does not verify if a licensed physician is operating through a legitimate business. A medical license does not guarantee that an actual business exists.

According to BMS staff, *"BMS does not currently have information regarding the number of providers who have 'dropped out' of the Medicaid system in the past three to six years."* The BMS upgraded data systems during the course of this evaluation and is now able to track providers who have left the Medicaid system during this year. The BMS is unable to provide this information from past years. The BMS also has provider data in multiple databases and is, therefore, not readily retrievable. Information about a particular provider should be readily available but its retrieval is a time-consuming process due to the use of incompatible data systems.

The lack of provider re-enrollment in West Virginia has not gone unnoticed by the federal government. The U.S. CMS has required all Medicaid providers in West Virginia to receive a National Provider Number during CY 2006 in order to continue participating in the system. Each provider is given a unique National Provider Number to assist in tracking the providers. The BMS should conduct provider re-enrollment and update provider information on a regularly scheduled basis in order to maintain program integrity.

Require Background Checks Through the State Police and FBI for Medicaid Providers

The BMS does not require providers in the Medicaid Program to undergo a criminal history background check. Thirteen (13) states require criminal background checks of high-risk providers. Florida requires providers to undergo fingerprinting and criminal background screening. All officers, directors, managers and owners of a provider business are screened. Employees of hospitals are not screened. According to the *CMS Medicaid Alliance for Program Safeguards*, *"The data provided through criminal background checks can be an important tool in shielding a vulnerable population from known felons"*. A criminal history background check conducted by the West Virginia State Police costs $20. The State Police check lists all crimes committed in the state. The BMS may legally perform criminal background checks of all Medicaid providers through the State Police but does not currently do so.

According to the CMS Medicaid Alliance for Program Safeguards, "The data provided through criminal background checks can be an important tool in shielding a vulnerable population from known felons".

A criminal history background check through the Federal Bureau of Investigation costs $18. FBI criminal history background checks list all felonies and occupation-related misdemeanors committed nationwide. Public Law 92-544 declares that in order for states to access the FBI criminal history information, the state must have legislation in place authorizing criminal background checks through the FBI. To comply with Public Law 92-544, state statutes must satisfy the following criteria:

According to the BMS, the agency relies on professional licensure boards to "provide assurance that health care providers meet the necessary qualifications and standards to legally practice their professions".

1. *A state statute must exist as a result of a legislative enactment*;
2. *The state statute must require the fingerprinting of applicants who are to be subjected to a national criminal history background check*;
3. *The state statute must expressly ("submit to the FBI") or by implication ("submit for a national check"), authorize the use of FBI records for the screening of applicants*;
4. *The state statute must identify the specific category(ies) of licensees/employees falling within its purview, thereby avoiding overbreadth*;
5. *The state statute must not be against public policy*;
6. *The state statute may not authorize receipt of criminal history information by a private entity.*

According to the BMS, the agency relies on professional licensure boards to "*provide assurance that health care providers meet the necessary qualifications and standards to legally practice their professions"*. However, very few professional licensure boards in West

Virginia conduct criminal background checks. The Board of Medicine and the Board of Osteopathy, the boards responsible for licensing physicians, do not conduct criminal background checks. In order to provide another level of protection against fraudulent providers, the Legislature should consider amending the *Code* to give the BMS the authority to conduct FBI criminal background checks on all Medicaid provider applicants as well as existing providers.

West Virginia conduct criminal background checks. The Board of Medicine and the Board of Osteopathy, the boards responsible for licensing physicians, do not conduct criminal background checks.

Require Online Pre-approval for Prescriptions

Expenditures for prescription drugs account for a significant portion of the Medicaid Program's operational cost. In FY 2006, the state spent $236 million on prescription drugs. During FY 2005, the total was nearly $310 million and $271 million during FY 2004. The BMS could require online preapproval of prescriptions as a form of prescription drug control. Online pre-approval software has the capacity to examine claims history, both pharmaceutical and medical. It also has the ability to seek information on diagnoses and prior drug use to determine if criteria has been met. This process eliminates the need for a time intensive manual review of the information in addition to reducing the chance of human error. The BMS is currently upgrading systems and technology and plans to pursue online pre-approvals for prescription drugs at a later date. In communications with the Legislative Auditor's staff, a representative of the BMS said the following regarding online pre-approval:

Online pre-approval software eliminates the need for a time intensive manual review of the information in addition to reducing the chance of human error.

