



Mitigating the Risk of Improper Payments in the Virginia Medicaid Program



In Brief

In response to House Joint Resolution 127 (2010), JLARC staff examined improper payments (errors, abuse, and fraud) in Medicaid.

Errors in determinations of Medicaid eligibility made by local departments of social services may have resulted in improper payments with an estimated negative general fund impact of \$18 million to \$263 million in federal FY 2009. Significant investments are needed to reduce the effect of these errors, including new information technology, training, and oversight.

By contrast, fraud committed by providers and recipients in FY 2009 was estimated to cost the general fund about \$6.1 million. A higher percentage of these improper payments had been collected from providers (73 percent) than recipients (27 percent).

Audits of providers by the Department of Medical Assistance Services (DMAS) detected 91 percent of all improper payments made in FY 2009. To further improve and sustain a high level of performance, DMAS would benefit from more centralized audit planning, additional analysis, and implementation of prepayment auditing.

In FY 2011, Virginia's managed care organizations received \$2 billion in capitated payments. However, the data used to set capitated rates undergo little validation. DMAS should perform additional oversight to ensure that rates are not inflated because of improper payments.

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Walter J. Kucharski, Auditor of Public Accounts

Director

Glen S. Tittermary

JLARC Staff for This Report

Nathalie Molliet-Ribet, Division Chief
Ashley Colvin, Project Leader
Janice Baab
Brad Marsh
David Reynolds

**This report is available on the JLARC website at
<http://jlarc.virginia.gov>**



COMMONWEALTH of VIRGINIA

Glen S. Tittermary
Director

Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capitol Square
Richmond, Virginia 23219

(804) 786-1258

January 31, 2012

The Honorable Charles J. Colgan
Chair
Joint Legislative Audit and Review Commission
General Assembly Building
Richmond, Virginia 23219

Dear Senator Colgan:

House Joint Resolution 127 of the 2010 General Assembly directed staff of the Joint Legislative Audit and Review Commission to study the Commonwealth's medical assistance program (Medicaid). Specifically, staff were directed to examine the nature and extent of waste, inefficiency, fraud, and abuse in Virginia's Medicaid program, and to identify ways to reduce resulting improper payments in Virginia.

An interim report was briefed to the Commission and approved for printing on October 12, 2010. This final report was briefed to the Commission and approved for printing on October 11, 2011.

On behalf of the Commission staff, I would like to thank the staff at the Departments of Medical Assistance Services and Social Services, local Departments of Social Services, Virginia's Medicaid managed care organizations, and the Medicaid Fraud Control Unit in the Office of the Attorney General for their assistance during this study.

Sincerely,

A handwritten signature in black ink that reads "Glen S. Tittermary".

Glen S. Tittermary
Director

GST/asc

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JLARC Report Summary:

Mitigating the Risk of Improper Payments in the Virginia Medicaid Program

Key Findings

- Recipient and provider fraud cost the general fund about \$6.1 million in fiscal year 2009.
- A 2009 federal review of the State's eligibility determination process indicates a large number of individuals who were enrolled in the Virginia Medicaid program may not have been eligible. Based on a federal extrapolation of potential costs, JLARC staff estimate that the negative impact of the resulting improper payments on the State general fund may have ranged from \$18 million to \$263 million. Additional investments are needed to reduce future errors through improved State oversight of local departments of social services, modernized information technology, and provision of additional training to local caseworkers. (Chapter 2)
- Program integrity activities by the Department of Medical Assistance Services (DMAS) successfully detected 91 percent of improper payments the agency made to providers, based on a 2009 federal review. However, improvements still need to be made to the provider review process to further minimize these improper payments and to help maintain a strong level of performance. (Chapter 3)
- While DMAS has collected the majority of improper payments identified in FY 2009, some collections were not pursued because of inadequate internal controls. DMAS could also better use collection rates to assess the cost-effectiveness of its program integrity activities. (Chapter 4)
- Additional oversight by DMAS is needed to ensure that managed care organizations (MCOs) consistently detect improper payments and report accurate expenditure data. Otherwise, DMAS may pay inflated rates to MCOs. (Chapter 5)
- There appear to be systemic weaknesses in program integrity activities that span multiple divisions and agencies. To comprehensively address weaknesses found across the entire Medicaid system, a special interagency task force is needed to determine the most appropriate means of minimizing the risk of improper payments. (Chapter 6)

Medicaid is the largest program in Virginia's budget, accounting for more than \$7.2 billion in fiscal year (FY) 2011. Because Medicaid is so large, even a relatively small amount of improper payments (resulting from fraud, abuse, or errors) is costly. In recognition of this concern, House Joint Resolution (HJR) 127 (2010) directed the Joint Legislative Audit and Review Commission

(JLARC) to identify opportunities to reduce waste, fraud, and abuse in Medicaid. Findings of the first year of this two-year study can be found in the JLARC report *Interim Report: Fraud and Error in Virginia's Medicaid Program*, published in December 2010.

While the State has experienced success in controlling improper Medicaid payments, there are opportunities to further reduce the financial risk they pose. This report describes the types of improper payments that are known to occur and the processes used to prevent, detect, and collect them. The report includes 26 recommendations and concludes that comprehensive solutions are needed to fully address systemic issues and further reduce the fiscal impact of improper payments on the State.

**Findings From 2010
JLARC Interim
Report**

Interim Report: Fraud and Error in Virginia's Medicaid Program found that errors in eligibility determination, and delays in eligibility redeterminations, likely result in unnecessary Medicaid costs because some ineligible Virginians receive Medicaid-funded services.

In addition, local departments of social services and DMAS may not have been fully investigating and prosecuting recipient fraud.

Lastly, while the State's Medicaid Fraud Control Unit reported over \$700 million in recoveries from FYs 2005 to 2009, DMAS had received only \$49 million.

**MEDICAID PROGRAM INTEGRITY ACTIVITIES ARE DESIGNED
TO REDUCE IMPROPER PAYMENTS**

The cost of Medicaid is shared between the federal government and the states, and in Virginia the program is administered by the Department of Medical Assistance Services (DMAS). Virginia's Medicaid recipients have access to various health care services from medical providers that are enrolled in the program. These services range from preventive and acute care services (such as hospitalization) to long-term care services.

DMAS pays many health care providers directly through an approach known as "fee-for-service," and also uses managed care organizations (MCOs) to act as intermediaries with other providers. Under fee-for-service, DMAS processes provider claims and directly reimburses providers. In contrast, under managed care the MCOs enroll and reimburse providers on behalf of DMAS.

Although 61 percent of recipients were enrolled in managed care in FY 2011, they accounted for only 28 percent (\$2.0 billion) of Virginia's Medicaid expenditures because these recipients tend to be younger and healthier (therefore incurring lower medical costs) than those enrolled in the fee-for-service program. Only 39 percent of recipients were enrolled in fee-for-service, but they accounted for 67 percent (\$4.8 billion) of Medicaid expenditures.

HJR 127 directed JLARC to describe the extent of waste, inefficiency, fraud, and abuse in Virginia's Medicaid program. Generally speaking, these activities result in "improper payments," which are expenditures that should not have been incurred or payments made for an incorrect amount. Errors that lead to improper payments are inadvertent while fraud and abuse are intentional. For example, errors can occur when providers use an incorrect code on reimbursement claims, when caseworkers enroll ineligible recipients, or when recipients do not report information that affects

their eligibility. If done intentionally, these acts constitute fraud or abuse.

Because improper payments reduce the State's general fund, State and local agencies conduct a variety of program integrity activities designed to minimize the risk of incurring improper payments. The primary agencies that engage in these activities are DMAS, the State Department of Social Services (DSS) and local departments of social services, the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General, and Commonwealth's Attorneys. At the federal level, the Centers for Medicare and Medicaid Services (CMS) reviews DMAS's efforts to reduce improper payments, and the Office of the Inspector General for the U.S. Department of Health and Human Services (OIG) supervises the MFCU.

The program integrity activities used by State and local agencies can be grouped into four processes: (1) the enrollment process is intended to ensure that only eligible recipients and providers participate in Medicaid; (2) the pre-payment review process blocks some improper claims before they are paid; (3) the post-payment audit process is conducted to detect improper payments in paid claims (and in cases of potential fraud, referrals are made for prosecution); and (4) the collection process is undertaken to recover improper payments from providers and recipients.

ENROLLMENT OF INELIGIBLE MEDICAID RECIPIENTS PRESENTS GREATEST RISK OF IMPROPER PAYMENTS

Payment Error Rate Measurement Review

The Centers for Medicare and Medicaid Services conducts Payment Error Rate Measurement (PERM) reviews of state Medicaid programs on a rotating three-year cycle. The most recent review of Virginia's Medicaid program was conducted in federal FY 2009 (October 2008 through September 2009), and the next review is scheduled to occur in federal FY 2012.

A 2009 federal review of the State's eligibility determination process indicates a large number of individuals enrolled in the Virginia Medicaid program were not eligible for services, resulting in improper payments by the State and federal government in federal FY 2009. JLARC staff reduced the federal estimate to account for subsequent changes in eligibility policy. The revised estimate suggests the impact of these errors on the State general fund may have ranged from approximately \$18 million to \$263 million; an additional cost of up to \$397 million may have been incurred by the federal government. Major investments are needed to reduce the number of future errors by ensuring caseworkers at local departments of social services have the tools needed to implement the Virginia Medicaid program as it is intended.

During the course of this review, DMAS staff raised a concern about the validity of the methodology used by CMS to extrapolate a dollar estimate. Although the CMS methodology appears appropriate, it should be noted that the estimated improper payments calculated by CMS and revised by JLARC staff are intended to convey the potential magnitude of the State's financial exposure associated with Medicaid eligibility errors and may lack the accu-

racy needed for determining a precise budgetary impact. However, these data remain the only available means of estimating the potential value of eligibility errors.

Improper payments incurred on behalf of recipients generally occur when recipients (1) are erroneously enrolled by caseworkers, (2) misuse or abuse medical services, or (3) commit fraud or error during or after enrollment. Responsibility for avoiding and addressing unnecessary costs is shared between DMAS and DSS. Local departments play the primary role in preventing unnecessary costs by determining whether individuals are eligible for Medicaid and by investigating potential fraud, using guidance, oversight, and information technology (IT) provided by DSS and DMAS.

