

FY 2011 & FY 2012 Program Integrity Report

**Fraud and Abuse Prevention and Detection
In Virginia Medicaid**



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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Dear Fellow Virginians:

I am pleased to present the Virginia Medicaid Program Integrity Annual Report for State Fiscal Years 2011 and 2012. The report is a testament to the fine work of the staff of the Department of Medical Assistance Services (DMAS) and our many partners. The Program Integrity Division (PID) is entrusted with the responsibility of ensuring that the Virginia Medicaid is equipped to combat fraud, waste and abuse. Medicaid program integrity efforts are not limited to a single division in DMAS, but involve the entire agency and coordination with a variety of outside partners. Fortunately, only a small percentage of Medicaid providers and recipients engage in various forms of fraud and abuse. However, fraud and abuse affects everyone: the recipients of care; the taxpayers who pay for it; and, the providers who provide quality care. Each dollar lost to fraud is one less dollar available for someone in need of care.

DMAS has consistently achieved results while fulfilling its mission to protect the integrity of Virginia's Medicaid program and the health and welfare of its beneficiaries. During FY 2011 and FY 2012, DMAS program integrity efforts identified over \$61 million in improper expenditures and prevented the payment of more than \$363 million in potential improper expenditures. In addition, PID made efforts to expand fraud identification and prosecution, making 145 referrals of potential fraud, and continually improving coordination with the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU). DMAS Program Integrity and Health Care Services Divisions worked with DMAS' managed care partners to enhance program integrity within their organizations as well as within Virginia Medicaid. Lastly, the agency has some exciting future program integrity initiatives that will augment current practices through the use of new contractors and innovative analytical modeling.

The attached report provides information about DMAS program integrity efforts over the 2011-2012 Biennium. Additionally, the report includes statistical information such as estimated savings and audit outcomes. I trust that you will find this report helpful in gaining insight into this complex and vital program. It represents the combined efforts of a diverse and committed team of state employees and fellow citizens.

Sincerely,

Cindi Jones, Director
Department of Medical Assistance Services

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Executive Summary

Under Virginia's Medicaid program, taxpayer dollars are used to provide healthcare to low-income individuals. Program Integrity (PI) is the collective term given to activities conducted by the Department of Medical Assistance Services (DMAS) to ensure Medicaid dollars are spent effectively and appropriately. DMAS has molded PI efforts to continually increase the Commonwealth's capacity to prevent, detect, and address fraud and abuse in the Medicaid program. The mission of the Program Integrity Division (PID) is to protect the Medicaid program from external abuse and fraudulent activities, recover inappropriate Medicaid payments, as well as support the integrity efforts of the various Medicaid programs through oversight and technical assistance. The activities of PID are supported by the PI efforts of other DMAS divisions, as well as the efforts of contractors and partner agencies to identify fraud and abuse.

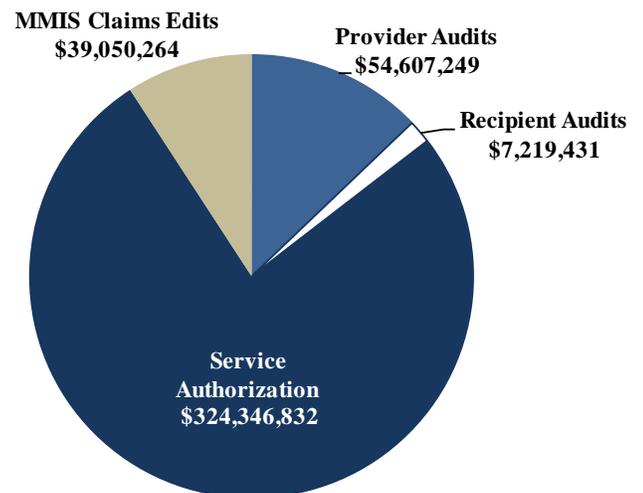
During FY 2011 and FY 2012, Program Integrity Division activities uncovered and/or prevented over \$386 million in improper expenditures in the Virginia Medicaid program. In addition to efforts by PID, prepayment edits in DMAS' claims processing system saved over \$39 million by blocking or reducing reimbursement on improperly-filed claims.

As seen in the chart, a large portion of program integrity savings in FY 2011 and 2012 came from cost avoidance due to the service authorization process, which denies medically unnecessary service requests. While prevention is preferable, not all improper payments can be detected before payment occurs. For that reason, DMAS conducts a variety of audit activities to identify misspent funds. As a result, \$61.8 million in recoveries is attributable to audits of providers and recipients conducted by Program Integrity Division staff and contractors.

