Roderick L. Bremby
Commissioner

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

Telephone
(860) 424-5053
Facsimile
(860) 424-5057
TDD/TYY
1-800-842-4524
Email
Commis.dss@ct.gov

February 20, 2018

Honorable Paul Formica, Appropriations Senate Chair
Honorable Catherine Osten, Appropriations Senate Chair
Honorable Toni Walker, Appropriations House Chair
Legislative Office Building
300 Capitol Avenue Room 2700
Hartford, CT 06106

Honorable Joe Markley, Human Services Senate Chair
Honorable Marilyn Moore, Human Services Senate Chair
Honorable Catherine Abercrombie, Human Services Senate Chair
Legislative Office Building
300 Capitol Avenue, Room 2000
Hartford, CT 06106

RE: PUBLIC ACT No. 13-293
AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAID PROGRAM INTEGRITY

Dear Honorable Co-Chairs and Ranking Members of the Appropriations and Human Services Committee:

The attached joint report has been prepared by the Department of Social Services in coordination with the Office of the Chief State's Attorney and the Office of the Attorney General. The joint report represents the state's efforts to prevent and control fraud, abuse, and errors in the Medicaid payment system and to recover Medicaid overpayments. Included in this report is a final reconciled and unduplicated accounting of identified, ordered, collected and outstanding Medicaid recoveries for all sources. This report is for activity during the period July 1, 2016 through June 30, 2017.

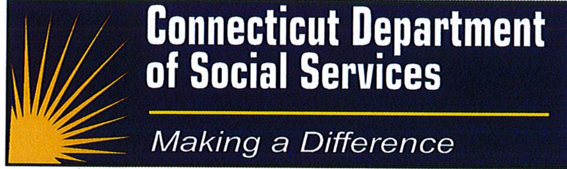
Sincerely,

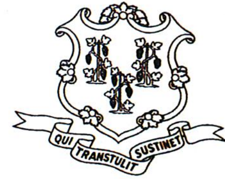
Roderick L. Bremby (by KM Brennan)

Roderick L. Bremby
Commissioner

RLB:JFM
Attachment

cc: Neil Ayers, Office of Fiscal Analysis
Emily Shepard, Office of Fiscal Analysis
Holly Williams, Office of Fiscal Analysis
Kathleen Brennan, Deputy Commissioner
George Jepsen, Attorney General
Kevin Kane, Chief State's Attorney
Krista Ostaszewski, Legislative Liaison





Medicaid Program Integrity-Legislative Report

Pursuant to Public Act No.13-293

Department of Social Services
Commissioner Roderick L. Bremby

Table of Contents

Introduction 1-2

Audit Division Statistics 07/01/16-06/30/17 3-4

Number of audits, overpayments identified, overpayments recovered, and number of audits referred to Provider Investigations (by provider type) [Table 1.1] 3

Number of self-audits, integrity reviews and internal audits, overpayments identified, avoided costs identified and overpayments recovered [Table 1.2] 3

Number of complaints received and reason for complaint by source [Table 1.3] 4

Audit Contractor Statistics 07/01/16-06/30/17 4

HMS audits conducted, overpayments identified, avoided costs identified and overpayments recovered [Table 1.4] 4

Long Term Care audits conducted, overpayments identified and overpayments recovered [Table 1.5] 4

Special Investigations Division Statistics 07/01/16-06/30/17 5-7

Number of investigations opened and closed (referred to law enforcement) by source and provider type [Table 1.6] 5-6

Overpayments due to investigations identified and collected 6

Time elapsed from case opening to case closing/referral [Table 1.7] 6

Investigations resulting in suspension in payment or termination of provider enrollment [Table 1.8] 6-7

Investigations and Recoveries Division Statistics 07/01/16-06/30/17 8

Cost avoidance and recoveries [Table 1.9] 8

Third Party Liability Division Statistics 07/01/16-06/30/17 9-10

Number of claims billed and amount billed for claims selected for billing to commercial insurance and Medicare SFY 2015-2017 [Table 2.0] 9