As part of a federal Payment Error Rate Measurement (PERM) review, CMS estimated that the erroneous enrollment of ineligible recipients in Virginia's Medicaid program could have resulted in improper payments of \$910 million in federal FY 2009 (shown in the figure on the next page). However, this estimate is not an actual amount of improper payments that occurred but rather an extrapolation of the potential value of errors based upon a sample of recipient case files. In addition, only 40 percent of this estimated amount would have involved State general funds, because the State received an enhanced Medicaid federal match rate in that year.

Formula for State Share of Medicaid Costs

The State's share of Medicaid costs can be expressed as follows:

State Share = 0.45 x
[State Per Capita
Income / U.S. Per Cap-
ita Income]

The formula is based on a rolling three-year average per capita income for the State and the U.S. However, the State's share never exceeds 50 percent. In addition, federal stimulus funding decreased the State's share in certain years.

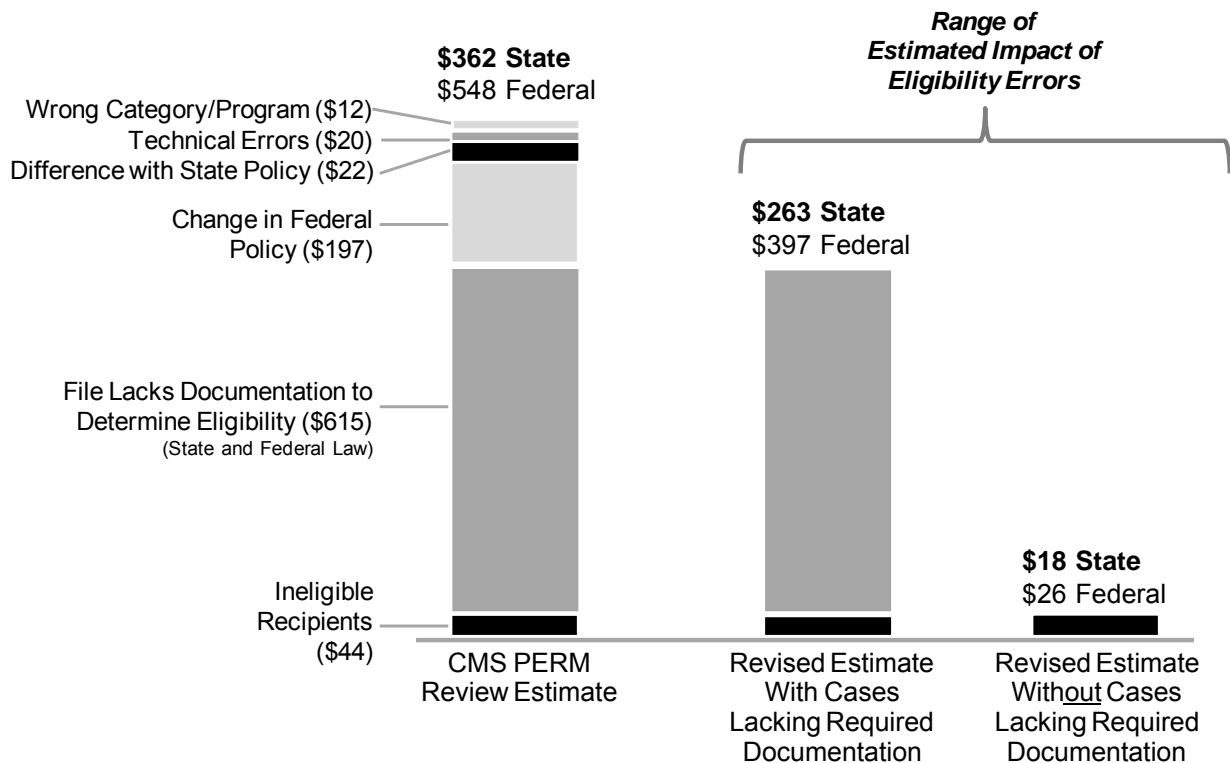
To better capture the magnitude of eligibility errors that Virginia may face going forward, JLARC staff revised the CMS estimate by subtracting the value of errors associated with changes in eligibility policy since FY 2009 and differences in interpretation between DMAS and CMS. Accordingly, JLARC staff subtracted costs attributable to individuals who (1) were eligible for a medical program other than Medicaid which was paid in part with State funds (\$12 million), (2) were eligible for Medicaid but whose files contained technical errors (\$20 million), (3) were eligible under State policy but were ineligible according to the process used by PERM to assess State residency (\$22 million), and (4) would have been found eligible in the federal CMS PERM review under the most recent federal policy (\$197 million). The JLARC staff estimate is shown in the figure on the following page.

The vast majority of the improper payments remaining in the JLARC staff estimate is attributable to "undetermined" cases in which the recipients' files lacked the necessary documentation (or in some instances, the entire file) to establish whether they were eligible for Medicaid services. As with the CMS PERM review estimate, these cases were treated as errors because the case files did not contain documentation required by both Virginia and federal policy. Despite repeated attempts by certified mail and phone

to contact these types of recipients whose files were reviewed during the PERM review process, it was not possible for DMAS staff to obtain the information needed to establish their eligibility. In accordance with Medicaid policy and based on the best information available at the time of the PERM review, these individuals were terminated from the program because recipients whose eligibility cannot be proven with requisite documents are considered ineligible for services at that time, even if they are subsequently found to have been eligible.

Because documentation could not be obtained to confirm eligibility status, it is possible that some of these recipients were eligible at the time they applied for Medicaid and/or during the PERM review. Accordingly, JLARC staff calculated the estimated State general fund impact of eligibility errors as a range from as low as \$18 million (assuming all undetermined cases were eligible) to \$263 million (assuming none were eligible).

Eligibility Errors Resulted in Estimated State General Fund Impact of Approximately \$18 Million to \$263 Million in FFY 2009 (JLARC Staff Estimate)



Note: Estimates are intended to convey the potential magnitude of financial exposure, but may lack the accuracy needed for determining a budgetary impact.

Source: JLARC staff analysis of CMS Payment Error Rate Measurement (PERM) data and literature, and DMAS data.

To address the possibility that some of the undetermined cases may have pertained to eligible individuals, a possibility which has been raised by Virginia and other states since 2009, CMS will begin reporting two estimates of improper payments: one that excludes all undetermined cases and another estimate (as currently reported by CMS) which includes all undetermined cases. This approach is functionally similar to the range calculated by JLARC staff, which is based on the CMS estimate. Still, at the very least, the absence of required documentation raises concerns that proper documents are not verified to determine eligibility and/or that local departments lack adequate internal controls over the enrollment process.

Among cases that involved recipients whose ineligibility was ascertained, most of the errors identified by the federal PERM review occurred because local caseworkers improperly calculated the financial resources and income of applicants and recipients. To help prevent these and other caseworker errors and ensure that local departments comply with Medicaid policy, improvements are needed in four areas:

- DSS should use its existing authority to improve local department oversight and assistance by identifying systemic errors and implementing steps to address them statewide.
- Local departments need to enhance their monitoring of caseworker errors. However, DSS has little ability to direct the nature and type of monitoring by local departments.
- DSS and DMAS need to improve the training provided to caseworkers, which both agencies have indicated is inadequate. Specifically, local departments have noted the need for training related to the review of estates and other complex legal and financial transactions.
- DSS and DMAS need to ensure the success of ongoing efforts to update and improve the IT available to local caseworkers. In addition, DSS should expand the use of an existing system that tracks caseworker errors, which is currently used only for the SNAP (Food Stamp) program. DSS should also develop new systems that would allow caseworkers to verify the financial and real property assets of Medicaid applicants.

In addition to eligibility errors committed by local caseworkers, delays in redetermining recipients' Medicaid eligibility every 12 months may also result in improper payments. Unlike SNAP and other benefit programs, DSS lacks the authority under federal

regulations to automatically terminate Medicaid benefits if a redetermination is overdue. Instead, DSS cannot take any action until the redetermination process has been initiated by a local department and the recipient has been found to be ineligible. Because local department decisions can delay the redetermination process, the use of a partially automated administrative redetermination process may be needed to ensure redeterminations are completed in a timely manner.

JLARC staff analysis of DSS and DMAS data indicates that overdue Medicaid redeterminations may have cost Virginia approximately \$5 million in FY 2009. According to DSS and local department staff, these delays may have occurred because some local departments have responded to recent increases in caseloads by prioritizing enrollment of new recipients over the redetermination of eligibility for existing recipients. It is recommended that a partially automated administrative redetermination process be used as a means of promoting more timely Medicaid redeterminations.

Improvements are also needed to the process used by DMAS and MCOs to prevent overuse of medical services by recipients. When recipients are found to have previously misused or abused medical services, they are enrolled in a “lock-in” program in which services are monitored for at least 36 months. However, DMAS and the MCOs do not consistently review the same type of medical services for potential misuse; thus, undetected abuse could occur if an individual switches from fee-for-service to managed care. In addition, because re-enrollment in a lock-in program is not automatic, some recipients may be able to disenroll from a lock-in program by switching from fee-for-service to managed care or by moving from one MCO to another during the defined open enrollment period. As a result, recipients that have a choice of managed care plans may be able to disenroll from a lock-in program by switching from one MCO to another or by switching from managed care to fee-for-service. DMAS should develop process and policy changes to increase coordination between lock-in programs.

The fragmented nature of the responsibilities assigned to DMAS and local departments for investigation of recipient fraud appears to hinder investigations and lead to wasted or duplicated efforts by local and State fraud investigators. Depending upon the type of public assistance program involved, some fraud investigations are handled locally while others are investigated by DMAS. Local department staff report that certain types of fraud, such as the presence of an unreported adult who contributes to the household’s income, are more easily investigated by local staff who can conduct at-home surveillance, but in some cases these investigations are assigned to DMAS. Both DMAS and DSS should reconsider their

respective responsibilities for investigating recipient fraud and error, and identify options for a realignment of responsibilities.

In addition, many cases of potential Medicaid recipient fraud are not prosecuted because of two primary barriers. First, it is difficult for fraud investigators to establish intent “beyond a reasonable doubt,” which is needed to support a criminal fraud prosecution. Second, not all Commonwealth’s Attorneys agree to accept a referral for prosecution. Currently, restitution is sought for cases that are not prosecuted. However, the recipient is not disqualified from Medicaid and continues to receive services. The State should consider using an administrative disqualification hearing process, similar to those used in other benefits programs, because it allows recipients to be disqualified from Medicaid when evidence of fraud exists but criminal intent cannot be established, or when a Commonwealth’s Attorney declines to accept a referral.