PID's program integrity activities are further supported by the integrity-related efforts of the Department's major contract partners including the transportation broker, and the integrity programs of each managed care organization.

In addition to these successes in preventing, detecting and recovering improper payments, Virginia has received national recognition for its efforts in Medicaid program integrity. The director of the PI Division serves on the Center for Medicare and Medicaid Services (CMS) PI Technical Advisory Group (TAG), which is fundamental in developing and evaluating national PI efforts. PID staff members present for various seminars and national conferences including training sessions at the Medicaid Integrity Institute (MII), a joint program of the Department of Justice (DOJ) and the Centers for Medicare and Medicaid Services (CMS.)

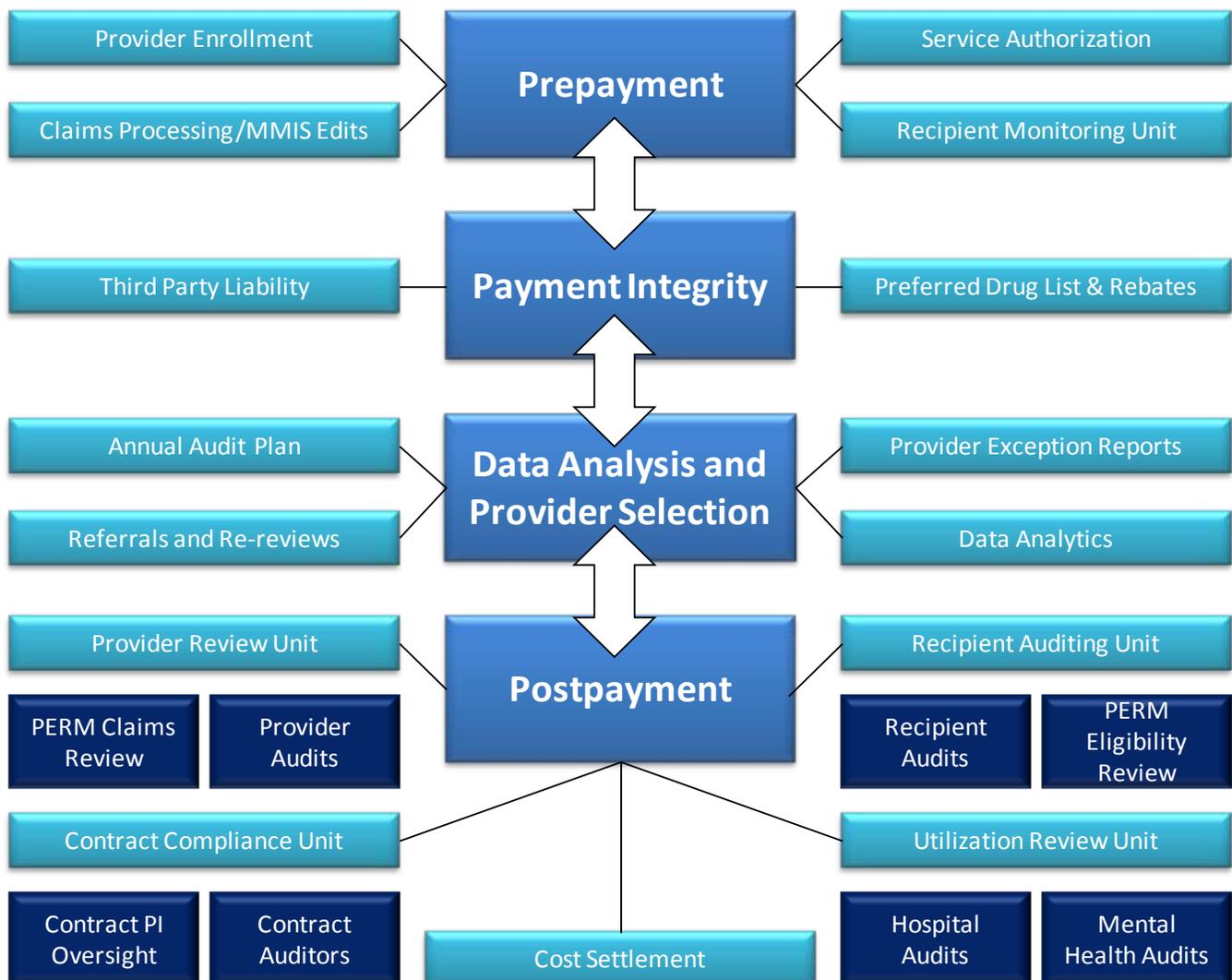
DMAS PI Savings and Retractions (FY 2011 & FY 2012)