Number of claims recovered and amount recovered for claims billed to commercial insurance and Medicare SFY 2015-2017 [Table 2.1] 9

Claims denied by commercial health insurance SFY 2015-2017 [Table 2.2] 10

Explanation of claim denials 10

Files updated with third party insurance information SFY 2015-2017 [Table 2.3] 10
Number of claims denied and costs avoided due to client health insurance or Medicare [Table 2.4] 10
Home Health and Skilled Nursing Facility services recovered through Medicare appeals [Table 2.5] 10
Performance Standard 10
Return on Investment by Division [Table 2.6] 10
Projected Cost Savings 11-12
Audit Division [Table 2.7] 11
Investigations and Recoveries Division [Table 2.8] 11
Special Investigations Division [Table 2.9] 12
Third Party Liability Division [Table 3.0] 12
New Initiatives to Prevent and Detect Overpayments 12-14
Audit Division 12
Investigations and Recoveries Division 12-13
Special Investigations Division 13
Third Party Liability Division 13-14

The Office of Quality Assurance ("QA") is responsible for ensuring the fiscal and programmatic integrity of programs administered by the Department of Social Services ("Department"). In addition, QA is responsible for ensuring the integrity of administrative functions of the Department. QA has five separate divisions, each with unique program integrity functions: Audit, Investigations and Recoveries, Special Investigations, Quality Control and Third Party Liability.

Audit Division

The Audit Division ensures compliance, efficiency, and accountability within federal and state programs administered by the Department by detecting and preventing mismanagement, waste and program abuse and ensuring that state and federal dollars are spent appropriately, responsibly, and in accordance with applicable laws and regulations. To achieve this objective, the Audit Division:

- Performs federally mandated audits of medical and health care providers that are paid through the various medical assistance programs administered by the Department;
- Reviews medical provider activities, audits claims, identifies overpayments, and educates providers on program integrity issues;
- Provides support and assistance to the Department Special Investigations Division in the ongoing effort to combat fraud and abuse;
- Performs audits of the Department's operations, involving review of administrative and programmatic functions and the electronic data processing systems used in their support;
- Coordinates the Department's responses to all outside audit organization's reviews performed on the Department, including but not limited to, the State Auditors of Public Accounts and federal audit organizations;
- Reviews federal and state single audit reports and performs audits of financial, administrative and programmatic functions of the Department's grantees;
- Performs data analytics to identify aberrant billing activity and pursues collection of such overpayments; and
- Substantiates whether complaints received from various sources are valid and determines the proper disposition of the complaint including conducting an audit or forwarding to the Department's Special Investigations Division.

Investigations and Recoveries Division

The Investigations and Recoveries Division is comprised of two units; the Client Investigations Unit and the Resources and Recoveries Unit. Both units have investigation staff located at both central and statewide field office locations.

- **Client Investigations Unit** investigates alleged client fraud in various programs administered by the Department. This unit performs investigations via pre-eligibility, post-eligibility and other fraud investigation measures that include, but are not limited to, data integrity matches with other state and federal agencies. This unit also oversees the toll-free Fraud Hotline 1-800-842-2155 that is available to the public to report situations where it's perceived that a public assistance recipient, a provider, or a medical provider may be defrauding the state.

- **Resources and Recoveries Unit** is charged with ensuring that the Department is the payer of last resort for the cost of a client's care by detecting, verifying, and utilizing third-party resources; establishing monetary recoveries realized from liens, mortgages, and property sales; and establishing recoveries for miscellaneous overpayments.

Special Investigations Division

The Special Investigations Division is comprised of two units; Provider Investigations and Provider Enrollment. Integration of the Office of Quality Assurance's Provider Enrollment functions within the Special Investigation Division enhances the CMAP's program integrity. The review of provider enrollment applications is the first line of defense against fraud.