CHANGES NEEDED TO FURTHER IMPROVE AND SUSTAIN DMAS’ STRONG PERFORMANCE OF PROVIDER REVIEW ACTIVITIES

While DMAS provider review activities successfully prevented and detected most improper payments based on a 2009 federal review, several improvements should be made to further minimize the risk of improper payments created by provider claims payments and to help maintain a consistent level of high performance. In FY 2011, fee-for-service expenditures totaled \$4.2 billion, suggesting that even a small amount of improper payments creates a financial risk for the State. Greater use of information obtained during provider enrollment screenings and coordination between the provider enrollment and program integrity functions could help DMAS better target its efforts toward providers that present more risk. In addition, creating a single, comprehensive audit plan for all provider audit activities could help ensure that all sources of improper payment risk are addressed. Moreover, additional analysis of audit outcomes could help DMAS allocate resources more efficiently and more clearly ascertain whether existing audit activities cost-effectively minimize the risk of improper payments.

A review conducted by the federal government indicates that DMAS paid more than 99 percent of Medicaid claims correctly. As discussed above, CMS conducted a PERM review in federal FY 2009. In addition to reviewing eligibility determination errors, CMS reviewed a sample of fee-for-service claims paid by DMAS to determine if any were paid in error. Based on this examination, PERM estimated that DMAS paid only 0.7 percent of all fee-for-service Medicaid claims in error, which the federal government estimated had a cost of \$32 million to the State and federal governments. Virginia’s error rate was well below the national error rate

of 1.9 percent. The PERM review also indicates that DMAS made very few errors when processing capitation payments to MCOs. Only one error was identified, resulting in an error rate of 0.01 percent, well below the national error rate of 0.13 percent for capitation payments.

While the provider enrollment process offers DMAS its first opportunity to scrutinize providers, the process has not been fully utilized to identify providers who may pose a financial risk. DMAS has seldom denied a provider's request to enroll in the program, which agency staff report is due to the agency's limited statutory authority and insufficient resources to conduct more extensive enrollment screenings. However, health care reform will likely increase the information available to DMAS about providers who want to participate in Medicaid by requiring more extensive enrollment screenings. JLARC staff recommend that DMAS use information gathered during provider enrollment to identify providers at high risk for inappropriate billing and share this information with the divisions that conduct pre- and post-payment reviews. Similarly, it is recommended that DMAS require MCOs to report information about providers terminated from their networks so that DMAS can use that information to identify potentially high-risk providers in the fee-for-service program.

In FY 2009, DMAS used a prior authorization process and extensive claims processing to prevent improper payments of up to \$50.3 million. However, DMAS could improve upon this process by using prepayment auditing, which requires certain providers to submit medical documentation before claims are paid. This kind of prepayment review thereby avoids the "pay and chase" situation created when an audit identifies an improper payment after a claim has been paid. In addition, DMAS should continue its pursuit of a commercially available Medicaid fraud and abuse detection system, which can provide a better means of identifying providers that pose a risk of improper payments before a claim is paid.

After claims are paid, the Program Integrity Division (PID) conducts provider audits to identify improper payments. Although the PERM review of claims indicates that DMAS identified 91 percent of all improperly paid claims in the fee-for-service program in 2009, several shortcomings should be addressed to sustain these efforts in a cost-effective manner and better inform policymakers about the extent to which audit goals are achieved. To ensure improper payments are meaningfully reduced in a cost-effective way, the post-payment audits conducted by PID must be effectively coordinated with the program integrity activities conducted by other divisions, such as pre-payment reviews. It is equally important to ensure activities within PID are coordinated. To ensure this coordination occurs, several shortcomings in the audit process should

be addressed. This includes the adoption of a unified audit plan that fully coordinates the activities of PID's constituent units as well as those of third-party contract auditors, and clearly indicates how the risk of improper payments is addressed by each of these audit activities. Moreover, additional analysis of audit outcomes could help PID ensure the division does not miss opportunities to sharpen its focus on high-risk providers. Addressing these shortcomings would also allow PID to ensure it continues to be successful in identifying improper payments and to better demonstrate this success to policymakers.

Some of these concerns were raised by the Auditor of Public Accounts (APA) in a 2005 audit of DMAS. PID has partially addressed the APA's recommendations by adopting a risk-based audit plan, but there is currently no apparent relationship between the risk scores assigned to each type of provider and the number of audits planned or conducted for each provider type. This occurs in part because PID's audit plan does not reflect how many audits each contract auditor is expected to conduct, although nearly 80 percent of all post-claims audits were performed by contractors in 2010. As a result, it is not possible to determine whether the total number of audits planned for a provider type is proportional to the assigned risk score. Moreover, the actual number of audits performed for each provider type does not align with the provider type's risk score because PID staff often deviate from the number of audits they planned to conduct, and the documentation to support those decisions is inadequate.

PID also does not sufficiently analyze data to measure its performance in order to improve future audits and prevent waste. For example, PID does not calculate the return on investment of its audits or identify needed corrective action if audit findings are reduced during the appeals process. This appears to have resulted in missed opportunities to improve the focus of its audits to further limit the risk of improper payments and to reduce the potential waste of resources. Finally, PID does not have a formal means of ensuring that all referrals it receives result in an audit.

To address these shortcomings in the audit process, it is recommended that DMAS (1) ensure PID's audit plan reflects how many audits each contract auditor will conduct for each provider type, (2) better document the reasons why PID staff deviate from the number of planned audits, and (3) analyze the return on investment and outcome of audit activities as one means of measuring the performance of PID staff and contract auditors.

Although PID's referrals to the MFCU increased sharply in FY 2010, it is not clear if all potential fraud has been addressed because PID lacks certain controls: it has not consistently defined

specific criteria for use in determining if a referral should be made to the MFCU, nor do all units in PID maintain data that could be reviewed to ensure these criteria are consistently and reasonably applied. DMAS should create these controls.

DMAS COLLECTS MAJORITY OF IMPROPER PAYMENTS BUT PROCESS COULD BE IMPROVED

While DMAS appears to recover most improper payments resulting from provider and recipient errors and fraud, there are opportunities to improve the collection process. A JLARC staff analysis of invoices created by DMAS to collect payments improperly made to providers and recipients in FY 2009 indicates that 69 percent (\$19.8 million) has been collected to date. Collecting improper payments is necessary to reduce State Medicaid costs, deter future fraud, and repay the federal government for its share of costs. However, some amounts were not collected because certain providers and recipients were unable to pay back what they owed, and because DMAS did not create invoices for all identified improper payments. To improve the collection process, DMAS should utilize collection rate information to assess the cost-effectiveness of its program integrity activities, and develop clearer policies and controls to ensure invoices are always created.

The rate at which DMAS collects improper payments varies substantially. A detailed analysis of DMAS collections for improper payments made in FY 2009 indicates that the agency has a higher collection rate from providers (73 percent) than from recipients (27 percent). Similarly, the collection rate for improper payments resulting from errors (76 percent) is typically higher than the collection rate for fraud (61 percent). This suggests that some collection efforts will generally be more successful than others, depending upon the population that owes the State money.

Because states are required to repay the federal share of improper payments regardless of whether funds are collected, a low collection rate can be costly to the State. For example, the State owed the federal government approximately \$3.5 million for its share of restitution amounts resulting from provider criminal fraud in FY 2009, but collected only \$0.8 million. Because the amount collected from providers found guilty of fraud was less than the amount owed to the federal government, the State had to pay the difference using general funds (\$2.7 million).

Improved information on collection rates could allow DMAS to identify the program integrity activities that are most cost effective and assess their fiscal impact on the State. However, DMAS has not routinely calculated accurate collection rates for its program integrity activities, in part because of shortcomings in its ac-

counts receivable system. DMAS should improve its accounts receivable system to allow for greater analysis and use this information to report collection rates.

In addition, some provider and recipient improper payments have not been collected because of procedural shortcomings. JLARC staff identified \$0.8 million in FY 2009 improper payments that have not been collected because invoices were never created. In some cases it appears that the DMAS Fiscal Division lacked the necessary controls to ensure invoices were created, and in other cases it is unclear whether improper payment information was effectively conveyed to the division in order to create an invoice. To improve the collection process, DMAS should develop clearer policies regarding how information should be shared across divisions and between agencies, and establish better controls to ensure invoices are created.

STATE OVERSIGHT OF MANAGED CARE ORGANIZATIONS MAY NOT ENSURE RATES EXCLUDE IMPROPER PAYMENTS

Oversight of MCOs by DMAS is insufficient to ensure that the flat monthly capitated rates paid to MCOs are not inflated because of undetected improper payments. The capitated rates paid to MCOs are calculated based on claims expenditures and other data MCOs report to DMAS. In FY 2011, DMAS payments to MCOs totaled \$2 billion, suggesting that even a small amount of improper payments in the data MCOs report to DMAS could have a substantial negative financial impact on the State. However, JLARC staff's review suggests that DMAS has taken few steps to ensure that payments to MCOs do not contain improper payments. To reduce the risk of improper payments in Medicaid managed care, DMAS should increase its oversight of MCOs.

The five MCOs participating in Virginia's managed care program receive a flat capitated rate for each recipient enrolled in their plan. The difference between the capitated payments received from DMAS and the payments made to providers, along with administrative costs, constitutes an MCO's profit (or loss). After paying providers within their networks, MCOs submit the expenditure data to DMAS. In 2010, MCOs submitted data for over 20 million claims and other administrative expenses, which DMAS used to set capitated rates for FY 2012.

Because capitated rates are based on expenditure data MCOs report to DMAS, any improper payments contained in these data can inflate future rates. This can occur if MCOs (1) do not detect or recover all improper payments from providers within their networks, or (2) submit inaccurate expenditure data to DMAS. However, DMAS staff have stated that a capitated payment structure mini-

mizes the risk of improper payments because MCOs face a financial incentive to keep their costs below the capitated payment. However, concerns about fraud and abuse in managed care have long been documented, including fraud and abuse in capitated payments, and a review of DMAS and MCO practices suggests that current processes may not be sufficient to ensure improper payments do not lead to inflated capitated rates.