> *Due to the implementation of a new Point of Sale system and CMS certification readiness, adding this new technology had not been our priority. We will soon upgrade the system now that CMS certification exercises have been completed in order to comply with upcoming HIPAA and DRA requirement deadlines. Although this technology would be an attractive addition to our system, these deadlines must take precedence at this time. Once the upgrade is underway and federal deadlines are met, BMS is interested in pursuing online pre-approvals.*

The online pre-approval option is not available through the state's current prior- authorization vendor. The BMS is currently applying for a technology upgrade grant from the U.S. CMS. The BMS should develop an online pre-approval system for prescriptions, as soon as possible.

The BMS Has a Contract With a Recovery Vendor: Health Watch Technologies

During 2001, the BMS contracted with a recovery vendor called Health Watch Technologies (HWT) for the purpose of conducting algorithmic analysis of claims data. HWT queries large databases for specific situations that do not meet the definition of covered services under Medicaid. HWT stores the claims date, runs the algorithms and works with the BMS Office of Quality and Program Integrity (OQPI) to validate the results, then sends letters identifying overpayments. HWT also supports the OQPI in the event that a provider requests an administrative hearing to dispute an overpayment issue. Currently, a total of 15 states have contracts with HWT.

A representative of the BMS claimed that it is not capable of conducting these activities itself:

During 2001, the BMS contracted with a recovery vendor called Health Watch Technologies (HWT) for the purpose of conducting algorithmic analysis of claims data.

> *...the algorithms make up a large part of OQPI activity with HWT. These algorithms are based on hundreds of code pairs. Hours of staff time would be required to develop the initial sets of code pairs. Additionally, new codes are released annually, requiring a review of each code set, an insertion of new codes and changes in the algorithms.*

The BMS also does not have the software or the trained staff to perform the work carried out by HWT. The BMS representative stated:

> *These algorithms require the particular expertise of a pharmacist, which OQPI does not have . The other issue is that the queries often create results sets which are larger than OQPI can handle with its conventional business software...This is an extremely complex process that requires a significant level of specialization...We do not have the technical expertise to perform these functions.*

The following table lists total overpayments collected and identified by HWT along with the amount the state paid to HWT for its services. FY 2001 and FY 2002 were training periods and no amounts were identified or collected, nor were funds paid to HWT. HWT is paid 12% of the funds it recovers each fiscal year.

Table 2 Medicaid Overpayments Identified, Collected, and Paid to Health Watch Technologies			
Fiscal Year	**Overpayments Identified**	**Amounts Collected**	**Amounts Paid to Health Watch Technologies**
2003	$3,675,631	$2,270,514	$276,029
2004	$2,986,195	$2,227,533	$736,991
2005	$2,256,442	$1,811,659	$593,602
2006	$8,890,100	$3,608,718	$726,375
Source: Department of Health and Human Resources Data			

The BMS Only Recently Began to Participate in the Medicaid Fraud and Abuse Technical Assistance Group

In an effort to better protect federal funds, the U.S. CMS has created the Medicaid Fraud and Abuse Technical Assistance Group (TAG) monthly teleconference. TAGs are joint state-U.S. CMS workgroups formed to discuss policy and procedures in various program areas. TAGs are a means for states and the federal government to discuss methods of fraud control and prevention. TAG members are selected from nominations from state Medicaid agency directors. The members of TAG set the agenda for the conferences. The BMS had not participated in TAG until 2006 due to the DHHR's understanding that only TAG members were allowed to participate in the conference. This belief was incorrect since, according to a report issued by the U.S. GAO, all states are allowed to participate in the Medicaid Fraud and Abuse TAG. As of 2004, 29 states and the District of Columbia participate in TAG. The BMS began participating in the Medicaid fraud and Abuse TAG during the course of this evaluation after the Legislative Auditor's staff inquired about their involvement.