- **Provider Investigations Unit** is charged with the responsibility of coordinating and conducting activities to investigate allegations of fraud in the Connecticut Medical Assistance Program. When appropriate, credible allegations of fraud are referred to the Department's law enforcement partners pursuant to a memorandum of understanding (MOU). Parties to the MOU are the Office of the Chief State's Attorney, the Office of the Attorney General and the U.S. Department of Health and Human Services' Office of the Inspector General. Each entity is responsible for independently investigating the Department's referral to determine if a criminal and/or civil action is appropriate.
- **Provider Enrollment Unit** is responsible for the review and approval of all provider enrollment and re-enrollment applications, on an on-going basis. This Unit also shares responsibility for ensuring federal (42 CFR 455 Subpart B and E) and ACA requirements for provider enrollment are instituted and adhered to. Coordination of efforts between the Provider Investigations Unit and Provider Enrollment Unit strengthens Connecticut's program integrity efforts.

Quality Control Division

The Quality Control Division is responsible for the federally-mandated reviews of child care, Medicaid, and the Supplemantal Nutrition Assistance Programs (SNAP). A newly-established set of federally-required Medicaid reviews has been implemented under the Payment Error Rate Measurement program. Reviews of Temporary Assistance for Needy Families cases and special projects may also be performed by this unit.

Third Party Liability Division

The Third Party Liability Division is responsible for the Department's compliance with federal Third Party Liability requirements and recovering tax-payer funded health care from commercial health insurance companies, Medicare and other legally liable third parties The Division manages programs that identify client third party coverage and recover client health care costs.

Audit Division Statistics 07/01/16 – 06/30/17

Audits were conducted on 86 providers. The total amount of overpayments identified due to audits was $24,729,918, the total amount of avoided costs identified was $10,595,555 and the total amount of overpayments recovered was $27,120,226. See Table 1.6 for the number of audits that resulted in referrals. [Table 1.1]

Table 1.1

Provider Type	Number of Audits	Amount of Overpayments Identified	Amount of Avoided Costs Identified	Amount of Overpayments Recovered
Behavioral Health Clinician	0	$0	$0	$4,258
Community Clinics	1	$0	$0	$175,000
CT Home Care Program	3	$26,208	$13,104	$277,753
DDS Waiver Program	13	$558,052	$279,026	$105,236
Dental Group	4	$1,381,733	$690,867	$1,428,438
Dentist	4	$830,857	$415,429	$800,607
General Hospital	2	$10,408,269	$3,434,729	$10,609,603
Home Health	5	$5,650,271	$2,825,136	$5,651,031
Independent Laboratory	0	$0	$0	$487,043
Medical Equipment Supplier	8	$885,158	$442,579	$1,294,252
Pharmacy	30	$929,168	$464,584	$1,096,266
Physician, MD-Group	16	$4,060,202	$2,030,101	$5,190,739
Total	86	$24,729,918	$10,595,555	$27,120,226

Note: Amount of overpayments identified is representative of audits closed in SFY 2017; however, overpayments recovered may be for audits conducted and closed prior to SFY 2017.

In addition to audits referenced in Table 1.1, the Audit Division also completed 233 integrity reviews/audits which resulted in identifying $25,867,570 of overpayments, $5,763,052 in avoided costs and $25,794,479 of recovered overpayments. [Table 1.2]

Table 1.2

Type of Audit/Review	Number of Audits	Amount of Overpayments Identified	Amount of Avoided Costs Identified	Amount of Overpayments Recovered
Required self-reporting audits	56	$6,643,205	$0	$6,643,205
Claims Analysis Integrity Reviews	167	$17,074,737	$4,688,238	$17,035,917
Global Settlements/Medicaid Settlements	10	$2,149,628	$1,074,814	$2,115,357
Total	233	$25,867,570	$5,763,052	$25,794,479

A total of 313 complaints were received. Table 1.3 identifies the number of complaints received and the reason for complaint for each source. See Table 1.6 for the number of complaints that resulted in referrals.