DMAS should exercise more effective oversight of existing contractual requirements for MCOs to perform program integrity activities, in order to ensure MCOs detect improper payments within their provider networks. Instead, DMAS has focused on enforcing contractual provisions related to quality and access to care. To assess the adequacy of MCO program integrity efforts, JLARC staff analyzed data provided by each MCO. The analysis indicates that MCOs conduct fewer audits of their network providers than DMAS does of fee-for-service providers, and that MCOs do not always collect improper payments from their providers. These shortcomings suggest that claims data submitted for rate setting may contain improper payments.

In addition, other evidence suggests that DMAS needs to more thoroughly assess the accuracy and validity of the expenditure data submitted by the MCOs. Absent effective oversight, MCOs could over-report expenditures, leading to inflated rates. Presently, the accuracy of data used to set rates is validated at a basic and limited level, such as ensuring that recipients were actually enrolled in managed care on the date of service. In contrast, other data submitted to DMAS by MCOs for use in submitting reports to CMS are subject to over 500 automatic checks, though DMAS staff report concerns with the utility of some of these checks. Moreover, even though expenditures reported in both data sets should match, discrepancies identified by DMAS staff between the total dollar amounts reported in each data set have raised concerns about the accuracy of both sets of data. Concerns about the accuracy of expenditure data used to set rates were also noted in prior audits conducted by DMAS, which found that administrative cost data included expenses that should not be included in data used to set rates, such as lobbying expenses and charitable contributions.

Concerns about the accuracy of expenditure data used to set rates suggest that greater oversight is warranted. To reduce the potential for improper payments to inflate capitated rates, it is recommended that DMAS (1) use one set of data for rate setting and all other purposes, (2) systematically assess the data for completeness, accuracy, and potential errors, and (3) periodically audit (or require audits of) all MCO expenditure data used to set rates.

COMPREHENSIVE CHANGES NEEDED TO MEANINGFULLY REDUCE THE RISK OF IMPROPER PAYMENTS

Collectively, the findings of this review indicate that comprehensive changes are needed to address program integrity weaknesses within Virginia's Medicaid system, which spans multiple agencies and levels of government. Specifically, JLARC staff identified five areas in which systemic concerns need to be addressed (listed below). Improvements in any single area will partially reduce the risk of improper payments, but changes must be comprehensive in all areas to close gaps in the program integrity process as a whole.

Taken as a whole, these areas of concern indicate that the present operation of Medicaid represents a serious internal control risk, which may be exacerbated by the increase in Medicaid enrollment resulting from health care reform. However, although there are potential solutions to the individual weaknesses, it is not clear how to best implement all individual recommendations into a single and comprehensive plan, and whether comprehensive changes can be addressed by one agency, or even by one administration. A special interagency task force appears needed to evaluate how to best address systemic concerns in a comprehensive manner across the entire Medicaid system.

Addressing Systemic Concerns in Medicaid Program Integrity Activities Requires Improvements in Five Areas

1. Additional internal controls of program integrity activities are needed to ensure accountability and effectiveness.
2. New information technology and data are needed to improve internal controls and increase performance measurement.
3. The Departments of Medical Assistance Services (DMAS) and Social Services (DSS) need to increase the use of data analysis to measure operational effectiveness and efficiency.
4. Improved coordination is needed to enable a more systematic approach to program integrity.
5. DSS and DMAS need to improve oversight of local departments and MCOs to ensure compliance with Medicaid policies.

Source: JLARC staff.

Medicaid Program Integrity Activities Are Designed to Reduce Improper Payments

In Summary

Medicaid is the largest program in Virginia's budget, accounting for about \$7.2 billion in fiscal year (FY) 2011. The federal government and the State typically split evenly the cost of Medicaid, which is administered by the Department of Medical Assistance Services (DMAS). Recipients and providers enroll in either the Medicaid "fee-for-service" program, in which DMAS pays providers directly, or in the managed care program that uses contractors to oversee and pay medical providers. Because Medicaid is so large, even a relatively small proportion of improper payments (resulting from fraud, abuse, or errors) is costly. To prevent and detect improper payments, DMAS works in conjunction with State and local Departments of Social Services to conduct several program integrity activities. If these agencies identify instances of potential fraud, the case is referred for prosecution to either the Office of the Attorney General or to a local Commonwealth's Attorney.

House Joint Resolution (HJR) 127 from the 2010 General Assembly session directs the Joint Legislative Audit and Review Commission (JLARC) to study the Commonwealth's medical assistance program, Medicaid, to identify opportunities to reduce waste, inefficiency, fraud, and abuse (Appendix A). The Department of Medical Assistance Services (DMAS) operates Medicaid, which is presently the largest program in Virginia's budget, and accounted for about \$7.2 billion in fiscal year (FY) 2011. Of that \$7.2 billion in expenditures, \$402 million was paid to cover the Medicare premiums of individuals eligible for both Medicare and Medicaid. This report focuses on the remaining \$6.8 billion in expenditures for medical services paid by DMAS directly or through the managed care system. These expenditures were made on behalf of 992,816 recipients, at an average annual cost of \$6,059 per person who received services. As federal health care reform is implemented, the size and cost of Medicaid will grow even larger.

Because Medicaid expenditures are so large, even low rates of improper payments (resulting from fraud, abuse, or errors) are costly. DMAS and the federal Centers for Medicare and Medicaid Services (CMS) share responsibility for protecting the fiscal integrity of Medicaid. DMAS has a more direct responsibility for Virginia's program, and must ensure payments are properly made and that misspent funds are collected. DMAS administers several program integrity activities designed to prevent, detect, and collect improper payments.

**Findings From 2010
JLARC Interim
Report**

Interim Report: Fraud and Error in Virginia's Medicaid Program found that errors in eligibility determination, and delays in eligibility redeterminations, likely result in improper Medicaid payments because some ineligible Virginians receive Medicaid-funded services.

In addition, local departments of social services and DMAS may not have been fully investigating and prosecuting recipient fraud.

Lastly, while the State's Medicaid Fraud Control Unit reported over \$700 million in recoveries from FYs 2005 to 2009, DMAS had received only \$49 million.

While the State has had some success in controlling Medicaid fraud and error, there appear to be opportunities to improve these program integrity activities and further reduce improper payments in Virginia. This report describes the complex effort, spread across several agencies, on which the State relies to control improper payments and includes findings and 26 recommendations.

In conducting the research for this report, JLARC staff interviewed personnel at DMAS, Virginia's five Medicaid managed care organizations, State and local Departments of Social Services (DSS), and the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General. JLARC staff also reviewed and analyzed reports, manuals, and data on the program integrity activities of these agencies. (Appendix B contains more details about these research activities.) Additional background information can be found in the JLARC report *Interim Report: Fraud and Error in Virginia's Medicaid Program* published in December 2010.

**MEDICAID USES FEDERAL AND STATE FUNDS TO PROVIDE
MEDICAL CARE TO ELIGIBLE RECIPIENTS**

Medicaid was created in 1965 as Title XIX of the Social Security Act to provide medical care to certain individuals and families. Because the federal government typically pays 50 percent of the total annual cost of Medicaid in Virginia, about half of any funds identified by program integrity activities must be repaid to the federal government regardless of what is collected. This must occur before the State receives any funds.

States operate the Medicaid program within broad federal guidelines but have some flexibility in establishing eligibility standards, determining which services to provide, and setting payment rates. Compared to other states, Virginia's Medicaid program has more restrictive income eligibility requirements for recipients, covers fewer services, and does not provide coverage to some categories of recipients that are covered by many other states. For example, in Virginia most childless adults are not eligible for Medicaid. With these restrictions in place, Virginia's Medicaid expenditures per capita ranked 47th among the states as of 2009. In Virginia, Medicaid recipients have access to various health care services from medical providers that are eligible to receive Medicaid payments. These services range from preventive and acute care services (such as hospitalizations) to long-term care services (including nursing home care and community-based care through waiver programs).

DMAS administers the federally required State Plan for Medical Assistance Services, which contains the recipient eligibility requirements for Medicaid. The State Plan, which is promulgated in the *Virginia Administrative Code*, assigns primary responsibility

for determining an applicant's eligibility for Medicaid to DSS. (Some applications are processed by DMAS.) This designation reflects a statutory requirement that applications for public assistance should be made to local departments of social services unless the State Plan directs otherwise. In keeping with this long-standing role, local departments process most Medicaid applications, using information technology, guidance, and oversight provided by DSS. The respective responsibilities of DMAS and DSS are also defined in an interagency agreement.

MEDICAID IS OPERATED THROUGH FEE-FOR-SERVICE AND MANAGED CARE PROGRAMS

States may pay health care providers directly, through an approach known as “fee-for-service,” or use managed care organizations (MCO) to act as intermediaries between the Medicaid agency and medical providers. Under the fee-for-service program, health care providers are reimbursed for each individual service or group of services. Each service has an associated fee or rate, and the provider reimbursement varies according to the number of services provided. DMAS administers the fee-for-service program directly (although some functions are performed by contractors), and is responsible for ensuring provider reimbursement claims are processed and paid in a timely manner.

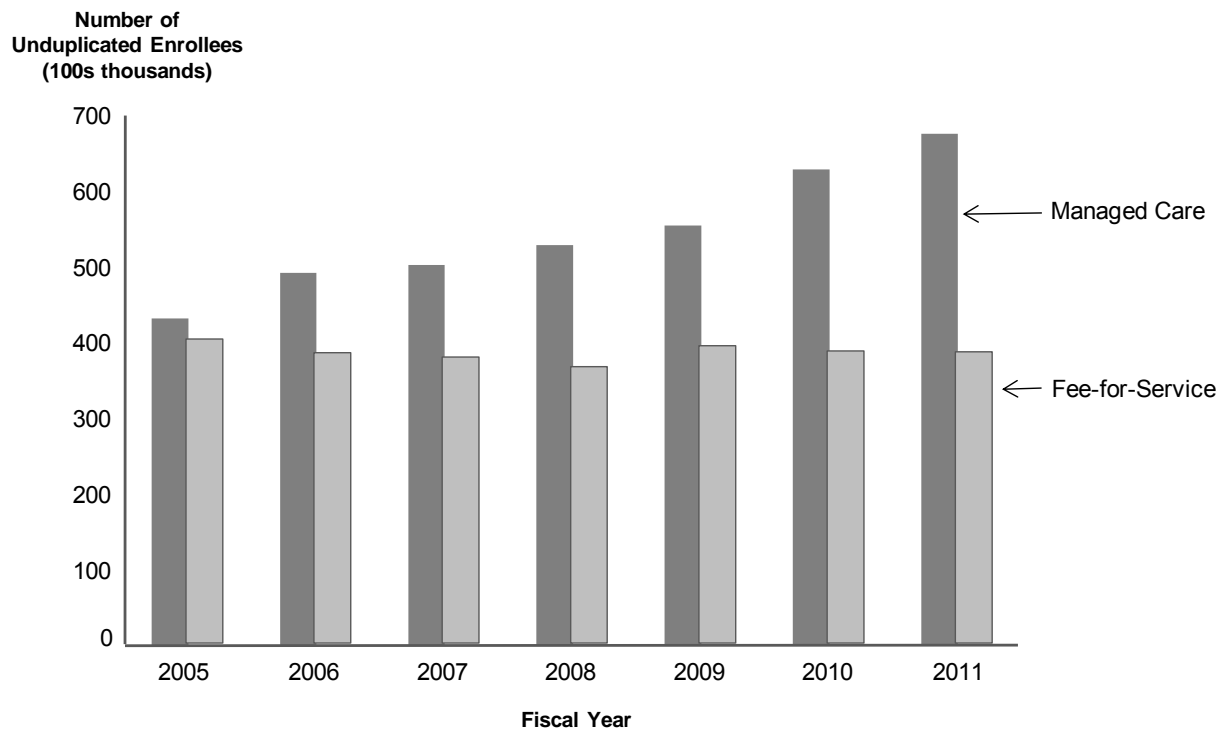
MCOs and Fee-for-Service Serve Different Populations