Executive Summary

DMAS' PI efforts are summarized in four major areas:

- **Prepayment** processes to enhance cost avoidance by preventing improper expenditures on 1) services that are not medically necessary (Service Authorization), and 2) providers who are not eligible to participate in Medicaid (Provider Exclusion). Prepayment programs also ensure claims are paid according to DMAS policy (Claims Processing) and control over-utilization of Medicaid services by recipients (Recipient Monitoring Unit.)
- **Payment Integrity** processes that ensure DMAS pays only its share of recipient medical expenditures (Third-Party Liability) and that DMAS receives all of its pharmacy rebates.
- **Data Analysis and Provider Selection** processes identify potential risk areas to help inform decisions on where to target program integrity resources.
- **Post-payment** processes that identify instances of improper provider billings and improper recipient enrollment through investigation of referrals and audits of paid claims, some of which are forwarded on for fraud prosecution.



Preventing Improper Medical Expenditures

Preventing improper claims from being paid is always preferable to identifying improper payments after they have been paid because it avoids the need to collect erroneous payments and provides an additional deterrent to providers who knowingly submit inaccurate claims. Two major components of prepayment program integrity are the MMIS claims processing system and the Service Authorization process. MMIS is an automated system that ensures certain rules are met before a claim is processed for payment to a provider. For some services, providers are required to obtain Service Authorization, an evaluation of whether the service is medically necessary, before a claim can be paid. Together, these processes prevented over \$363 million in improper expenditures during FY 2011 and FY 2012.

MMIS Claims Processing Edits

DMAS has always subjected claims to rigorous prepayment scrutiny through its automated claims processing and review system called the Medicaid Management Information System (MMIS). Currently there are over 1,550 edits in the Virginia MMIS. These edits are rules that must be passed before claims are adjudicated for payment. For example, these edits reject duplicate claims and claims for services or service levels that are not authorized under Medicaid policy. One particular set of prepayment edits utilized by DMAS is the McKesson ClaimCheck software, which cost-avoided over \$6.5 million in FY 2011 and FY 2012. Another edit pends emergency room claims for further review, as well as reduces the reimbursement from the emergency rate to the lower non-emergency rate where appropriate. These processes saved \$32.4 million in FY 2011 and FY 2012. In June 2013, DMAS will implement the CMS-mandated prepayment National Correct Coding Initiatives to improve the prepayment claims review process.

Service Authorization

DMAS requires providers to obtain prior authorization of the medical necessity of certain services (referred to as Service Authorization) before a claim can be paid through MMIS. DMAS contracts with Keystone Peer Review Organization (KePRO,) which provides telephone and internet access for providers to request authorization. KePRO medical staff review the information submitted by providers and determine if the service is medically necessary under DMAS policy. As seen in the table below, service authorization avoided costs of over \$324 million in FY 2011 and 2012. The increase in avoided costs in FY 2012 resulted from the implementation of the VICAP program discussed in greater detail on the following page.

Type of Review	FY 2011 Denied Units/Days	FY 2011 Program Savings	FY 2012 Denied Units/Days	FY 2012 Program Savings
Inpatient	9,618	\$5,459,493	10,222	\$5,289,375
Outpatient	2,012,764	\$114,436,735	2,840,123	\$176,378,298
Waivers/Other Services	623,499	\$9,796,455	824,331	\$12,986,506
Total	2,645,881	\$129,692,682	3,674,676	\$194,654,150

In addition to cost avoidance from denied service requests, the service authorization process also creates a “sentinel effect” as providers are deterred from submitting requests for medically unnecessary services. Service authorization also helps to facilitate fraud prosecutions by requiring additional documentation which can be compared to the medical record to identify discrepancies.