Table 1.3

Source of Complaint	Client Paid Cash	Falsifying Documentation	Incorrect Coding	Other	Services Not Performed	Unlicensed Provider	Number of Complaints
Allied		25	2	6	66		99
CHN		3		8		2	13
DSS		10	5	8	13		36
Fraud Hotline	21	24	11	53	30	2	141
DXC			1	3	10		14
Other	1	2		2		1	6
Provider				4			4
Total	22	64	19	84	119	5	313

Audit Contractor Statistics 07/01/16 – 06/30/17

Three audits were conducted by HMS Recovery Audit Contractor (RAC) which resulted in a total of $1,360 in overpayments identified, $680 in avoided costs identified and $144,805 in overpayments being recovered. [Table 1.4]

Table 1.4

Provider Type	Number of Audits	Amount of Overpayments Identified	Amount of Avoided Costs Identified	Amount of Overpayments Recovered
ABI - Acquired Brain Injury	0	$0	$0	$4,518
Dental Group	3	$1,360	$680	$140,287
Total	3	$1,360	$680	$144,805

231 Long Term Care audits were conducted by HMS and Myers & Stauffer which resulted in a total of $9,918,679 in overpayments identified and $9,918,679 in overpayments being recovered. [Table 1.5]

Table 1.5

Contractor	Number of Audits	Amount of Overpayments Identified	Amount of Overpayments Recovered
HMS	136	$8,944,177	$8,944,177
Myers & Stauffer	95	$974,502	$974,502
Total	231	$9,918,679	$9,918,679

Provider Investigations Unit

A total of 41 investigations were opened and 33 investigations were referred to law enforcement for further action. Per a memorandum of understanding, referrals to law enforcement include the Connecticut Office of the Chief State's Attorney – Medicaid Fraud Control Unit (MFCU); the Connecticut Office of the Attorney General (AG); and the United States Department of Health and Human Services, Office of the Inspector General, Office of Investigations (OI). A total of 30 investigations were closed by Investigations and, if applicable, forwarded to the Audit Division for whatever action deemed appropriate. [Table 1.6]

Table 1.6				
Source	Provider Type	Investigations Opened	Investigations Referred to Law Enforcement	Investigations Closed
Audit Division	APRN	1	1	1
Audit Division	Behavioral Health Clinician	1	1	0
Audit Division	CT Home Care Program	1	2	1
Audit Division	Dental Group	0	0	2
Audit Division	Dentist	2	2	1
Audit Division	DME/MEDS*	0	0	1
Audit Division	Home Health	3	1	3
Audit Division	Personal Care Services	1	1	0
Audit Division	Physician	1	1	1
Audit Division	Physician Group	2	2	0
Audit Division	Therapist Group	1	1	0
Complaint	Behavioral Health Clinician	0	0	1
Complaint	Behavioral Health Clinician Group	1	1	0
Complaint	Personal Care Services	0	0	1
Complaint	Physician	0	0	1
Contractor	Behavioral Health Clinician Group	0	1	0
Contractor	Clinic	0	0	1
Contractor	Dental Group	0	0	1
Contractor	Dentist	0	0	1
Contractor	Home Health	0	0	1
Contractor	Laboratory-Independent	0	0	1
Contractor	Physician Group	1	0	0
Contractor	Therapist Group	1	1	0
Data Mining	Behavioral Health Clinician	5	2	1
Data Mining	Behavioral Health Clinician Group	5	2	2
Data Mining	CT Home Care Program	1	1	0

Table 1.6				
Source	Provider Type	Investigations Opened	Investigations Referred to Law Enforcement	Investigations Closed
Data Mining	Dentist Group	1	0	1
Data Mining	Personal Care Services	10	11	7
Data Mining	Physician	1	1	0
Other State Agency	Behavioral Health Clinician Group	1	0	0
Other State Agency	DDS IFS* Waiver Provider	1	1	1
Total		41	33	30

*DME/MEDS – Medical Equipment, Device and Supplies
IFS- Individual and Family Support

A total of $7,675,730 in overpayments in SFY 2017 was identified due to referrals to law enforcement.

All 33 investigations referred to law enforcement were completed by the Investigations Division within 12 months or less. Table 1.7 identifies the length of time that elapsed from the opening of the investigation to the closing of the investigation (referral).