The populations served by MCOs and the fee-for-service program are different. Managed care recipients are typically newborns, children, or single parents (typically the mother) who incur relatively low medical costs, on average. By contrast, fee-for-service recipients tend to be older, have a physical or intellectual disability, and/or receive long-term care services, and incur higher medical costs, on average.

In contrast, under the managed care program certain contracted organizations act as intermediaries between DMAS and health care providers. DMAS currently has five participating MCOs: Amerigroup Virginia, Anthem HealthKeepers, Inc., Optima Family Care, Virginia Premier Health Plan, and Southern Health Care-Net. Each MCO receives a flat or “capitated” monthly payment from DMAS for each Medicaid recipient enrolled in its plan. The MCO is then responsible for enrolling providers into its network, as well as processing and paying provider claims. The difference between an MCO's capitated payment from DMAS and the reimbursements the MCO makes to providers and its administrative costs constitutes the profit (or loss) experienced by that organization.

While enrollment in managed care grew by more than 50 percent from FY 2005 to FY 2011, fee-for-service enrollment has declined slightly over the same period (Figure 1). As a result, most individuals are enrolled in the managed care program. However, fee-for-service payments still comprise the majority of overall Medicaid expenditures because of differences in the two populations of enrollees. Of the 1.06 million individuals enrolled in Medicaid in FY 2011, 64 percent were enrolled in managed care but accounted for only 29 percent (\$2.0 billion) of Virginia's overall medical

Figure 1: Medicaid Managed Care Accounts for a Growing Portion of Enrollment



Note: The number of unduplicated *enrollees* is higher than the number of *recipients*. While all managed care enrollees are considered recipients because the MCO receives a capitated payment for each person enrolled in its plan, only a portion of fee-for-service enrollees actually receive services paid for by Medicaid (318,008 out of 386,032 in FY 2011).

Source: JLARC staff analysis of Medicaid unduplicated annual enrollment data provided by DMAS in September, 2011.

assistance expenditures in FY 2011. In contrast, 36 percent of individuals were enrolled in the fee-for-service program and accounted for 71 percent (\$4.8 billion) of Medicaid expenditures.

ERROR, FRAUD, AND ABUSE ARE EXAMPLES OF IMPROPER PAYMENTS

HJR 127 specifically refers to waste, inefficiency, fraud, and abuse in Virginia's Medicaid program. Generally speaking, these activities are referred to as "improper payments." As defined in the federal Improper Payments Information Act of 2002, the term "improper payment" means "any payment that should not have been made or that was made in an incorrect amount." This definition includes payments on behalf of an ineligible recipient or for an ineligible service, any duplicate payment or payments for services not received, and any payment that does not include a credit for applicable discounts. Most improper payments are the result of inadvertent errors, but some are intentional and constitute abuse or fraud. Although fraudulent or abusive actions often receive more attention, all improper payments pose a financial risk to the State's general fund.

Improper Payments Information Act of 2002

The law requires federal agencies to identify programs (such as Medicaid) and activities that are vulnerable to improper payments, to estimate the amount of improper payments, and to report to Congress on steps being taken to reduce such payments.

This law was expanded by the Improper Payments Elimination and Recovery Act of 2010, but the definition of an improper payment was not changed.

Five Types of Improper Payments Occur Most Frequently in Medicaid

In response to the Improper Payments Information Act, CMS and the Office of the Inspector General for the U.S. Department of Health and Human Services (OIG) increased their efforts to identify errors that lead to improper payments. Audits conducted by the OIG indicate that the following five categories of improper payments occur most frequently:

- Billing for an item or service that lacks adequate documentation. When providers fail to maintain adequate medical records, claims reviewers cannot determine the extent of the services provided, their medical necessity, or whether they were even provided to a Medicaid recipient.
- Billing for medically unnecessary services, as determined by a claims reviewer who reviewed the medical records.
- Billing for costs or services that Medicaid will not reimburse because they do not meet the State's reimbursement rules and regulations.
- Using incorrect medical codes. Providers are supposed to use standard codes when submitting Medicaid claims. In a coding review, claims reviewers determine whether the medical records support a lower or higher reimbursement code than was actually submitted.
- Failing to properly bill a third party, such as Medicare or private insurance. When this occurs, or the state Medicaid agency fails to prevent it, Medicaid inappropriately pays a claim and may not be reimbursed.

Improper Payments Can Result From Errors

As defined by CMS and the OIG, errors include inadvertent actions by providers and state and local agencies resulting from errors, misinterpretations of rules, or poor recordkeeping. CMS indicates that providers can inadvertently commit medical review errors when submitting a claim for reimbursement. Examples of these errors include

- missing or insufficient documentation,
- use of incorrect procedure or diagnostic codes,
- use of medically unnecessary services, and
- violations of policies and other administrative errors.

In addition, State and local agencies can make data processing and eligibility errors. Data processing errors include payment for du-

plicate items, services that are not covered by Medicaid or which should have been paid by a third party, and data entry and pricing errors. Eligibility errors occur when the misapplication of federal and State policies and procedures results in payment for services on behalf of an individual who was ineligible for Medicaid, or was eligible for Medicaid but not for the service received. Eligibility errors can also include instances in which a review of the recipient's case file indicates a lack of sufficient documentation to definitively determine eligibility status. Finally, some eligibility errors may be attributed to recipients if an individual inadvertently failed to report information needed to accurately determine their eligibility.

Improper Payments Resulting From Intentional Actions Constitute Fraud or Abuse

Within the context of the Medicaid program, federal regulations define “fraud” as “intentional deception or misrepresentation” made to obtain unauthorized benefits. Fraud can be committed by a provider, applicant, recipient, agency staff, or contractor. According to the National Health Care Anti-Fraud Association, the majority of health care fraud is committed by providers.

One of the most common types of provider fraud, according to the OIG, is billing for services that were never rendered. This could occur when a provider knowingly bills Medicaid for a treatment or procedure that was not actually performed, such as blood tests when no samples were drawn or x-rays that were not taken. Because the distinction between error and fraud rests on intent, the same activity (such as use of incorrect codes) could result from either error or fraud. Other common types of provider fraud include

- billing for more expensive services or procedures than were actually provided or performed (“upcoding”),
- performing medically unnecessary services,
- misrepresenting services provided (for example, billing a covered procedure code and providing a non-covered service),
- accepting kickbacks for patient referrals, and
- submitting separate bills for services that should be billed in combination, such as tests or procedures that are required to be billed together at a reduced cost (“unbundling”).

Although both fraud and abuse involve intentional action, fraud may be committed without any services being rendered. In contrast, abuse always involves the provision of health care. Abuse is defined as actions by providers or recipients that are “inconsistent with sound fiscal, business, or medical practices” and that result in unnecessary cost. Examples of abuse include

- billing and receiving payment from a recipient for the difference between the provider charge and the Medicaid reimbursement for the service,
- billing Medicaid a higher fee than private pay patients, and
- excessive charges for services or supplies.

Waste and Inefficiency Are Not Clearly Defined

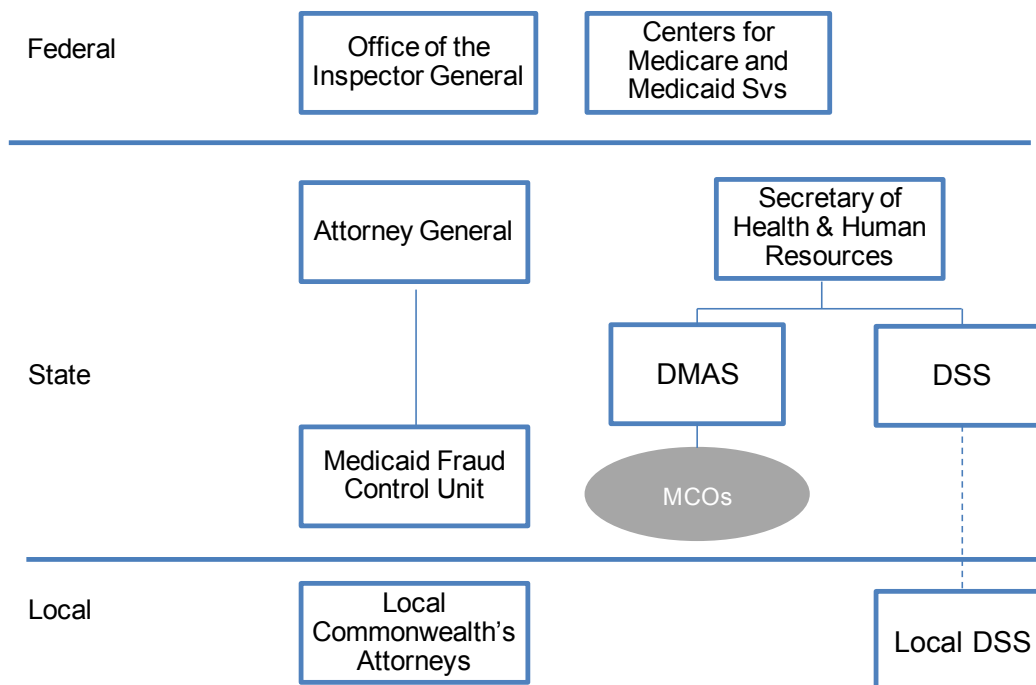
Neither federal nor State law appears to define waste in the context of the Medicaid program, but the U.S. Government Accountability Office defines waste as “extravagant and unnecessary expenditures.” Likewise, there does not appear to be a definition of inefficiency within the Medicaid program, but HJR 127 defines it as “regulatory barriers” that increase State expenditures while potentially allowing fraud and abuse to occur.