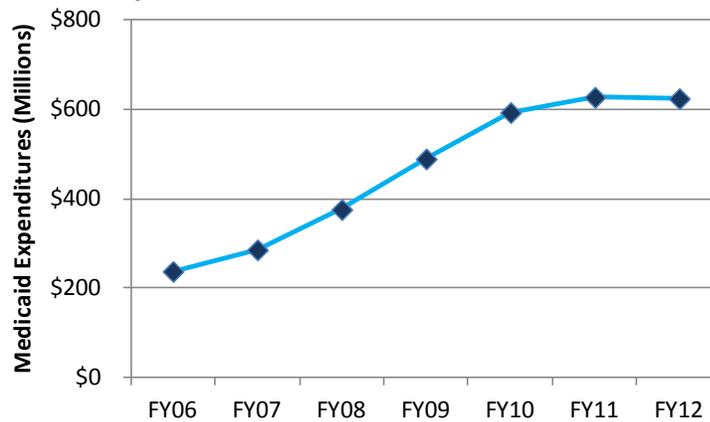
Preventing Improper Medical Expenditures

DMAS has brought a variety of new services under the Service Authorization contract in recent years, centralizing the determination of medical necessity. Regulatory changes have also been instituted to limit the duration of services covered by a single authorization to ensure that medical necessity is evaluated at regular intervals. Utilizing a combination of regulatory changes and Service Authorization, DMAS has been quite successful in preventing improper expenditures on behavioral health services.

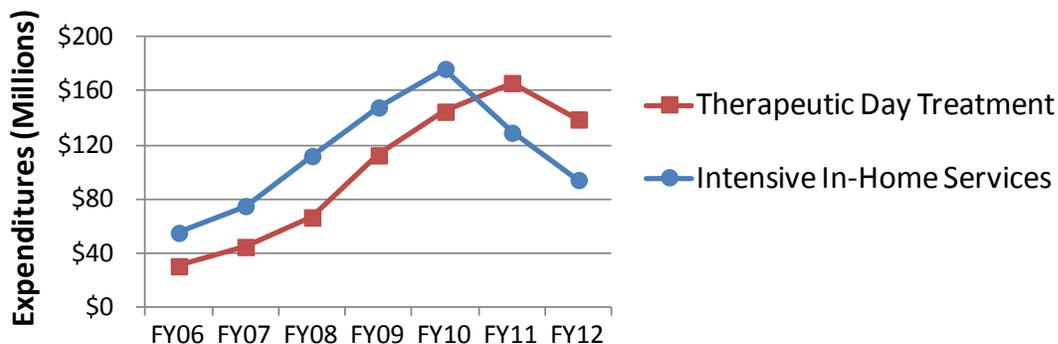
Preventing Improper Behavioral Health Care through Assessment and Authorization

As shown in the chart below, DMAS expenditures on Behavioral Health Services increased substantially between FY 2006 and FY 2009, more than doubling from \$237 M to \$489 M. The vast majority of this increase (70%) came from two service types, Intensive In-Home (IIH) and Therapeutic Day Treatment (TDT).

DMAS Expenditures on Behavioral Health Services



Pursuant to the 2011 Acts of Assembly, DMAS began the Virginia Independent Clinical Assessment Program (VICAP) that required an independent clinical assessment (ICA) be completed by a Community Services Board (CSB) prior to receiving IIH and TDT services. In July and August of 2011, CSBs began conducting ICAs for new service requests and re-authorizations. The Service Authorization contractor now reviews information from the ICA and the service provider when making a determination whether the service meets medical necessity guidelines. Over 30,000 requests for VICAP service authorization were processed in 2012 alone. The “sentinel effect” of the combination of the VICAP program and Service Authorization is illustrated in the following graph as IIH expenditures decreased \$82.1M (47%) from \$176.5M in FY 2010 and TDT expenditures decreased \$26.9 M (16%) from \$166.1M in FY 2011.



Ensuring Accurate Recipient Eligibility

In addition to preventative efforts, DMAS conducts a wide variety activities to ensure the integrity of Virginia Medicaid expenditures. Audits are conducted to identify recipients who do not meet eligibility requirements, as well as to uncover improperly paid provider claims. DMAS also collaborates with a variety of program integrity partners, including the Medicaid Fraud Control Unit (MFCU,) PI staff from DMAS Managed Care Organizations, and the provider community. DMAS initiatives to improve overall Medicaid PI include centralized contractor oversight, enhanced data analysis, and engagement of a contingency-based audit contractor.