Other States Have Adopted False Claims Acts

Sixteen (16) states have passed False Claims Acts (FCA's) to increase funds recovered by fraud litigation. The Deficit Reduction Act of 2005 contains provisions which create incentives for states to enact anti-fraud legislation modeled after the federal False Claims Act. The FCA provides for penalties including the repayment of overpaid funds up to three times the amount paid for fraudulent claims. Under the FCA's *qui tam* provisions, a person with evidence of fraud, also known as a whistle

blower or relator, is permitted to sue on behalf of the state and federal government. The relator is also entitled to share in any funds the government may recover. States with false claims acts that have *qui tam* provisions include California, Delaware, Florida, Illinois, Louisiana, Nevada, New Mexico, Virginia, Tennessee and Massachusetts. The current administration not only encourages but also rewards the creation of a false claims act. States that pass FCAs resembling the federal FCA will gain an additional 10% of funds recovered through legal action.

In Arkansas, courts are authorized to issue payments to whistle blowers for amounts of up to 10% of recoveries, to a maximum of $100,000, for information which helps to detect and punish those guilty of fraud. By providing those who report fraud with monetary rewards, the motivation to report fraud to the proper authorities becomes greater, thus increasing the number of fraudulent activities reported each year. State employees, whose normal job is to identify and prosecute Medicaid fraud, are exempt from the reward.

Qui tam lawsuits may already be filed in federal courts on behalf of the federal government, in which case, the federal government handles the workload and associated costs. States still recover funds from a successful qui tam lawsuit even if it is filed in a federal court instead of a state court.

Analyst in Missouri estimated that over-billing by providers accounted for $575 million lost annually to fraud. In 2005, the Missouri Senate formed a committee to examine fraud and methods to address the issue. As a result of the committee, Missouri introduced legislation allowing private citizens to file lawsuits against providers who fraudulently bill. The legislation also prohibits individuals who report fraud from being demoted, suspended, threatened, discharged, harassed or discriminated against in any manner.

The creation of a FCA would potentially cost West Virginia millions of dollars due to paying the relators share of the recovery as well as the associated court cost. In addition, *qui tam* lawsuits may already be filed in federal courts on behalf of the federal government, in which case, the federal government handles the workload and associated costs. States still recover funds from a successful *qui tam* lawsuit even if it is filed in a federal court instead of a state court. The former director of the MFCU, in communications with PERD, said *"A FCA would be a mistake for West Virginia. It would cost the state millions because the state would have to pay the relators share."*

Deter Fraud Through Better Enforcement of the State Code

In order to discourage fraud, 24 states assess an administrative penalty against fraudulent behavior. Penalties range from $1,000 to as much as $10,000 *per incident*. The FCA suggest penalties starting at $5,000 plus three times the amount of damages incurred by the fraud. West Virginia currently has no administrative penalties against Medicaid fraud. In West Virginia, any person convicted of a criminal health care violation or a fraud related charge is barred from participation in any federally-funded healthcare program for at least ten years.

West Virginia does have a process for pursuing civil action against providers but this option is rarely pursued.

In West Virginia, many providers settle cases with the BMS OQPI. Cases resolved in this manner are considered mistakes, rather than fraud. Mistaken billings carry no penalty under West Virginia law. A provider may repay overpaid funds with no other financial penalties. The OQPI negotiated settlements in 1,608 cases during FY 2005 and 2,128 cases during FY 2004.

West Virginia does have a process for pursuing civil action against providers but this option is rarely pursued. WV Code §9-7-6 states 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, itself, or others, obtains or attempts to obtain benefits or payments or allowances under the medical programs of the department of welfare to which he or it is not entitled, or, in a greater amount than that to which he or it is entitled, shall be liable to the department of welfare in an amount equal to three times the amount of such benefits, payments or allowances to which he or it is not entitled, and shall be liable for the payment of reasonable attorney fees and all other fees and costs of litigation.*

In addition, *WVC* §9-7-5 provides for a fine of up to $10,000 to be levied against any person found guilty of fraud. Only two civil suits were filed during FY 2005 and FY 2004. Only one was filed during FY 2003, in which the state won $428,000 in damages in addition to $214,000 recovered through criminal prosecution. During FY 2002, two civil suits were pursued, awarding the state $303,000 and $1.3 million, respectively.