FOUR PROCESSES ARE USED BY STATE AND LOCAL AGENCIES TO MINIMIZE RISK OF IMPROPER PAYMENTS

Several State and local agencies are involved in the effort to reduce improper Medicaid payments. Although DMAS plays a key role, it relies upon DSS, a peer agency, to ensure that local departments properly enroll recipients into Medicaid and investigate suspected cases of Medicaid recipient fraud. Similarly, DMAS also relies upon local Commonwealth’s Attorneys to prosecute cases of suspected recipient fraud, and upon the MFCU to prosecute provider fraud. These efforts are overseen at the federal level by CMS and the OIG, which review the program integrity activities undertaken by DMAS and the MFCU. The relationship between each agency is illustrated in Figure 2, which also indicates that responsibility for the minimization of improper payments is spread across agencies at all three levels of government.

The program integrity efforts used by DMAS and other State and local agencies may be conceptualized as four processes designed to prevent, identify, and collect improper Medicaid payments at various stages (Table 1). Generally speaking, each step applies to both recipients and providers, although each group is subject to different standards and procedures. The first two (enrollment and pre-payment review) are *prospective* processes that are designed to prevent improper Medicaid payments before any payment is made. The remaining two (post-payment audits and collections) are *retrospective* processes that seek to identify and collect improper payments already made.

Figure 2: Responsibility for Medicaid Program Integrity Is Dispersed Among Many Agencies and Levels of Government



Source: JLARC staff analysis of statutory and regulatory responsibilities.

Table 1: State and Local Agencies Use Four Processes to Minimize Financial Risk of Improper Payments

Process	Lead Entity Performing Step	
	Recipient	Provider
(1) Enrollment	Local DSS and DMAS	DMAS Program Operations Division
(2) Pre-Payment Review	DMAS Program Operations Division	DMAS Program Operations Division
(3) Post-Payment Review and Prosecution	DMAS Program Integrity Division	DMAS Program Integrity Division
	Local DSS	Medicaid Fraud Control Unit
(4) Collections	Commonwealth's Attorneys	
	DMAS Fiscal Division	DMAS Fiscal Division

Source: JLARC staff analysis of program integrity responsibilities assigned to, and procedures performed by, DMAS, DSS, MFCU, and Commonwealth's Attorneys.

The Medicaid fee-for-service and managed care programs use similar program integrity processes. Both programs engage in efforts to prevent payment of improper payments, detect improper payments that have been made, and collect funds. This section discusses the State and local agencies that conduct program integrity activities in the fee-for-service program, which has been the focus of this review. However, two units in DMAS play key roles in administering the program integrity activities performed by MCOs. The Health

Care Services Division oversees the Medicaid managed care program generally by administering the contract between DMAS and each MCO. In addition, the Provider Reimbursement Division sets provider rates for both the fee-for-service and managed care programs.

Enrollment Activities Are Intended to Prevent Ineligible Recipients and Providers From Participating in Medicaid

Local departments of social services are primarily responsible for determining the eligibility of all recipients and enrolling them into the Medicaid fee-for-service program, whether or not they are subsequently enrolled into managed care.

All providers wishing to be reimbursed by the Medicaid fee-for-service program must be enrolled by DMAS's Program Operations Division. In contrast, providers in Medicaid managed care networks are directly enrolled by the responsible MCO. Because providers may be enrolled through two different avenues, some providers only serve fee-for-service recipients while others only serve managed care enrollees; some providers serve both.

Pre-Payment Review Activities Are Intended to Block Erroneous Provider Reimbursement Claims

In FY 2009, DMAS's Program Operations Division and its contractor used the Medicaid Management Information System, DMAS's automated claims processing system, to process about 35 million reimbursement claims submitted by more than 41,000 providers. These claims were reviewed by a series of automated and manual procedures designed to identify known irregularities and block claims that are not eligible for payment. (Payments to the five MCOs are also reviewed, but to a lesser extent.) By blocking claims before they are paid, DMAS avoids the so-called "pay and chase" scenario wherein funds must be recovered from providers who (if fraud or error has occurred) may be difficult to locate or lack the funds needed to make restitution. These steps also increase operational efficiency by limiting the need to audit a paid claim.

Post-Payment Investigations of Recipients and Providers Are Designed to Identify Errors and Potential Fraud

DSS and DMAS are required to investigate fraud and other violations of Medicaid laws and regulations. Many of these activities occur retrospectively, after enrollment and claims processing, through investigations of recipients and providers. As part of this process, a determination must be made regarding whether the violation resulted from inadvertent error or constituted willful fraud.

Certain Recipients Are Enrolled Into Managed Care

In geographic areas where two or more MCOs are available, certain Medicaid recipients must be enrolled in a MCO (certain categories of recipients are never enrolled in managed care). In areas where no managed care coverage exists, all Medicaid recipients are enrolled in fee-for-service. In areas with only one MCO, Medicaid recipients can choose either fee-for-service or managed care coverage.

As a program integrity practice, DMAS uses a third-party contractor to enroll recipients into managed care and thereby prevent the MCOs from selecting only healthy individuals.

After a recipient has been enrolled, DMAS's Program Integrity Division (PID) monitors the usage of services by recipients to look for abuse. In addition, local departments and PID share responsibility for investigating suspected cases of Medicaid recipient fraud. In many cases, these investigations result from referrals made by community members or by eligibility workers who identified concerns regarding the information provided on an initial application or on the annual eligibility redetermination form. If the concern appears to have resulted from intentional action, the case is referred to the local Commonwealth's Attorney.

Similarly, PID investigates provider reimbursement claims after they have been processed and paid. Selected claims are reviewed as part of an audit process to identify those that were erroneously paid. These improper payments could include either overpayments for valid claims or claims that should not have been paid according to federal or State Medicaid program rules.

If audits of providers conducted by PID staff detect irregularities that may constitute fraud, this information is referred to the Attorney General's Medicaid Fraud Control Unit (MFCU). The MFCU's mission is to examine these referrals and determine if a legal case for fraud exists. The MFCU prosecutes providers who attempt to defraud Medicaid in order to collect funds and to deter other providers from engaging in fraudulent behavior. In addition, convictions of Medicaid fraud often lead to the removal of providers from the Medicaid system.

Collections of Improper Payments Are Needed to Reimburse State and Federal Governments

DMAS is responsible for recovering improper payments identified as a result of recipient and provider investigations, as well as restitution amounts ordered by State and federal courts in cases of recipient and provider fraud. These activities are conducted by the Fiscal and Purchases Division (hereafter referred to as the "Fiscal Division"). In most cases, a recipient or provider investigation will indicate that an improper payment resulted from error. DMAS will then begin an administrative collections process, which it can initiate up to three years after payment was made. Improper payments that result from fraud, however, often result in a court-ordered restitution award. DMAS does not initiate these the collections process for these awards, which result from actions of a Commonwealth's Attorney or the MFCU, but tracks the funds it receives. DMAS must also ensure that the federal government is repaid for its share of the improper payment (typically, 50 percent) within one year even if no funds have been collected.

FEDERAL HEALTH CARE REFORM WILL INCREASE MEDICAID ENROLLMENT AND ADD NEW FEDERAL AND STATE PROGRAM INTEGRITY REQUIREMENTS

Federal health care reform will result in an expansion of both the Medicaid-eligible population and the requirements for state program integrity efforts. These requirements are found in two recently passed acts, the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010. Beginning in 2014, the acts expand some existing eligibility categories and require states to add new recipient categories. In combination, DMAS estimates that these changes will add between 270,000 and 425,000 more people to Virginia's Medicaid-eligible population, a potential enrollment increase of 32 to 50 percent. Several program integrity changes are also required by federal health care reform, including changes to provider enrollment procedures, the establishment of internal program integrity procedures for certain providers, and a requirement that states use contract auditors to identify improper payments.

Enrollment of Ineligible Medicaid Recipients Presents Greatest Risk of Improper Payments

In Summary

A 2009 federal review of the State's eligibility determination process indicates a large number of individuals enrolled in the Virginia Medicaid program were not eligible for services. The federal government estimated the amount of improper payments that could have occurred in that year, and JLARC staff reduced this estimate to account for subsequent changes in eligibility policy and differences in interpretation between the State and federal governments. Based on the federal extrapolation of potential costs, JLARC staff estimate that the negative impact of the resulting improper payments on the State general fund may have ranged from approximately \$18 million to \$263 million; the federal government could have incurred an additional cost of \$26 million to \$397 million. To reduce the risk of making improper payments on behalf of ineligible recipients, additional investments are needed in the processes used by the Department of Medical Assistance Services (DMAS), the Department of Social Services (DSS), and local departments of social services to oversee, monitor, and train caseworkers. Investments are also needed to update the information technology systems used to determine eligibility. Improper payments can also result from delays in the annual redeterminations of eligibility by local departments, which could be addressed by implementing an administrative redetermination process at DSS. Improved coordination between DMAS and managed care organizations could also reduce the risk that recipients will abuse medical services. To reduce recipient fraud, steps could be taken to improve coordination, realign investigatory responsibilities between DMAS and local departments, and use administrative hearings in lieu of criminal prosecution in some cases.

House Joint Resolution 127 directs JLARC to describe the nature and scope of fraud or abuse committed by Medicaid beneficiaries. Improper payments associated with Medicaid beneficiaries could result from fraud or error committed by applicants or recipients, who might fail to report all sources of income or other information needed to determine their eligibility. Improper payments also occur due to errors committed by caseworkers who process Medicaid applications, if they misapply Medicaid policy, make mathematical errors when assessing an applicant's financial resources, or fail to obtain documents necessary to support recipients' eligibility. After enrollment, caseworkers do not always complete the annual redetermination of eligibility in a timely manner, and recipients sometimes do not notify caseworkers of changes in circumstances that affect eligibility. Any of these scenarios can result in the improper expenditure of Medicaid funds on behalf of individuals who are ineligible under Medicaid policy.