Recipient Audit Unit

The Recipient Audit Unit (RAU) is responsible for the investigation of allegations of acts of fraud or abuse committed by recipients of the Medicaid, Family Access to Medical Insurance Security (FAMIS) and State & Local Hospital (SLH) programs. The investigations may result in the identification of misspent funds, administrative recoveries from recipients, or criminal prosecution. These allegations typically involve recipient eligibility issues such as: deceit in application; illegal use/sharing of a Medicaid card; uncompensated transfer of property; excess resources or income; or fraudulent household composition. The unit also investigates drug diversion and performs joint investigations with various law enforcement entities (the Virginia State Police, the FBI, etc.), as well as the Social Security Administration, and other federal/state agencies.

In SFY 2011 and SFY 2012, the RAU received over 4,000 referrals from various sources, such as citizens, providers, and local Departments of Social Services. RAU investigated 4,095 referrals over that time period and uncovered a total of \$7,219,431 in improper payments. In addition, 45 individuals were convicted of fraudulently obtaining benefits and ordered to pay \$461,654 in restitution. These recipients also are banned from the Medicaid program for one year (the maximum time allowed under federal law,) and can be subject to jail time as well.

Payment Error Rate Measurement (PERM) Review

The federal government conducts the PERM review every three years in each state to measure improper payments in state Medicaid program. The findings of the PERM project are used to determine how Virginia measures up on a national level in the area of payment accuracy. Virginia's last review of recipient eligibility determination occurred in federal fiscal year 2009 and found that local departments of social services had made errors in approximately 17 percent of cases. The vast majority (2/3) of these "errors" were undetermined cases, where information needed to establish eligibility could not be obtained. The PERM review for the FFY 2012 cycle began in August 2011. DMAS has engaged a contractor to facilitate these reviews with the main goal of minimizing the number of "undetermined" cases and lowering substantially Virginia's final PERM error rate. DMAS and the contractor are working closely with the Virginia Department of Social Services to ensure that all efforts are made to obtain necessary eligibility documentation.

Auditing Improper Provider Payments

The Program Integrity Division (PID) and its contractors focus extensively on providers, particularly audits of paid claims to Medicaid FFS providers. These audits generally examine a selection of claims filed during prior fiscal years to ensure that the claims were filed in accordance with DMAS and Medicaid policy. In most cases, these audits involve examining medical records to ensure that the record exists, supports the claim as billed, and is completed in accordance with DMAS policies. In addition, some may examine the credentials of the servicing provider to ensure they are qualified to provide the service that was billed. Contractors play an integral role in provider auditing, supplementing staff audits and providing knowledge and expertise in identifying audit targets and conducting reviews. During FY 2011 and 2012 audit activities, DMAS and its contractors identified over \$54 million in overpayments to Medicaid providers.

	FY 2011 Total Audits	FY 2011 Overpayments	FY 2012 Total Audits	FY 2012 Overpayments
DMAS - Provider Review Unit	176	\$1,827,415	156	\$1,071,533
DMAS - Mental Health	52	\$3,948,332	55	\$2,962,497
DMAS - Hospital	96	\$8,149,662	95	\$1,393,622
PID Audit Total	324	\$13,925,409	306	\$5,427,652
Xerox Pharmacy & DME	79	\$2,082,161	80	\$1,688,343
Health Management Systems DRG	90	\$3,173,822	87	\$5,867,252
Health Management Systems Mental Health	88	\$1,679,743	125	\$3,724,883
Clifton Gunderson/PHBV Partners LLP Physicians & Waiver Services	209	\$8,392,790	309	\$8,645,195
Contractor Audit Total	466	\$15,328,516	601	\$19,925,673
Total, PID and Contractor Audits	790	\$29,253,924	907	\$25,353,325