More frequent civil actions in addition to criminal suits against those who knowingly and purposely attempt to acquire funds from Medicaid through fraud would serve as a deterrent against fraud and aid the state in recovering more funds. In addition, the potential for combined monetary loss from losing a civil and criminal lawsuit could serve to make those accused of fraud more willing to reach a settlement outside of court. The current director the Medicaid Fraud Unit also believes *"the state needs to pursue more state actions against providers via the provision in WV Code §9-7-6".* The Director also feels that "*the current definition of 'abuse and neglect' in the WV Code are not sufficient and need to be expanded and clarified."* The MFCU and the BMS should communicate more frequently in order to pursue action against providers via the provisions in *WV C* §9-7-6.

The current director the Medicaid Fraud Unit also believes "the state needs to pursue more state actions against providers via the provision in WV Code §9-7-6".

The BMS Should Conduct Pre-Payment Review of Claims Filed Providers Who Have Had Fraud-Related Issues in the Past

A representative of the BMS stated in communications with the Legislative Auditor's staff that BMS software has the capability to flag providers for pre-payment review. The BMS, however, does not use this option and has never flagged any providers for review. During FY 2006, the BMS identified several providers as having received Medicaid overpayments who have been the target of fraud investigations in the recent past. In FY 2004, West Virginia received $406,000 from a settlement against the a major pharmacy chain. Currently, this chain owes $17,000 to the BMS as a combined total from several overpayments. During FY 2002, the MFCU received $111,523 in a recovery action against another pharmacy chain. During FY 2006, an overpayment amount of $20,388 was identified for a single case from this chain. During FY 2003, a hospital appearing on the current overpayment list had to repay $489,000. All of these cases are discussed in MFCU annual reports. Several other providers also appear in both the MFCU annual reports as well as the BMS FY 2006 overpayment cases list. If the BMS maintained proper communications with the MFCU, then the BMS would know about these providers and be able conduct pre-payment review on their claims. The lack of communications between the BMS and the MFCU is discussed in further detail in Issue 2 of this report. Medicaid claims filed by providers who have a suspect past should receive added scrutiny in the form of pre-payment review.

BMS software has the capability to flag providers for pre-payment review. The BMS, however, does not use this option and has never flagged any providers for review.

Conclusion

The BMS has relied on detecting fraud and overpayments after they occur and not on preventive measures to minimize the costs of Medicaid fraud and overpayments. Investigating fraud after it occurs does not control fraud adequately. Post-payment investigation is only one method of fraud detection. The BMS should incorporate more preventive measures in its fraud control system as have other states. The focus of the BMS should be on preventing Medicaid fraud as well as improving efforts to detect fraud after it occurs.

Recommendations

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

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

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

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.*

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

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.*

7. *The Bureau for Medical Services should conduct pre-payment review of claims filed by providers who have been the object of fraud investigations or litigation in the recent past.*

Issue 2

The Bureau for Medical Services Refers Few Cases to the Medicaid Fraud Control Unit

Issue Summary

The inability to initiate data mining operations forces fraud units to be dependent on outside sources of referral to perform their essential functions.

The Legislative Auditor found there is potential for Medicaid billing fraud in West Virginia to go unpunished. The BMS and the MFCU could improve their communications with each other and improve the coordination of their actions. The number of referrals from the BMS to the MFCU has declined during recent years. When the BMS identifies overpayments, providers must simply repay the overpaid amounts and there is rarely an investigation to determine if fraud was involved. As a result of a lack of communications and referrals from the BMS, 86% of funds recovered by the MFCU are from recovery actions begun in other states or by the federal government. The result is a lack of disincentives for providers operating only in West Virginia to avoid committing fraud.

Global recoveries accounted for more than 78% of the MFCU's total recoveries during the period from FY 2002-FY2006.

The Medicaid Fraud Control Unit Recovers Little From Fraud Cases Initiated in West Virginia

Federal law prohibits state MFCU's from initiating data mining operations. Data mining is the analysis of large databases of payment information to identify unusual billing patterns. States that attempt to perform prohibited functions risk losing federal funding. The inability to initiate data mining operations forces fraud units to be dependent on outside sources of referral to perform their essential functions. Sources of referrals to the MFCU include other states, private citizens and the Federal Government. Fraud referrals result in investigations and possibly the filing of criminal charges. The MFCU has recovered large amounts due to the work of other agencies and cases in which the MFCU had little, if any, involvement (see Table 3). Fraud investigations begun in other states or by the federal government are referred to as global cases by the MFCU. **Global recoveries accounted for more than 78% of the MFCU's total recoveries during the period from FY 2002-FY2006.** The relatively low amount of recoveries from West Virginia sources was the result of a lack of referrals from the BMS. Table 3 illustrates funds the MFCU recovered through various sources.