ERRORS MADE DURING RECIPIENT ENROLLMENT MAY HAVE RESULTED IN SUBSTANTIAL UNNECESSARY COSTS

Payment Error Rate Measurement Review

The Centers for Medicare and Medicaid Services conducts Payment Error Rate Measurement (PERM) reviews of state Medicaid programs on a rotating three-year cycle. The most recent review of Virginia's Medicaid program was conducted in federal FY 2009 (October 2008 through September 2009), and the next review is scheduled to occur in federal FY 2012.

Each year, the federal Centers for Medicare and Medicaid Services (CMS) conducts a Payment Error Rate Measurement (PERM) review designed to measure improper payments in Medicaid and produce state- and national-level error rates that resulted from the enrollment of recipients that may have been ineligible for services. In federal fiscal year (FFY) 2009, the PERM review analyzed data from Virginia and 16 other states, using statistically-significant samples of recipient case files. The review also calculated the extent to which applicants or recipients may have been improperly denied Medicaid coverage or had that coverage improperly cancelled after enrollment. However, because no payments were incurred on behalf of these individuals, CMS did not estimate the potential amount of improper payment. More details about the PERM review and the methodology used by CMS to quantify improper payments based on errors identified through PERM, as well as JLARC staff's approach in estimating potential unnecessary costs based on the CMS figure, can be found in Appendix B.

Federal Review Estimated Significant Costs May Have Resulted From Errors Made by Enrolling Ineligible Recipients

After assessing a sample of cases for individuals enrolled in Medicaid in FFY 2009, the PERM review found that local departments of social services in Virginia had made errors in approximately 17 percent of the cases. Virginia's error rate was the second highest, behind another state with an error rate of 70 percent. In contrast, the error rates in each of the 16 other states reviewed were ten percent or less.

Federal Stimulus Provided States With Additional Funds for Medicaid

The 2009 federal American Reinvestment and Recovery Act provided states with a one-time increase in their Medicaid matching rate (from October 1, 2008 through December 31, 2010). This action temporarily increased Virginia's matching rate from 50 percent to as high as 61.59 percent for FY 2010 and the first half of FY 2011.

CMS estimated that as a result of these errors, \$910 million in improper payments could have occurred in Virginia in FFY 2009. However, this estimate is not the actual amount of enrollment-related improper payments that occurred in that year. Instead, it is an extrapolation of potential cost based upon a statistically significant sample. As a result, the actual amount may be lower or higher than the estimate calculated by CMS. In addition, only 40 percent of this estimated amount would have involved State general funds, because the State received an enhanced Medicaid federal match rate of 60 percent in that year. (In a more typical year, Virginia and the federal government share the cost of Medicaid evenly, such that 50 percent of improper payments would be paid from State general funds.)

JLARC Staff Adjusted CMS Estimate to Better Reflect the Prospective Potential Unnecessary Cost of Eligibility Errors

To better capture the magnitude of eligibility errors that Virginia could face going forward, JLARC staff revised the CMS figure to account for changes in policy and differences in interpretation between the State and CMS. The revised estimate suggests the State general fund impact of these errors may have ranged from approximately \$18 million to \$263 million; an additional cost of up to \$397 million may have been incurred by the federal government. In contrast, in FY 2009 the total amount of recipient and provider error and fraud detected in Virginia was approximately \$32 million. (Additional background information on FY 2009 fraud and error can be found in the JLARC interim report, published in December 2010.)

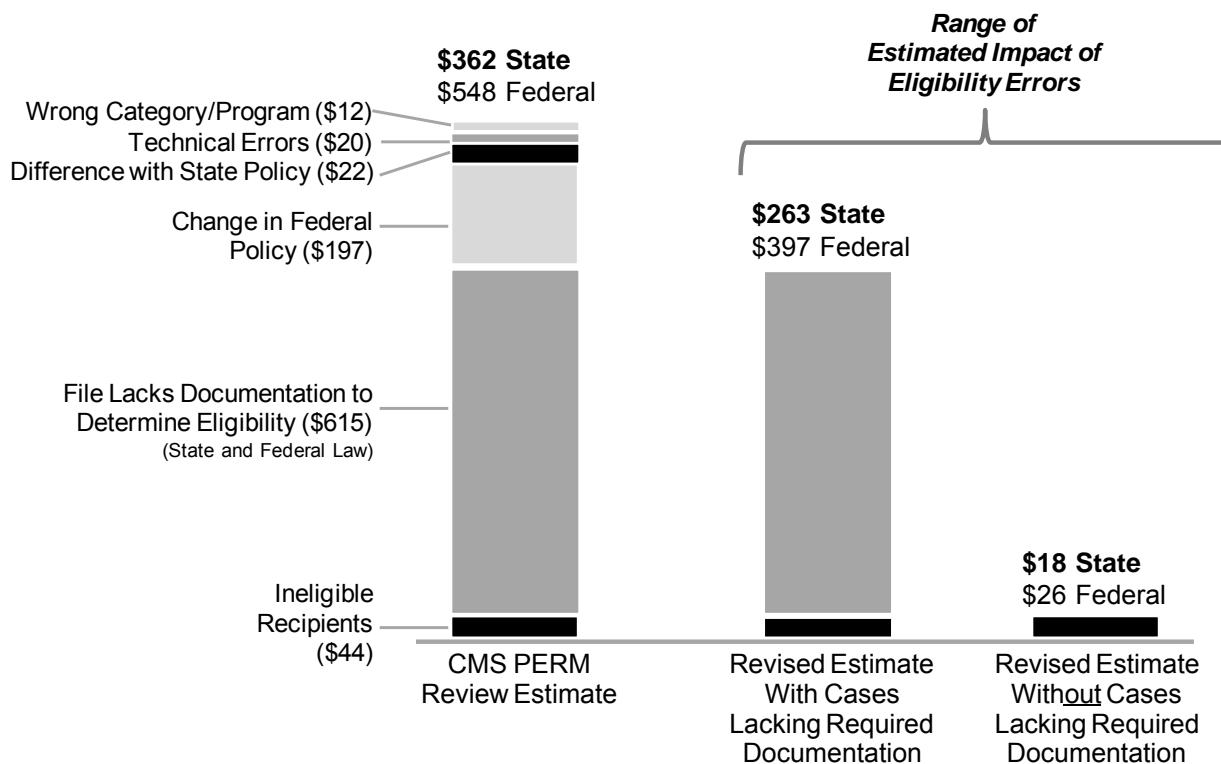
During the course of this review, DMAS staff raised a concern about the validity of the methodology used by CMS to extrapolate a dollar estimate. Although the CMS methodology appears appropriate, it should be noted that the estimated improper payments calculated by CMS and revised by JLARC are intended to convey the potential magnitude of the State's financial exposure associated with Medicaid eligibility errors and may lack the accuracy needed for determining a precise budgetary impact. However, these data remain the only available means of estimating the potential value of eligibility errors.

As shown in Figure 3, the JLARC staff estimate built upon the CMS PERM review estimate, but subtracted costs attributable to individuals who appeared eligible for services under current policy, including those who

- were eligible for services but were enrolled in the wrong Medicaid aid category or program (\$12 million),
- were eligible for Medicaid but for whom the wrong form was completed (\$20 million),
- were eligible under State policy but were ineligible according to the process used by PERM to assess State residency (\$22 million), and
- would have been found eligible in the federal CMS PERM review under the most recent federal policy pertaining to the documentation of citizenship and identity (\$197 million).

Additional information on errors found in the PERM review is provided in Exhibit 1.

Figure 3: Eligibility Errors Resulted in Estimated State General Fund Impact of Approximately \$18 Million to \$263 Million in FFY 2009 (JLARC Staff Estimate, \$ in Millions)



Note: Estimates are intended to convey the potential magnitude of financial exposure, but may lack the accuracy needed for determining a budgetary impact.

Source: JLARC staff analysis of CMS Payment Error Rate Measurement (PERM) data and literature, and DMAS data.

The vast majority of the potentially unnecessary costs remaining in the JLARC staff estimate is attributable to “undetermined” cases in which the recipients’ file lacked the necessary documentation (or in some instances, the entire file) to establish whether they were eligible for Medicaid services. As with the CMS PERM review estimate, these cases were treated as errors because the case files did not contain documentation required by both Virginia and federal policy. Despite repeated attempts by certified mail and phone to contact these types of recipients whose files were reviewed during the PERM review process, it was not possible for DMAS staff to obtain the information needed to establish their eligibility. In accordance with Medicaid policy and based on the best information available at the time of the PERM review, these individuals were terminated from the program because recipients whose eligibility cannot be proven with requisite documents are considered ineligible for services at that time, even if they are subsequently found to have been eligible.

Exhibit 1: JLARC Staff Revised the Federal PERM Estimate of Improper Payments by Excluding Errors Associated With Individuals Who Appear Eligible for Services

<u>Excluded Errors</u>	<u>Explanation</u>
Recipients Assigned to Wrong Aid Category or Program	The PERM review treated as erroneous all cases in which eligibility workers assigned a recipient to the wrong Medicaid aid category or to the wrong medical assistance program such as the Family Access to Medical Insurance Security (FAMIS) plan. However, DMAS staff demonstrated that the actual amount of improper payments made was lower because the correct assignment of aid category or program would have still resulted in the expenditure of State funds in FAMIS. JLARC staff used DMAS data to subtract the improper payments associated with these assignment errors.
Technical Errors	All technical errors, in which local caseworkers used the wrong forms when determining Medicaid eligibility, were treated as errors by PERM. However, DMAS staff stated that these mistakes did not result in the improper enrollment of applicants. Therefore, JLARC staff treated these cases as correct and subtracted the associated costs.
Difference with State Policy	The PERM review treated all cases in which the case file lacked all required documentation, or the file was missing, as eligibility errors. However, DMAS staff identified a subset of these “undetermined” cases that they assert did not result in eligibility errors because based on Virginia policy, the missing documentation pertained to information to which individuals could self-certify, such as Virginia residency and the size of their household, in their application.
Citizenship and Identity	The PERM review used an earlier process to document citizenship and identity that conflicts with current federal policy following enactment of the Children’s Health Insurance Program Reauthorization Act of 2009. The new process does not require applicants to submit documentation verifying citizenship and identity. However, if a match cannot be made between the information on the application and Social Security Administration data, the applicant must provide documentation within 90 days. In contrast, at the time of the PERM review, applicants had to provide this documentation before being enrolled. JLARC staff excluded these errors in its estimate of improper payments in order to better reflect current policy.