Risk Analysis and Audit Planning

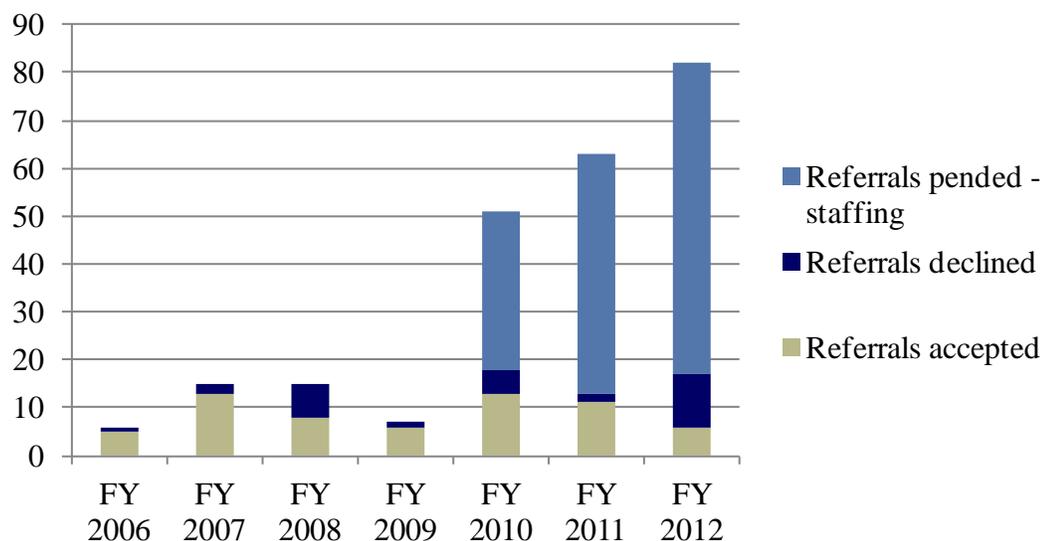
Because DMAS collects only the overpayments identified in audited claims, audits must be focused on service types and providers that are most likely to have improper payments. PID utilizes a contractor to perform a risk evaluation of each provider type that participates in the Medicaid FFS program. This evaluation consists of scoring each provider type based on 10 risk factors which include things like average claim cost, proportion of total Medicaid dollars, and history of fraud. Provider types with high scores are prioritized for audit when planning the number of audits to conduct that year. PID then works to coordinate planned staff and contractor audits to ensure an adequate number of audits are conducted on risky provider types. Individual providers are identified for audit through complaints and referrals or identified for audit through analysis of paid claims data often called “data mining.” This analysis identifies providers for audit based on the fact that their billings are out-of-line with other providers in their peer group and are likely to have the largest amount of improper claims.

Working Together to Fight Medicaid Fraud

In addition to identifying improper payments for collection, audits conducted by DMAS and its contractors may uncover evidence of potential fraud. Medicaid fraud is a criminal act that occurs when a Medicaid provider or recipient intentionally misrepresents themselves in order to receive an unauthorized benefit. Pursuant to federal law, Virginia's Medicaid Fraud Control Unit (MFCU) was established as a division of the Office of the Attorney General in 1982 and works closely with DMAS to investigate and prosecute suspected cases of Medicaid provider fraud. In addition to establishing restitution for past fraudulent activities, fraud convictions play an important role in program integrity more broadly, as convicted providers are banned from Medicaid participation for life. PID has an exceptional working relationship with the MFCU which continues to improve through constant communication and collaboration, including monthly meetings between staff of the two agencies.

In FY 2011 and FY 2012, MFCU obtained convictions of 32 health care providers in state and federal courts. **Those cases resulted in a total of \$54,834,631.93 in court-ordered fines, penalties, and restitution to the Virginia Medicaid program.** In addition, each of the 32 health care providers was barred for life from participating in the Medicaid program.

As seen in the graph below, DMAS referrals to MFCU increased substantially beginning in FY 2010. In FY 2011 and FY 2012, DMAS made 145 referrals of suspected fraud to the MFCU. In response to the increase in referrals of suspected fraud, the Attorney General authorized the MFCU to add 25 investigators, attorneys, and support staff in FY 2011 to investigate and prosecute fraudulent providers. As a result of this staffing increase, MFCU will be able to investigate a larger number of cases and potentially recover millions of additional dollars in fraudulently obtained Medicaid funds.



Enhancing PI Through Managed Care Collaboration

The majority of Medicaid recipients are covered by managed care organizations (MCOs) that receive a contracted monthly rate for each enrolled member, and each MCO is responsible for paying providers directly for the medical services incurred by its members. The MCOs are required to have policies and procedures in place to prevent, detect and investigate allegations of fraud, waste and abuse. While MCOs have a profit motive to minimize improper payments within their network, and overpayments made by MCOs are not paid directly by DMAS, inadequate detection of fraud and abuse may result in MCO rates being based on inflated expenditure data.

The Contract Compliance Unit (CCU) serves as the DMAS fraud and abuse liaison to the MCOs in addition to periodically evaluating the adequacy of MCO program integrity policies, procedures and outcomes. The unit works closely with the Health Care Services Division (HCSD) on any changes or clarifications to the MCO contract that are needed to ensure adequate MCO program integrity. Recent changes to the contract have improved the accuracy and consistency of MCO reports on PI outcomes and clarified the process for reporting cases of potential fraud.

