Medicaid Program Integrity

Presentation to the

Health Reform Initiative Advisory Committee
Medicaid Reform Task Force

Department of Medical Assistance Services

November 9, 2010

Virginia Medicaid Program Integrity

- **Program Integrity is a major initiative and priority for DMAS**
  - **DMAS is committed to detecting and eliminating waste, fraud, and abuse**
  - **DMAS has increased program integrity activities efforts over the past four years**
  - **Virginia increased its national involvement: PI Directors TAG, PERM TAG, NAMPI, Fraud Summit**
  - **Pre-payment initiatives such as ClaimCheck and provider enrollment initiatives such as NPI, OIG listings, TPL and pharmacy controls**

Provider Review Activities

- **Throughout the past four years, DMAS has focused on provider reviews, leading to new growth and necessary changes**

- **DMAS applies a mixed model for provider reviews**

  - contractors (60%)

  - internal staff (40%)

- **During last two fiscal years, over 750 providers have been reviewed and approximately $17 million identified as overpayments**

- **DMAS has achieved a 97% success rate for appeals**

- **Internal staff consist of 14 salaried and 4 hourly analysts**

Provider Review Process

- **DMAS' utilizes a risk-based, audit plan that is applied equitably across all provider types and service categories including hospitals, pharmacy, mental health, personal care, etc.**

- **Audit staff and contractors use tested and verified audit methodologies to ensure the scope of work is congruent with Medicaid regulations and manuals**

Provider Review Process

(continued)

- **Audit Process**
  - Data mining identifies providers to be audited based on their payment and utilization patterns
  - Notify providers of the audit and determine whether the audit will be on-site or a desk review
  - Conduct an entrance interview with provider
  - Perform a review of records
  - Compose a preliminary findings report to inform the provider, and discuss with DMAS staff, any discrepancies found during the audits
  - Providers are given a reasonable opportunity to supply additional documentation in connection with the discrepancies
  - Conduct an exit interview with provider
  - Write final audit report which includes findings and appeal rights
  - Remit collection letter

[Note: DMAS is conducting vendor product reviews currently to assess new potential opportunities in services authorization and pre-payment claims review]

Provider Review Contractors

- **Over the past four years, DMAS has engaged national firms to conduct provider audits and enhance the work of internal staff**
  - **Virginia is one of the first states to aggressively implement contractors**
  - **Contractors are hired through a competitive procurement process**
  - **No extrapolation or contingency fees are applied in contracts**
  - **Benefits of contractors**
    - **National expertise and experience**
    - **Advanced cutting edge technology**
    - **Administrative efficiencies**
    - **Increase referrals to the OAG and MFCU**

Provider Review Contractors

(continued)

- ACS Heritage – (2007) Pharmacy/DME audits
- Health Management Systems – (2007) Hospital diagnosis-related group (DRG) reviews
- Clifton Gunderson – (2007) Variety of provider types ranging from physicians to personal care agencies
- Health Management Systems – (2009) Community mental health reviews
- Contractor Results:
  - ROI of greater than 2:1
  - Contractors have identified approximately $17.6m in potentially inappropriate claims during the last two fiscal years
  - Project $21m in FY 2010

Recipient Audit Activities

- The Recipient Audit Unit (RAU) investigates referrals of fraudulent activity and abuse by enrollees, and eligibility determinations conducted by localities and the FAMIS CPU
- Internal staff consist of 4 salaried and 2 hourly investigators
- Investigators follow an “administrative” or “criminal” path to determine investigative outcomes
- Typical referrals of recipient ineligibility involve:
  - Misrepresentation or withholding of information involving resources or income (most common for income)
  - Uncompensated transfers of property
  - Illegal use/sharing of Medicaid ID card
  - Drug diversion
  - Agency error

Recipient Audit Activities

(continued)

- Collaborated with DSS to establish eligibility workgroups
- Worked with DSS on PERM and MEQC projects
- During last two fiscal years, over 1,000 cases have been investigated leading to approximately $4.1 million in restitution
- 123 cases have been referred to the Commonwealth Attorney for criminal prosecution