Table 1.7	
Time Range	Investigations Completed and Referred to Law Enforcement
Less than one month to six months	32
Seven months to twelve months	1
Thirteen months to twenty four months	0
Twenty five months or more	0
Total	33

In compliance with 42 CFR § 455.23, the Department initiated 12 temporary payment suspensions. At the end of SFY 2017 a total of 26 temporary payment suspensions were in place totaling $1,233,332. 15 provider enrollments were terminated or suspended. [Table 1.8]

Table 1.8				
Source	Provider Type	Payment Suspensions initiated in SFY 2017	Payment Suspensions in place SFYE 2017	Provider Enrollments Terminated or Suspended
Audit Division	DME/MEDS	1	1	0
Audit Division	Physician	1	1	0
Audit Division	Pharmacy	0	0	1
Complaint	Behavioral Health Clinician	0	2	1
Complaint	Behavioral Health Clinician Group	1	2	1
Complaint	Dentist	1	0	0
Complaint	Dental Group	0	1	0
Complaint	Physician	0	0	1
Contractor	Behavioral Health Clinician	2	2	0

Table 1.8				
Source	Provider Type	Payment Suspensions initiated in SFY 2017	Payment Suspensions in place SFYE 2017	Provider Enrollments Terminated or Suspended
Contractor	Behavioral Health Clinician Group	2	3	2
Contractor	Independent Laboratory	1	1	0
Data Mining	Behavioral Health Clinician	1	2	0
Data Mining	Behavioral Health Clinician Group	0	1	0
Data Mining	Independent Laboratory	0	1	0
DSS Prov Enrollment	MEDS	0	0	1
Law Enforcement-Federal	MEDS	0	1	0
Law Enforcement-Federal	Behavioral Health Clinician Group	0	0	1
Law Enforcement-Federal	Physician	0	0	2
Law Enforcement-State	Physician	0	0	1
Law Enforcement-State	Medical Resident	0	0	1
Law Enforcement-State	Dental Group	0	1	0
Law Enforcement -State	Physician Group	2	2	0
Other State Agency	Physician	0	0	2
Other State Agency	Physical Therapist	0	0	1
Other State Agency	APRN	0	1	0
Previous Referral	Behavioral Health Clinician Group	0	2	0
Previous Referral	Dentist	0	1	0
Previous Referral	Dental Group	0	0	0
Previous Referral	Independent Laboratory	0	1	0
Total		12	26	15

Investigations and Recoveries Division Statistics 07/01/16 – 06/30/17

The below information is supplemental to information required by Public Act No. 13-293.

A total of $35,740,874 in avoided costs and recoveries are reported from the Investigations and Recoveries Division. [Table 1.9]

Table 1.9	
	Amount
Cost Avoidance & Recoveries – Client Investigations	**$11,759,214**
Cost Avoidance & Recoveries – Resources and Recoveries	**$23,981,660**
Total	**$35,740,874**

In SFY 2017, in addition to the cost avoidance and recoveries referenced in Table 1.9, the Client Investigations Division also completed and referred seventy-six (76) arrest warrants to State Prosecutors for criminal prosecution.

Sixty-one (61) recipients were arrested for Public Assistance fraud as a result of arrest warrants. Eighteen (18) cases were court adjudicated.

Third Party Liability Division Statistics 07/01/16– 06/30/17

A total of 1,800,801 claims were selected for billing to commercial health insurance and Medicare with a total amount billed of $236,768,881 for SFY 2017. Below is a breakdown of this information for the last three fiscal years. [Table 2.0]

Table 2.0						
	SFY 2015		SFY 2016		SFY 2017	
	# of Claims	Amount Billed	# of Claims	Amount Billed	# of Claims	Amount Billed
Commercial Insurance	1,596,839	$202,531,223	1,278,756	$164,433,433	1,793,010	$230,419,838
Medicare	28,420	$14,924,309	10,496	$8,350,686	7,791	$6,349,043
Total	1,625,259	$217,455,532	1,289,252	$172,784,119	1,800,801	$236,768,881