In February of 2012, staff from the Program Integrity Division and Health Care Services Division implemented an annual audit of each MCO's compliance with the program integrity requirements under the MCO contract. During the initial Program Integrity Compliance Audit (PICA) MCOs were generally found to be compliant, and DMAS staff worked with the plans to correct any identified deficiencies. In the future, the PICA will dig deeper into the content of reports, annual audit plans, etc., to ensure that policies are being followed and that reporting appears accurate and complete. In addition, the PICA audit tool is being modified to assess similar PI requirements in other vendor contracts including the Consumer-Directed Care fiscal agent as well as the Dental and Transportation brokers.

In FY 2011, the unit began holding quarterly Managed Care Program Integrity Collaborative meetings that provide a venue where program integrity staff from the MCOs and DMAS are given the opportunity to share information about their PI functions and identify opportunities to improve overall Medicaid program integrity. This collaborative has enhanced the individual MCOs program integrity activities and provided the opportunity for a more comprehensive approach to fraud and abuse prevention across all Virginia Medicaid payers. In addition, the collaborative has been identified as a national best practice and DMAS staff have presented the model to Medicaid staff from other states at a variety of national conferences.

Working with Home and Community-Based Service Providers

Home- and Community- Based Services (HCBS) are provided to individuals enrolled in Medicaid who meet criteria for admission to a hospital, nursing facility (NF) or Intermediate Care Facility but choose to receive services in a less restrictive and less costly community setting. Services may include personal care, respite care, adult day health care, and a range of other support services. Language in the 2011 and 2012 Appropriations Acts directed DMAS to consult with HCBS providers and evaluate the effectiveness and appropriateness of the audit methodology. DMAS held a series of seven stakeholder meetings during the summers of 2011 and 2012 to obtain input from HCBS providers on the DMAS audit methodology.

Pursuant to these meetings, DMAS made or proposed several changes to HCBS regulations and policies, particularly the EDCD, Technology Assisted, and Developmental Disabilities (DD) waiver. In response to concerns raised by providers, DMAS:

- implemented check boxes to the DMAS 90 form, which is used to document personal care services, in order to streamline completion of the document;
- successfully implemented Senate Bill 265 of the 2010 General Assembly session, which required the licensure (including site visits) of Home Health Care Agencies by July 1, 2012. This legislation, which had broad-based support, strengthens protections for individuals needing care and led to the termination of 250 non-compliant providers;
- initiated efforts to adjust the methodology and conduct of audits including a reduction of the claim period for the review from 15 months to 12 months.

Greater detail on these initiatives is available in two reports to the General Assembly: *Evaluation of Effectiveness and Appropriateness of Review Methodology for Home and Community Based Services* (November 1, 2011;) and *Report of the Activities of the DMAS Advisory Group on Audit Methodology for Home- and Community-Based Services* (December 1, 2012.)

Future Initiatives

Contract Compliance Unit (CCU) Oversees Contract Auditors

In addition to its efforts related to managed care, the CCU also plays an important role in oversight of PID's contract auditors. As mentioned earlier, DMAS engages a substantial number of contractors to augment staff audit activities. Establishment of the CCU has brought the contract monitors for each of these audit contracts into one unit where staff can collaborate on best practices for contract oversight. This collaboration increases consistency in the development of contracts as well as in the ongoing management of contractor activities.

Data Analytics

DMAS is committed to the continuous improvement of its PI tools to contain costs, reduce inaccurate or unauthorized claims and reimbursement, and better detect fraud and abuse. As a result, DMAS issued an RFP in late FY 2012 for development of a Medicaid Fraud and Abuse Detection (MFAD) system that will enhance efforts to further identify potential fraud, waste, and abuse (FWA) target areas. The contract was awarded and the MFAD project began in July 2013. The system will create a series of tests that identify possible FWA behavior based on known patterns, issues, and scenarios as well as using statistical models to identify anomalies, outliers and trends. This system will allow DMAS to better understand PI issues and problematic providers as well as provide opportunities to examine trends across programs and across multiple program years. Once processing claims regularly, the MFAD system will be able to identify potentially improper claims shortly after the claim is processed, which may provide an opportunity to implement preventative measures to stop those claims before they are paid.