Notable Achievements

- **MCO collaboration**
- **Office of Behavioral Health (OBH) created based on audit findings**
- **Requested and received broader legislative authority to terminate providers agreements**
- **Many regulatory and manual changes have been put in place due to audit findings**
- **DMAS and MFCU have a positive working relationship. CMS has noted this relationship as a model**
- **Over $38m in overpayments identified in last two fiscal years**

Federal Oversight

- **Federal oversight intensifying**
  - **Reviewing proposed new CMS fraud and abuse regulations and conducting assessment as to additional steps DMAS can take to ensure a leading edge program integrity strategy**
  - **CMS has hired national contractors to conduct reviews in each State.**
  - **CMS internal staff has conducted on-site reviews the latest focusing on community mental health**
  - **States will be required to engage Recovery Audit Contractors (RACs) that will be contingency based auditors**

State Oversight

- **Recent (and On-going) JLARC Study of Medicaid Fraud**
  - **Interim Report Found:**
    - **In FY 2009, Virginia had known improper Medicaid payments & blocked claims of $87 M**
    - **Error in eligibility determinations leads to some improper payments**
    - **Some local DSS may not adequately investigate fraud & DMAS appears to lack resources**
    - **DMAS claims processing errors may need to be addressed**
    - **DMAS program integrity efforts have positive return**

State Oversight

(continued)

– **Interim Report Recommended:**

1. **DSS & DMAS should use a sample of cases of sufficient size to identify error rates for local departments of social services. This process should begin with a pilot study & conclude with a report by October 1, 2011**

2. **DSS should ensure all local DSS offices comply with federal redetermination requirements & report on an annual basis those local DSS offices that do not comply**

3. **The General Assembly may wish to amend the Code of Virginia to allow local DSS offices to recover a portion of the funds recovered as a result of Medicaid fraud they investigate or refer**

4. **The General Assembly may wish to consider amending the Virginia Public Procurement Act to exempt DMAS from the 30-day payment requirement if there is a reasonable basis to suspect that payment of a claim could be improper**

State Oversight

(continued)

- **JLARC Review is On-going**
  - **Additional review needed**
  - **New issues include:**
    - **Improved coordination between agencies**
    - **DMAS' oversight of MCOs & other contractors**
    - **Use of additional program integrity activities from other states**
    - **Potential creation of Medicaid Inspector General**

Options Exist to Enhance Program Integrity

- **Discussion Point: What enhancements should DMAS focus upon to improve program integrity?**
  - **Potential Options:**
    - **Better Coordination of Program Integrity Activities Across Agencies**
      - **Increased Coordination in Formalized Audit Plans**
      - **Increased Coordination with Licensing Agencies**
      - **Increased Oversight of DMAS Contractors**
      - **Increased Emphasis on Fraud Investigation at the Local DSS Offices**
      - **Increased Referrals for Prosecution**
    - **Enhanced Program Integrity Tools**
      - **Increased pre- and post-payment analytics (data mining, for example)**
      - **Increased data checking ability with various data sources (both within Virginia and external (other state integrity programs, the federal government, provider exclusion lists, etc.)**
      - **Use of statistical extrapolation**

Options Exist to Enhance Program Integrity

(continued)

- **PROs:**
  - **Current program integrity efforts have shown a positive return on investment (ROI) for both DMAS staff and contractors engaged in these activities**
  - **As funding needs under Medicaid increase (due to the economy and eventually from Federal Health Reform), it will be increasingly important to ensure the efficient use of funds available to the program**
  - **Further enhancements represent a continuing emphasis on program integrity activities at DMAS**
  - **Advancements in health information technology have improved (and will continue to improve) the ability of DMAS and our partners to avoid inappropriate costs on the front-end and detect inappropriate payment on the back-end with efficiencies unavailable before**

- **CONs:**
  - **While the ROI is positive, enhanced program integrity efforts (across the spectrum of options) will require a significant influx of resources in both systems acquisition and personnel costs, prior to the medical savings**
  - **Certain options, such as statistical extrapolation, represent paradigm shifts for both providers (in terms of participation) and DMAS (in terms of sampling approaches and potential federal liabilities, among others)**