A total of 228,973 claims were recovered from commercial insurance and Medicare with a total amount of $29,920,049 collected for SFY 2017. Below is a breakdown of this information for the last three fiscal years. [Table 2.1]

Table 2.1						
	SFY 2015		SFY 2016		SFY 2017	
	# of Claims	Amount Collected	# of Claims	Amount Collected	# of Claims	Amount Collected
Commercial Insurance	245,310	$33,049,317	188,050	$31,783,756	226,405	$27,008,991
Medicare	4,262	$4,776,034	2,580	$2,693,099	2,568	$2,911,058
Total	249,572	$37,825,350	190,630	$34,476,855	228,973	$29,920,049

A total of 1,405,038 claims with a total amount of $176,985,903 were denied by commercial health insurance for SFY 2017. Below is a breakdown of this information for the last three fiscal years. [Table 2.2]

Table 2.2					
SFY 2015		SFY 2016		SFY 2017	
Claims	Dollars	Claims	Dollars	Claims	Dollars
1,385,315	$157,089,856	711,199	$98,410,427	1,405,038	$176,985,903

Reasons for commercial health insurance denial:

- Client did not have coverage that was in effect at time of service
- Health care service is not covered
- Deductible/copay was not met
- Health insurance plans maximum benefit for service had been met

Table 2.3 identifies the total number of files updated in the Department's client eligibility records; as well as, a breakdown of commercial health insurance policies added, changed or deleted.

Table 2.3											
SFY 2015				SFY 2016				SFY 2017			
Additions	Changes	Deletions	Total	Additions	Changes	Deletions	Total	Additions	Changes	Deletions	Total
138,750	37,552	2,839	179,141	157,707	61,894	1,498	221,099	167,035	32,823	6,573	206,431

A total of 595,367 health care claims were denied due to client health insurance or Medicare, resulting in a total amount of $527,686,481 in costs avoided for SFY 2017. [Table 2.4]

Table 2.4		
Other Payment Source	**Number of Claims**	**Dollar Amount**
Commercial Insurance	**338,429**	**$303,360,005**
Medicare	**256,938**	**$224,326,476**
Total	**595,367**	**$527,686,481**

Table 2.5 identifies the Medicaid dollar amount of Home Health and Skilled Nursing Facility services recovered through Medicare appeals.

Table 2.5	
Provider Type	**Dollar Amount**
Home Health	**$118,953**
Skilled Nursing Facility	**$6,168,836**
Total	**$6,287,789**

Performance Standard

Table 2.6 identifies the return on investment (ROI) by division. ROI was calculated as (Division Recoveries + Cost Avoidance)/Division Cost.

Table 2.6	
Division	**Return on Investment**
Audit Division	**14.03**
Investigations and Recoveries Division	**4.14**
Special Investigations Division	**28**
Third Party Liability Division	**60**

Projected Cost Savings

Audit Division

The Audit Divisions projected cost savings for SFY 2018 are $53,500,000. [Table 2.7]

Table 2.7	
Description	**Amount**
Audit Adjustments	$24,000,000
Audit Cost Avoidance	$10,000,000
Other Adjustments	$13,000,000
Other Cost Avoidance	$3,000,000
Total	$50,000,000

Investigations and Recoveries Division

The Investigations and Recoveries Division projected cost savings for SFY 2018 are $33,644,251. [Table 2.8]

Table 2.8	
Description	**Amount**
Resources & Recoveries	$25,692,291
Client Investigations	$7,951,960
Total	$33,644,251

Special Investigations Division

The Provider Investigations Unit projected cost savings for SFY 2018 are $3,233,332. [Table 2.9]

Table 2.9	
Description	**Amount**
Payment Suspensions	$1,233,332
Global Settlements	$2,000,000
Total	$3,233,332

Third Party Liability Division

The Third Party Liability Division projected cost savings for SFY 2018 are $519,690,512 Table 3 identifies the projected cost avoidance, health insurance and Medicare recovery and Medicare Maximization recoveries for SFY 2018.