Table 3
West Virginia Medicaid Fraud Control Unit Totals Recovered By Source
FY 2002 Through FY 2006

Fiscal Year	Amount Recovered From BMS Referrals	BMS Percent of Total	Amount Recovered From Other In-state Sources	Other In-State Sources Percent of Total	Amount Recovered From Global Cases	Global Percent of Total	Total Recoveries
2002	$0	0%	$366,226	12%	$2,594,066	88%	$2,960,292
2003	$183,492	6.5%	$1,678,827	60%	$941,232	33.5%	$2,803,553
2004	$0	0%	$1,443,988	20%	$5,856,972	80%	$7,300,960
2005	$0	0%	$410,288	5%	$7,475,944	95%	$7,886,232
2006	$226,000	8%	$888,811	31%	$1,751,577	61%	$2,866,388
Total	$409,492	2%	$4,788,140	20%	$18,619,791	78%	$23,817,425

Data Source: PERD Calculations Based Upon Medicaid Fraud Control Unit Annual Report Data

Historically, the MFCU has placed an emphasis on global cases rather than West Virginia specific fraud. According to the former Director of the MFCU, if a provider is defrauding the Medicaid system, it is likely to also defraud other programs such as Medicare and private insurance companies. Prosecuting fraud criminal cases results in substantial litigation and investigation costs. The former Director contends that someone will eventually detect fraud and that it is far more cost-effective to allow the federal government or other states to prosecute fraud cases. Historically, West Virginia specific fraud was of secondary importance to the MFCU, and therefore, the low number of BMS fraud referrals was not a primary concern.

The Bureau for Medical Services Has Made Fewer Fraud Investigation Referrals to the Medicaid Fraud Control Unit During Recent Years

From FY 2001-2005, the MFCU received referrals from 13 different categories of sources, as shown in Table 4. It is worth noting that not all referrals to the MFCU are fraud referrals as the MFCU also investigates patient abuse charges. The 121 referrals received from private citizens accounted for nearly 46% of all referrals made to the MFCU during that time frame. The MFCU received 10 referrals from the Department of Health and Human Services Office of the Inspector General during the

period from FY 2001 to FY 2005. Law enforcement agencies made 35 referrals.

The number of fraud investigation referrals from the BMS OQPI to the MFCU steadily declined from FY 2001 through FY 2006. The OQPI made a total of 33 referrals during this period. The OQPI referred 17 providers for investigations during FY 2001, which was the highest number of referrals for any single year during the period examined. The OQPI referred two cases to the MFCU each year during both FY 2004 and FY 2005. During FY 2005, the OQPI reviewed payments made to 1,608 providers and referred two providers to the MFCU. The BMS OQPI referred only one provider to the MFCU during FY 2006. **The 33 referrals from the BMS account for only 13% of all referrals made to the fraud unit.** Referrals from the BMS are vital to MFCU fund recoveries because these referrals are typically of higher quality than those from other sources and usually involve overpayments and not patient abuse.

During FY 2005, the OQPI reviewed payments made to 1,608 providers and referred two providers to the MFCU. The BMS OQPI referred only one provider to the MFCU during FY 2006. Referrals from the BMS are vital to MFCU fund recoveries because these referrals are typically of higher quality than those from other sources and usually involve overpayments and not patient abuse.

Table 4
West Virginia Medicaid Fraud Control Unit Referrals Received:
FY 2001 Through FY 2005

Referral Source	2001	2002	2003	2004	2005	Total
Bureau for Medical Services	17	7	5	2	2	**33**
DHHS- OIG*	0	2	5	1	2	**10**
Licensing Board	0	0	0	1	0	**1**
Insurance Department	0	0	0	0	1	**1**
Prosecutor	4	6	3	6	4	**23**
Law Enforcement	9	9	9	7	1	**35**
Provider	4	5	3	2	0	**14**
Provider Association	0	0	1	0	0	**1**
Private Citizens	17	29	27	33	15	**121**
Private Insurance Company	1	0	1	7	0	**9**
PEIA** or Workers' Compensation	5	0	4	5	0	**14**
Press/Media	0	1	0	0	0	**1**
Ombudsmen	0	0	0	1	0	**1**
Total	**57**	**59**	**58**	**65**	**25**	**264**

