

**House Committee on Government Reform
Subcommittee on Government Efficiency and Financial Management
Barlett, Tennessee
July 14, 2003**

Mr. Chairman and Members of the Committee, thank you for the opportunity to share with you today about the TennCare Program Integrity Unit.

My name is Tom Mathis, director of the TennCare Program Integrity Unit,



Program Integrity Unit

WHY WE EXIST

To help prevent, identify and investigate **fraud/abuse**
and recover dollars within the TennCare system.

FRAUD

Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.

ABUSE

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes **recipient practices** that result in unnecessary cost to the Medicaid/TennCare Program.

TYPES OF FRAUD AND ABUSE

Recipients:

- Unreported income or insurance
- Access to insurance / has insurance
- TennCare recipients living out of state
- Drug seeking behavior (drug diversion)
- Unreported deaths
- Incarcerated felons – failure to report- continue use of services
- Failure to probate estate- nursing home cost recoveries
- Illegal transfer of property

**TENNESSEE DEPARTMENT OF FINANCE AND
ADMINISTRATION**

OFFICE OF HEALTH SERVICES

PROGRAM INTEGRITY UNIT

TENNCARE

ENROLLEE / PROVIDER

FRAUD & ABUSE LINE

1-800-433-3982

615-253-4005 (Nashville)

FAX: 615-532-7509

www.state.tn.us/tenncare/fraudabuse.html

If you suspect fraud and abuse in TennCare, please call the Program Integrity Unit's toll-free number or the local Nashville number to report it.

You do not have to give your name and can remain anonymous.

**Remember, we all share in the responsibility for the success of
TennCare.**

Department of Finance & Administration Authorization No. _____, No. of Copies – 5,000. This public document was promulgated at a cost of \$._ per copy. ____. 10/01

Investigative Tools

SOLQ (Social Security On-line Query)
ACCENT (DHS MIS)
Driver's license/Wage files
CHOICEPOINT (National investigations data base)
Vital Records(State Birth, Death, Marriage Records)
FID (Federal Investigations Database)
MED-OIG Sanctions/Exclusions
Credit Reporting Bureau
DOD – Military- TRICARE
Medicare – (Public Safeguard Contractors)

Matches with:

PARIS (federal match program)
Employers
Contractors
Medicare
Insurance Carriers (future match)
Social Security Death Index
TOMIS (Tennessee Department of Correction data base)

- **Managed Care Contractors are required to develop and submit a fraud and abuse compliance plan. (See Contract language below) I don't have the time to go into detail; however the contract language is in your handout.**

1-5. a. Prevention/Detection of Provider Fraud and Abuse

The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.

1-5. b. Fraud and Abuse Compliance Plan

- 1-5.b. 1. The CONTRACTOR shall have a written Fraud and Abuse compliance plan. The CONTRACTOR's specific internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the CONTRACTOR for review and approval by TENNCARE and the Program Integrity Unit within ninety (90) days of the effective date of this Agreement. TENNCARE and the Program Integrity Unit shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) days of review. The CONTRACTOR shall make any requested updates or modifications available for review after modifications are completed as requested by TENNCARE and/or the Program Integrity Unit within thirty (30) days of a request. At a minimum the written plan shall:
- i. Ensure that all officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan;
 - ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract;
 - iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:
 - a. Claims edits;
 - b. Post-processing review of claims;
 - c. Provider profiling and credentialing;
 - d. Prior authorization;
 - e. Utilization management;

- f. Relevant subcontractor and provider agreement provisions;
 - g. Written provider and enrollee material regarding fraud and abuse referrals.
- iv. Contain provisions for the confidential reporting of plan violations to the designated person as described in item 3 below;
 - v. Contain provisions for the investigation and follow-up of any compliance plan reports;
 - vi. Ensure that the identities of individuals reporting violations of the plan are protected;
 - vii. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;
 - viii. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to Program Integrity;
 - ix. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.
- 1-5.b. 2. The CONTRACTOR shall comply with the applicable requirements of the Model Compliance Plan for HMOs when the final model plan is issued by the U.S. Department of Health and Human Services, the Office of Inspector General (OIG).
- 1-5.b. 3. The CONTRACTOR shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

➤ **LEGISLATION UPDATES TO ADDRESS MANAGED CARE;**

Tennessee Code Annotated (TCA) 71-5-118 amended 7-1-2000, stating that it is a felony offense to commit fraudulent offenses against TennCare. This legislation allows the District Attorney’s to prosecute fraud cases when providers or recipients commit fraudulent acts under the managed care programs or FFS programs. **AGAIN, I do not have time to review in detail; however we have inserted an extract from the law below for your review.**

(b) (1) (A) A person, including an enrollee, recipient or applicant, commits an offense who, knowingly, obtains, or attempts to obtain, or aids or abets any person to obtain, by means of a willfully false statement, representation, or impersonation, or by concealment of any material fact, or by any other fraudulent means, or in any manner not authorized by this part or by the regulations or procedures issued or implemented by the department pursuant to this part, medical assistance benefits or any assistance provided

pursuant to this part to which such person is not entitled, or of a greater value than that to which such person is authorized.