Table 3.0	
Description	**Amount**
Cost Avoidance	$477,065,000
Benefit Recovery	$30,945,871
Medicare Maximization Recoveries	$11,679,640
Total	$519,690,512

New Initiatives to Prevent and Detect Overpayments

Audit Division

Provider Audit Unit:

- Audit provider types that have not been audited recently.
- Develop internal audit reports for cost avoidance and increase federal reimbursement based on audits of providers.

Investigations and Recoveries Division

Client Investigations Unit:

- The Client Investigations Division handles investigations related to recipient EBT SNAP trafficking referrals as a priority through a coordinated and dedicated statewide team approach. In SFY 2017, the department received 40 Disqualified Retailer Trafficking Alert referrals from USDA/FNS flagging the potential of alleged recipient SNAP trafficking. As part of the 40 retailers disqualified by FNS, Client Investigations identified and completed 120 recipient trafficking investigations; executed 43 disqualification waivers and disqualified 43 SNAP recipients from SNAP program participation due to trafficking.
- The Client Investigations Division monitors social media websites (I.e. Craig's List, Facebook) and utilizes these social media sites as a viewing tool to uncover potential recipient SNAP trafficking.

- The Client Investigations Division continues to encourage staff development and to take advantage of federally reimbursed SNAP fraud conferences and training opportunities as they become available, as well as participate in quarterly FNS fraud conference calls.
- The Client Investigations Division continues to focus on increasing the number of arrest warrant affidavits referred for prosecution. In SFY 2017, Client Investigations completed and referred 76 arrest warrants for prosecution, up from 31 arrest warrants referred in SFY 2016.
- The Client Investigations Division will continue to emphasize staff individualized training plans focusing on increased knowledge of the latest technological advances to combat fraud, waste and abuse via social media monitoring and data analytics.
- The Client Investigations Division will continue to cross-train staff to assist in enhancing knowledge of the workforce.
- The Client Investigations Division will continue to share investigation techniques, updates and best practices with statewide Investigations staff.
- The Resources and Recoveries Division monitors recent home sale websites in their geographic area (I.e. Zillow and Trulia) to determine if any individuals who received past public assistance have acquired property. This proactive measure allows additional recoveries for the Department from these individuals by way of a lien.

Special Investigations Division

The primary mission of the Special Investigations Division is to investigate potential cases of provider fraud. This mission is accomplished through constant monitoring of national and local trends as well as seeking new ways to enhance the Division's detection of aberrant providers through data mining and collaboration with other state agencies.

Referrals to Law Enforcement:

- Collaboration between the Special Investigation's Division and the IT Division has resulted in a dedicated secure website where the DSS-SID and their law enforcement partners can collaborate on referrals. This website, managed by DSS, allows ease of transmission and retrieval of the DSS referrals and law enforcement's requests for assistance.

Provider Enrollment:

- Continue integrating the OQA's Provider Enrollment functions with those of the Special Investigations Division to enhance CMAP program integrity. This is done with the understanding that Provider Enrollment can be the first line of defense against fraud.

  The Department has begun shifting manually performed provider enrollment functions from DSS to the Department's MMIS contractor (DXC, Inc.). The contractor has the ability to automate these required functions therefore making the process more efficient. This shift will allow DSS to focus their attention the integrity of the CMAP rather than the processing of enrollment applications.

Staff:

- Encourage staff development by taking advantage of training provided by the Medicaid Integrity Institute, a federally reimbursed training program.

Third Party Liability Division

- Working in conjunction with Health Management Systems (HMS)The Department will continue to expand its matching and verification with Medicare Parts A, B & D to minimize the Medicaid payments for pharmacy, institutional and professional health care services. The Department plans to implement new Physician Pharmacy and Workers Compensation recovery projects.
- The Department is negotiating a settlement with the Center for Medicare & Medicaid Services (CMS) to resolve outstanding CTDSS home health and skilled nursing facility Medicare appeals at the Administrative Law Judge level of appeal.
- Expected savings will be approximately $5 million per year.