** Department of Health & Human Services, Office of Inspector General*

*** Public Employee's Insurance Agency*

Data Source: West Virginia Medicaid Fraud Control Unit Data

There is a correlation between the BMS contract with HWT and the reduction in the number of referrals to the MFCU. The number of referrals from the BMS to the MFCU shrank significantly after HWT entered into a vendor relationship with the BMS. The BMS negotiated a contract with HWT during FY 2001. The MFCU received 17 referrals from the BMS during that year. During FY 2002, the number of referrals was 7. In FY 2003, the contract went into full effect and HWT took over operations as the recovery vendor of the state. That year, the number of referrals dropped to five. During the period from FY 2004 to FY 2005 there were

a total of four cases referred to the MFCU and only a single case was referred during FY 2006. **The combined total referrals for the period from FY 2002 to FY 2005 (16) resulted in fewer referrals from the BMS than the single year total from FY 2001 (17).** The Commissioner of the BMS attributed the low number of referrals to the MFCU during FY 2004 to the implementation of the Unisys Computer System. The Commissioner stated the following regarding Unisys:

The combined total referrals for the period from FY 2002 to FY 2005 (16) resulted in fewer referrals from the BMS than the single year total from FY 2001 (17).

> *The shrinking number of referrals and the reference to Unisys is related to two issues. First, OQPI staff was re-assigned to support Unisys implementation activities and were consequently conducting fewer reviews resulting in few referrals to MFCU. In addition, access to data during the Unisys implementation phase also contributed to the smaller amount of referrals to MFCU. Staff is currently learning to use the new Unisys data format.*

Table 5 provides a partial list of overpayment cases identified by the BMS and HWT during FY 2006. These cases represent providers who received exceptionally large amounts of overpayments in comparison to similar providers. The data provided by the BMS to the Legislative Auditor's staff also included other examples of substantial overpayments. For the purposes of recovering overpayments, the BMS OQPI considers most over billing cases to be mistakes and not fraud. The OQPI should refer more cases to the MFCU and increase its efforts in identifying potential fraud cases. The BMS did not refer any of these cases to the MFCU during FY 2006.

The Commissioner of the BMS attributed the low number of referrals to the MFCU during FY 2004 to the implementation of the Unisys Computer System.

Table 5 Suspect Overpayment Cases Identified in FY 2006		
Provider	**Overpayment Amounts Identified**	**Amount Collected as of 12/1/2006**
Ambulance Services		
Ambulance Service 1	$48,723	$48,723
Ambulance Service 2	$44,882	$44,882
Ambulance Service 3	$419,729	$203,885
Ambulance Service 4	$99,939	$99,939
Ambulance Service 5	$89,800	$51,951
Ambulance Service 6	$61,313	$61,313
Ambulance Service 7	$407,458	$0
Ambulance Service 8	$56,388	$56,388
Hospitals		
Hospital 1	$1,173,439	$0
Hospital 2	$476,529	$476,529
Hospital 3 Case 1	$221,697	$221,697
Hospital 3 Case 2	$158,048	$158,048
Hospital 4	$737,358	$737,358
Hospital 5	$254,953	$254,953
Hospital 6	$190,559	$190,559
Hospital 7	$200,276	$0
Hospital 8	$120,106	$120,106
Hospital 9	$126,012	$126,012
Hospital 10	$109,728	
Hospital 11	$149,372	$0
Behavioral Health		
Behavioral Health 1	$142,228	$33,604
Physicians		
Case 1	$34,959	$34,959
Case 2	$16,043	$0
Case 3	$54,986	$54,986
Case 4	$11,286	$11,286
Pharmacies		
Pharmacy 1	$18,966	$18,966
Pharmacy 2	$20,389	$20,389
Pharmacy 3	$11,420	$11,420
Total	$5,456,584	$3,037,954
Source: Bureau for Medical Services Office of Quality and Program Integrity Data		

During FY 2006, the BMS OQPI and HWT identified approximately 400 cases with $7.9 million in overpayments. The 29 cases in Table 4 total $5.4 million in overpayments. These 29 cases account for 87% of total overpayments identified by the BMS and HWT. Some providers of interest in Table 4 have not yet fully repaid the BMS. Most notably, Hospital 1 received $1.17 million in overpayments and has yet to repay any. Hospital 7 currently owes $200,000 and Ambulance Company 7 owes $407,458. Ambulance Company 3 received $420,000 in overpayments and, as of December 1, 2006, has currently repaid $204,000.