Recovery Audit Contractors

As a result of the Affordable Care Act becoming federal law in 2010, States are required to establish programs to utilize Recovery Audit Contractors (RACs) to audit payments to Medicaid providers. RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they identify and collect from providers. RACs have been used since 2005 in the Medicare program, and the Centers for Medicare & Medicaid Services (CMS) reported that the RACs had succeeded in identifying more than \$1 billion in Medicare improper payments from March 2005 to March 2008, 96 percent of which was overpayments.

Pursuant to language in Virginia's FY 2011-2012 budget bill authorizing DMAS to employ RAC auditors, DMAS issued an RFP in March 2012 for proposals from qualified and innovative health care auditing firms to provide RAC services for Virginia's Medicaid program. The contract was awarded with an effective date of July 10, 2013. The cost to the State is minimal for this program, as the RAC's contingency fees will come out of recovered overpayments, and the Federal Government will cover 50 percent of any administrative costs. The RACs use proprietary software programs to identify potential payment errors in such areas as duplicate payments, fiscal intermediaries' mistakes, medical necessity and coding in addition to conducting standard audits. While DMAS will rely on the contractor's expertise in identifying potential opportunities for audit, the agency will still make the final decision on which audit scenarios are pursued by the RAC.

Future Initiatives

Enhanced Provider Enrollment Screening

The Affordable Care Act (ACA) requires enhanced screening of all participating Medicaid providers as well as additional screening of provider types classified by the Centers for Medicare & Medicaid Services (CMS) as moderate or high risk providers. All providers must undergo additional automated screening every 30 days against certain databases (the master death records from VDH, the federal List of Excluded Individuals and Entities (LEIE), etc.) in order to ensure no banned providers or owners receive federal funds. In order to perform these checks, ACA requires additional disclosure by providers of their ownership and managing partners, which DMAS will store in digital format. Provider types labeled moderate- or high-risk, such as Durable Medical Equipment and Home Health, must also undergo unannounced site visits. High-risk providers will have to undergo a criminal background check and FBI fingerprint check.

Healthcare Reform Requires Additional Provider Enrollment Screenings

Type of Screening	Provider Risk Category		
	Low	Moderate	High
License verifications (including across state lines)	✓	✓	✓
Federal Database checks	✓	✓	✓
Unscheduled or unannounced site visits		✓	✓
Criminal background check			✓
Fingerprinting			✓

DMAS estimates that there are currently about 5,700 moderate and high-risk providers enrolled in the Virginia Medicaid system. DMAS will be able to leverage CMS' screening on about 80% of those providers who are also Medicare providers. The additional provider enrollment measures will help DMAS to prevent improper payments by providing more complete and up-to-date information on ineligible providers as well as focus greater scrutiny on the enrollment of riskier providers. The new measures may also provide new opportunities for auditors to identify connections between fraudulent or problematic providers through shared ownership or management.

Conclusion

The combined program integrity efforts of DMAS identified and/or prevented over \$425 million in improper expenditures in the Virginia Medicaid program in FY 2011 and FY 2012. The vast majority of these dollars (\$363 million) were savings from prepayment activities such as Service Authorization and MMIS Claims Processing Edits, which stop improper payments before they are made. DMAS will look to prevent even greater amounts of unnecessary expenditure in the future through enhanced provider screening and the implementation of prepayment analytics through its newly-created fraud and abuse detection system.

In addition, audits of providers and recipients uncovered \$61.8 million in improper payments during FY 2011 and FY 2012. DMAS has also engaged a Recovery Audit Contactor which will audit providers and receive a contingency fee based on recoveries they identify. This incentive structure should lead to the identification and recovery of additional funds in future years. DMAS has also enhanced its risk analysis and data mining capabilities through development of a Medicaid Fraud and Abuse Detection system, which will help to identify providers and claims that are likely to contain improper payments.

DMAS has fostered a collaborative approach with its program integrity partners through monthly meetings with the Medicaid Fraud Control Unit as well as the quarterly Managed Care Program Integrity Collaborative. The collaborative has become a national model and has already helped to create an open and cooperative approach to PI in Virginia Medicaid across all payers. DMAS worked vigilantly to stamp out fraud, resulting in convictions of 45 Medicaid recipients and 32 Medicaid providers and over \$55 million in court-ordered fines, penalties, and restitution to the Virginia Medicaid program.