(B) An offense under this subdivision is a Class E felony.

2) (A) A person, firm, corporation, partnership or any other entity, including a vendor, other than an enrollee, recipient, or applicant, commits an offense who, knowingly, obtains, or attempts to obtain, or aids or abets any person or entity to obtain, by means of a willfully false statement, report, representation, claim or impersonation, or by concealment of any material fact, or by any other fraudulent means, or in any manner not authorized by this part or by the regulations or procedures issued or implemented by the department pursuant to this part, medical assistance payments pursuant to this part to which such person or entity is not entitled, or of a greater value than that to which such person or entity is authorized. For purposes of this subsection, "attempts to obtain" includes making or presenting to any person a claim for any payment under this part, knowing such claim to be false, fictitious or fraudulent

(B) An offense under this subdivision is a Class D felony unless the value of the property or services obtained meets the threshold set for a Class B or Class C offense under § 39-14-105, in which case the appropriate higher class shall apply

YEAR ENDING 6/30/2003

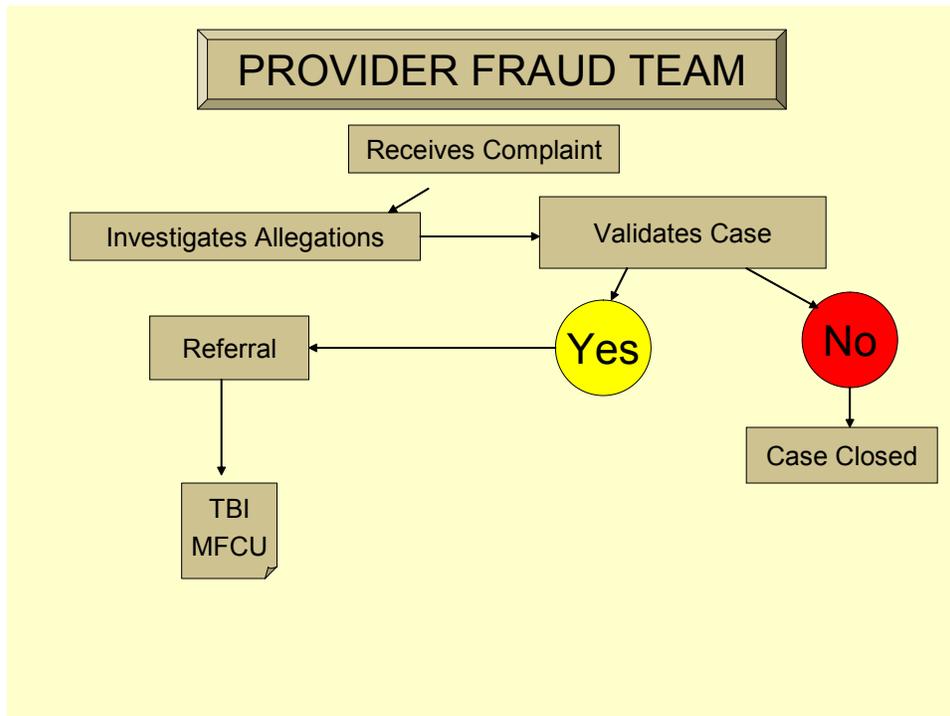
Summary of Enrollee Cases :

a. Cases closed	21,638
b. Recommended Terminations	6,487
c. Adjustments to Cases not Terminated	
1. Income Adjusted	171
2. Health Ins. Added	388

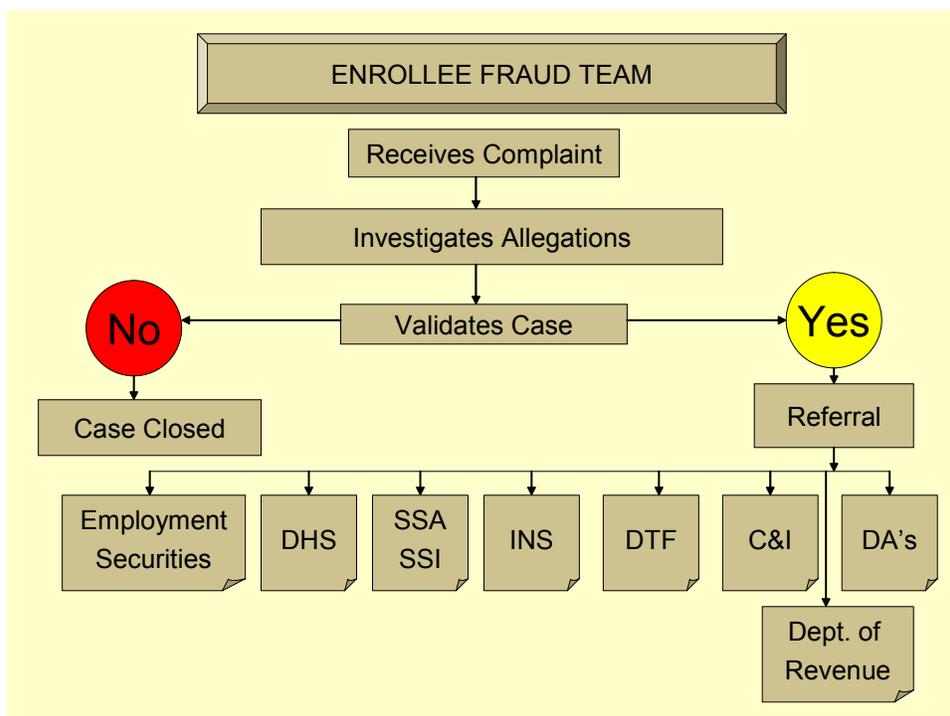
Summary Relating to Provider Cases:

a. Cases closed	176
b. Active Cases	67
c. Cases referred to TBI	14
d. Cases referred to HRB's (Health Related Boards)	3

- Program Integrity works very closely with the TBI- Medicaid Fraud Control Unit. Provider cases are worked as outlined in the diagram on page 8. However, before explaining, please allow me to say that we have a great working relationship between MFCU and PIU.



- Enrollee/recipient cases are worked and referred to various agencies as outlined below, with the majority of cases now being referred to the appropriate District Attorney's Office.



PIU Success Stories- Providers

PIU validated cases have resulted in the following actions during fiscal year 2002-2003:

I. Provider Cases

- a. Revocation of physician's license and \$50,000 in civil penalties
- b. US Attorney's Office indicted physician on 516 counts of drug trafficking; physician has plead guilty and sentence is pending. This case also lead to two recipients and one pharmacist pleading guilty.
- c. Probation of license for one year with supervision of practice, civil penalties, court cost, etc.
- d. Three cases currently pending in Federal Court
- e. 14 cases validated by Program Integrity, passed on to TBI-MFCU. These cases are in various stages of investigation with several awaiting direction/action of the prosecutor.
- f. 4 cases are being worked with other agencies, ie, FBI, HHS-OIG, and HRB's.

PIU Success Stories- Enrollees

II. Enrollee Cases

- a. Seven recipients prosecuted by D.A.'s for drug diversion (Three during fiscal year 2001-2002 and four during fiscal year 2002-2003)
- b. Four recipients are currently under indictment for drug diversion.
- c. 45 recipient cases validated and currently under investigation by the District Attorney Drug Task Force Units, for drug diversion.
- d. Recipient/provider indicted on 22 counts of fraud, impersonating a licensed insurance agent and selling letters of un-insurability.
- e. Four recipients currently under indictment - living out of state and obtaining TennCare fraudulently.
- f. Other cases being worked with US Dept of Defense, Workers Comp, OIG and Attorney General Office, TRICARE and Medicare.

PIU Success Stories- Recovery

III. Recovery/Collections

a.	Estate Recovery	\$3,077,516
b.	Overpayments (PA68's)	965,830
c.	Premium Underpayments	30,301
TOTAL		<u>\$4,073,647</u>

- **THE FUTURE IS CHANGING; NEW UP TO DATE TECHNOLOGY IS A REQUIRED TOOL. I WILL ADDRESS WHAT TENNESSE IS DOING IN TWO AREAS, FRAUD/ABUSE AND TPL.**

FRAUD AND ABUSE:

The most important tool in identifying and working fraud, and abuse cases, second only to having the personnel positions to work case, is the MMIS system. Tennessee has been working for the past two years plus, as we first developed the RFP, bid out, evaluated response, awarded contract to develop and implement a new state of the art MMIS system will include one of the best fraud and abuse identification packages in the country. Highlights of this new MMIS system are as follows;

- DSS profiler
 - Utilization patterns
 - Payment ranking
 - Age/gender status
- Ad Hoc and predefined reporting
- Immediate access to data
- Statistical Analysis
 - Identifies providers who are 4 standard deviations from norm
- Comparison reporting
 - Specialty compare
 - Professional group compare

- Pharmacy group compare
- Nursing home group compare
- Targeted Queries
 - Denied services
 - Duplicate services
 - Excessive daily billing
 - FFS claims from Capitated Providers
 - Financial summaries
 - Recipients with no encounters
 - Services provided after date of death
 - Upcoding
 - Pharmacy claims without medical visits
 - Transportation claims without medical visits
 - Recipients with Third Party Liability insurance coverage
 - Recipients reported with out of state address

■ TPL & SUBROGATION UPDATE:

- 270-271 (electronic means of validating TPL)
- Carrier matches and validation
- Employer Data Match
- Wage File Match
- Review of Encounter Claims
- Reports to monitor success of subrogation
- MCC Electronic Updates
- Etc, etc...

❖ **In closing, thank you for your time and I sincerely hope this has been informative. I will be happy to answer any questions.**