During FY 2006, the BMS OQPI and HWT identified approximately 400 cases with $7.9 million in overpayments. The 29 cases in Table 4 total $5.4 million in overpayments. These 29 cases account for 87% of total overpayments identified by the BMS and HWT.

Eighteen (18) providers in Table 4 repaid the identified funds to the BMS and the BMS took no further action. These providers include: Hospital 4 ($737,358), Hospital 3 ($380,000) Hospital 2 ($476,529) and Hospital 5 ($254,953). **It appears that the BMS OQPI does not actively pursue potential fraud against those providers who cooperate in refunding overpayments**. While not all of these cases may be the result of fraudulent billing practices, the overpayment amounts are substantial and these cases should at least be reviewed by the MFCU's trained fraud investigators. The Bureau for Medical Services should refer any cases involving a question of fraud to the Medicaid Fraud Control Unit.

Hospital 1 received $1.17 million in overpayments and has yet to repay any. Hospital 7 currently owes $200,000 and Ambulance Company 7 owes $407,458.

The Bureau for Medical Services and the Medicaid Fraud Unit Do Not Maintain Adequate Communications or Coordinate Their Activities

There is the potential for a large amount of fraud in West Virginia to go unprosecuted due to the state of relations between the BMS and the MFCU. The lack of free flowing information between the BMS and the MFCU is problematic. In conversation with the Legislative Auditor's staff, the Director of the MFCU said that the MFCU did not routinely keep the BMS informed regarding the progress of Medicaid fraud investigations. The lack of communications has served to slow fraud referrals from the BMS to the MFCU. The BMS and the MFCU also have not had regular meetings as previously agreed upon by the agencies in a "memorandum of understanding" between the agencies. This memorandum is a written agreement between the BMS and the MFCU discussing how the two agencies should cooperate with respect to fraud referrals and investigations.

The BMS and the MFCU also have not had regular meetings as previously agreed upon by the agencies in a "memorandum of understanding" between the agencies.

A provider pays no additional financial penalties if it simply refunds excess payments after the BMS identifies them. The BMS does charge interest if the provider fails to repay the amount owed within 60 days.

This has led to fewer referrals to the MFCU and more recoveries by the BMS, in some cases, when fraud investigations would have been more appropriate. According to the Director of the MFCU, there has been at least one instance in which the MFCU did not proceed on with a fraud case because the BMS had already made a recovery from the provider. Fraud investigations are complex and usually take at least two years to complete. Once the BMS makes a recovery, the MFCU will not pursue a criminal investigation except in very rare circumstances.

A provider pays no additional financial penalties if it simply refunds excess payments after the BMS identifies them.

Communications between the BMS OQPI and the MFCU must be improved as the MFCU lacks the data to review all overpayments made to providers and the OQPI does not have the training to conduct fraud investigations. The BMS is legally allowed to file a civil suit against providers through the provisions of *WVC* §9-7-6. There is, however, no evidence that there has ever been a legal judgement under *WVC* §9-7-6, allowing for triple recoveries in legal judgements involving fraud, in the absence of an investigation by the MFCU. Given the level of research involved in a legal case it is unlikely the BMS could adequately take legal action itself. For a provider who has been defrauding the Medicaid system the worse case scenario is they are caught and have to repay all funds gained through fraudulent billing. The BMS considers the questionable billings as mistakes instead of potential fraud and the provider is allowed to remain in the Medicaid system without receiving any additional scrutiny.

The BMS is legally allowed to file a civil suit against providers through the provisions of WVC §9-7-6. There is, however, no evidence that there has ever been a legal judgement under WVC §9-7-6, allowing for triple recoveries in legal judgements involving fraud, in the absence of an investigation by the MFCU.

The MFCU is prohibited by federal law from data mining operations. It would benefit the MFCU if the BMS, or its contractor, conduct data mining operations on targeted providers on a regular basis. That information should then be supplied to the MFCU for the manual review of claims data. The MFCU and the BMS should cooperatively identify the providers who should be the target of this data mining.

There are several providers identified as receiving overpayments during FY 2006 who have been involved in MFCU fraud investigations in the past.

Improving communications between the BMS and the MFCU would also have advantages for the BMS. As discussed in Issue 1, there are several providers identified as receiving overpayments during FY 2006 who have been involved in MFCU fraud investigations in the past. Improving communications would serve to make the BMS aware of these providers and would allow the BMS to target claims filed by these providers for more intensive pre and post-payment review.

Conclusion

The BMS refers very few cases to the MFCU. The MFCU is prohibited by federal law from data mining operations. States that attempt to perform prohibited functions risk losing federal funding. The inability to initiate date mining operations necessitates fraud units dependence upon outside sources of referral to perform their essential functions. One of the chief duties of the BMS OQPI is to refer cases of suspected fraud and abuse to the Medicaid Fraud Control Unit and it is currently not doing so. The BMS and the MFCU should take measures to improve communications. In addition, the BMS needs to refer more cases to the MFCU and utilize its trained fraud investigators.

Recommendations

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

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.*

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

WEST VIRGINIA LEGISLATURE

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John Sylvia
Director

December 22, 2006

Martha Yeager Walker, Cabinet Secretary
Office of the Secretary
West Virginia Department of Health & Human Resources
State Capitol Complex, Building 3 Room 206
Charleston, WV 25305

Dear Secretary Walker:

This is to transmit a draft copy of the Full Performance Evaluation of the Department of Health and Human Resources. This report is scheduled to be presented during the January 7th-9th interim meeting of the Joint Committee on Government Operations. 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 committee 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 on December 28th or December 29th. Please notify us to schedule an exact time. In addition, we need your written response by noon on Wednesday, January 3rd 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, January 4th 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

Enclosure

C: Nancy Atkins
David Bishop

Joint Committee on Government and Finance

Appendix B: Bureau for Medical Services Medicaid Expenditures by Provider Type

Provider Type	FY 2006 Expenditure
Inpatient Hospital Services	$209,860,932
Inpatient Hospital Services-Disproportionate Share Hospital (DSH) Adjustment Payments	$53,916,150
Mental Health Facilities	$36,085,565
Mental Health Facilities-DSH Adjustment Payments	$20,534,226
Nursing Facility Services	$402,903,863
Intermediate Care Facilities-Public Providers	$160
Intermediate Care Facilities-Private Providers	$53,642,336
Physicians Services	$126,950,184
Outpatient Hospital Services	$93,921,521
Prescribed Drugs	$378,095,030
Drug Rebate Offset-National Agreement	($112,878,531)
Drug Rebate Offset-State Sidebar Agreement	($29,528,976)
Dental Services	$38,320,543
Other Practitioners Services	$20,069,824
Clinic Services	$46,750,545
Lab and Radiological Services	$13,045,112
Home Health Services	$26,490,072
Hysterectomies/Sterilizations	$682,237
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	$3,450,995
Rural Health Clinic Services	$7,652,987
Medicare Health Insurance Payments- Part A Premiums	$17,903,197
Medicare Health Insurance Payments- Part B Premiums	$61,584,326
120%-134% of Poverty	$2,861,904
Medicaid Health Insurance Payments: Managed Care Organizations (MCO)	$213,950,846
Medicaid Health Insurance Payments: Group Health Plan Payments	$289,548
Home and Community-Based Services(Mental Retardation or Developmental Diseases)	$185,607,767
Home and Community-Based(Aged/Disabled)	$60,658,000
Personal Care Services	$27,037,173
Targeted Care Management Services	$9,026,219
Primary Care Case Management Services	$599,865
Hospice Benefits	$6,545,960
Federally Qualified Health Center	$17,133,735
Other Care Services	$117,082,516
Plus: Medicaid Part D Expenditures	$8,942,213
Plus: State Only Medicaid Expenditures	$4,507,995
Plus: Reimbursable	$4,446,206
Total Expenditures	$2,127,962,246

Source: BMS Medicaid Report November 2006

We did not receive a written response from the Agency.