Source: JLARC staff analysis of CMS Payment Error Rate Measurement literature and data, DMAS data.

Revisions to PERM Will Calculate Two Error Rates

In its June 2011 update of the *Payment Error Rate Measurement Manual*, CMS indicated that, based upon an August 2010 rule, it will calculate State and national error rates once with undetermined cases included as payment errors and once with undetermined cases excluded.

Because documentation could not be obtained to confirm eligibility status, it is possible that some of these recipients were eligible at the time they applied for Medicaid and/or during the PERM review. Accordingly, JLARC staff calculated the estimated potential State general fund impact of eligibility errors as a range from as low as \$18 million (assuming all undetermined cases were eligible) to \$263 million (assuming none were eligible).

To address the possibility that some of the undetermined cases may have pertained to eligible individuals, a possibility which has been raised by Virginia and other states since 2009, CMS will begin reporting two estimates of improper payments: one that excludes all undetermined cases, and the other (current) estimate which includes all undetermined cases. This approach is functionally similar to the range calculated by JLARC staff, which is based

on the CMS estimate. Still, at the very least, the absence of required documentation raises concerns that proper documents are not verified to determine eligibility and/or that local departments lack adequate internal controls over the enrollment process.

Federal Review Also Found Improper Denial of Enrollment Which May Offset Some Unnecessary Costs Due to Ineligible Recipients

In addition to measuring the rate at which local departments enrolled ineligible individuals, the PERM review also assessed the extent to which eligible applicants were denied Medicaid coverage or recipients improperly lost coverage after enrollment. This assessment was made by examining a sample of cases that included (1) applicants who had been found ineligible and (2) recipients who had been disenrolled following the annual redetermination process. The review found that 25 percent of cases in the sample were actually eligible but either were denied coverage (seven percent) or lost coverage (18 percent) as the result of error.

Redetermination Process Annually Reassesses Eligibility for Medicaid

The eligibility redetermination process is designed to ensure that only eligible recipients continue to receive Medicaid benefits.

Continuing eligibility is established by re-verifying certain information that is likely to change over time (recipients' residency, household composition, and income and resources), using the same processes as for determining initial Medicaid eligibility.

This finding has substantial ramifications for the Medicaid program's ability to carry out its mission, because improper cancellation of Medicaid coverage denies medical services to those who are entitled to them by law. In addition, errors that lead to the denial or termination of coverage result in improper payments in the form of underpayments. Although the PERM review did not estimate the amount of these underpayments, JLARC staff estimate that the improper denial and cancellation of Medicaid enrollment may have reduced Medicaid expenditures by as much as \$87 million in 2009, of which \$35 million may have accrued to the General Fund. This estimate is based on Department of Social Services (DSS) data on the number of eligibility cancellations and denied applications that occurred in the Medicaid program in State FY 2009, and DMAS data on average expenditures on all Medicaid recipients. Because this estimate uses the average cost of all Medicaid recipients, it reflects the most likely amount of underpayments based on available information. However, if the individuals who were denied or lost coverage are not typical of all Medicaid recipients, then the actual cost could be higher or lower.

HIGH RATE OF ENROLLMENT ERROR INDICATES NEED FOR IMPROVED OVERSIGHT AND RESOURCES IN LOCAL DEPARTMENTS OF SOCIAL SERVICES

The magnitude of eligibility error identified by the PERM review suggests fundamental improvements are needed to reduce improper payments resulting from the enrollment of ineligible individuals. Specifically, improvements appear needed in four areas: the degree and nature of oversight exercised by DSS over local departments, the extent to which local departments monitor case-

workers, the adequacy of training provided by DSS, and the completion of ongoing efforts to update and improve the information technology (IT) available to local caseworkers. Shortcomings in these areas appear to hinder not only the ability of local departments to consistently apply Medicaid policy, but also the ability of DSS and DMAS to effectively ensure local compliance with Medicaid policy.

Enrollment Errors Identified by Federal PERM Review Largely Result from Improper Calculation of Resources and Income

The most common type of error found in the PERM review was the improper calculation by local caseworkers of the financial resources and income of applicants and recipients, occurring in 41 percent of cases. Another 46 percent of errors resulted from an inability to determine if the individual was actually eligible for Medicaid because of a lack of adequate documentation in the case file or a missing case file. The remaining 13 percent of cases contained other types of error, including the use of incorrect forms or the assignment of an otherwise eligible recipient to the wrong Medicaid aid category (which could result in the receipt of services for which they are ineligible). These errors appear to result from a lack of training and the lack of IT systems that are capable of ensuring proper compliance with Medicaid policy and processes.

Improvements in Oversight, Monitoring, and Training of Local Caseworkers Are Needed to Reduce Eligibility Errors

The corrective action plan which DMAS and DSS drafted and reported to CMS in response to the PERM error review identifies a need for improved oversight, monitoring, and training of caseworkers in order to reduce eligibility errors. Meetings conducted by JLARC staff with caseworkers, supervisors, and directors at ten local departments of social services, as well as DSS and DMAS staff supported the findings in the corrective action plan and identified additional issues.

DSS Oversight of Eligibility Determinations Made by Local Departments Is Limited and Does Not Identify Systemic Issues. DSS is responsible for overseeing and monitoring staff at local departments, but the agency's oversight of the accuracy of local eligibility determinations is limited. This oversight is provided by Medicaid consultants at five DSS regional offices and quality assurance staff in the central office.

Reviews of eligibility determinations by regional staff are infrequent and do not identify systemic errors. Although DSS's regional offices have specialized Medicaid staff who regularly audit a small number of local eligibility determinations, State DSS staff report that resource limitations prevent these audits from occurring on

an annual basis. Instead, these reviews occur every one to three years, depending upon the size of the local department and the degree of risk that previous audits indicate is posed by that department. In addition to limitations in the frequency of reviews, the nature of the reviews is limited. Typically, regional reviews take small samples of local department eligibility determinations and identify specific corrective actions to be taken by that local department to address each case. As a result, each review is locality-specific and does not identify systemic issues that may occur in multiple localities. In fact, none of the corrective action plans reviewed by JLARC staff discuss systemic eligibility errors, their causes, or solutions.

PERM and MEQC Reviews Are Different Ways of Assessing Eligibility Error

Both the Payment Error Measurement Rate (PERM) program and the Medicaid Eligibility Quality Control (MEQC) program are used by the Centers for Medicare and Medicaid Services to establish eligibility error rates. The programs differ, in part, in the way the sample of cases is selected. PERM selects cases based on whether the recipient's eligibility was or was not determined or re-determined in the month they were reviewed. MEQC selects cases based upon a random statewide sample regardless of when eligibility was determined.

In addition to reviews by regional staff, DSS conducts federally required Medicaid Eligibility Quality Control (MEQC) reviews, but the reviews are typically not designed to allow the variation in locality error rates to be assessed. The MEQC reviews are instead intended to calculate a statewide error rate, and they often include cases from most local departments. However, any given review typically includes only one or two cases per locality. As a result, locality-specific error rates cannot be determined. Moreover, DSS and DMAS staff have stated that error rates likely do vary among localities. As a result, the determination of a statewide error rate is only of limited use because it cannot be used to distinguish between those errors that occur statewide and those that occur only in particular localities.

The 2010 JLARC report *Interim Report: Fraud and Error in Virginia's Medicaid Program* recommended that DSS modify its implementation of the MEQC program by using a statistically significant sample of cases in three localities and ultimately statewide in order to calculate reliable local eligibility error rates. DSS and DMAS staff report that a pilot effort to implement this recommendation is underway, although it will be conducted in only two localities because of resource constraints. Although this pilot will provide valuable information, its value will be limited unless it is applied to additional local departments. The results of the pilot should be available in calendar year 2012.

Variation in the Extent to Which Local Departments Monitor Caseworkers May Also Contribute to Eligibility Errors. Although certain monitoring practices could help limit the extent of eligibility errors made by caseworkers, DSS has no direct means of requiring local departments to use these practices. One type of monitoring involves the review of caseworker eligibility determinations by a supervisor, a practice which is not consistently conducted by all local departments. Reviews of caseworker decision-making can be an effective quality control and training tool, and DSS staff have stated that local departments which use this practice typical-

ly have fewer eligibility errors. However, State DSS staff add that local departments can independently determine the frequency and extent to which this practice is used, and that some supervisors are unable to adequately review eligibility determinations because of resource constraints.

In some local departments, Medicaid eligibility is determined by generalists, who are responsible for establishing an individual's eligibility for multiple programs at the same time, rather than by Medicaid specialists. This practice was noted as a potential source of eligibility error by DSS and DMAS in their PERM corrective action plan. The use of generalists has gained popularity among local departments because it streamlines the application process and helps ensure the receipt of all the benefits for which an applicant is eligible. However, the use of generalists can also lead to errors if caseworkers are insufficiently trained and monitored, because they may fail to properly follow the complex requirements that exist for Medicaid but not for other benefit programs. For example, each benefit program has a unique set of income and resource thresholds. Generalists must therefore be knowledgeable about all of these requirements, and keep up-to-date as the requirements change and evolve over time. Figure 4 shows the manuals used by an eligibility supervisor in an agency in southwest Virginia. The Medicaid, Food Stamp, and TANF manuals alone total more than 3,000 pages.

Figure 4: Manuals and Handbooks for Eligibility Programs Used by a Local Department Eligibility Supervisor



Source: JLARC staff photograph.

DSS staff have stated that each local department has the authority to decide whether to use generalists, and that they lack the authority to direct the use of generalists or specialists.

Current Training of Caseworkers Appears to Be Inadequate to Ensure Compliance With Medicaid Policy. DMAS and DSS have indicated that improved and increased training of local department eligibility workers is needed to address the extent and nature of Medicaid eligibility errors identified by the PERM review. Specifically, the PERM corrective action plan identified the need for the following changes to eligibility worker training:

- Require new worker training within three months from hire date.
- Require face-to-face training at least once a year.
- Re-establish training sessions that were reduced due to local/state budget cuts.

Local department representatives interviewed by JLARC staff have also identified the need for additional training, such as on the review of applications that involve estates and other complex legal and financial transactions.

Information Technology Updates and Improvements Are Also Needed to Reduce Eligibility Errors

In response to the PERM review eligibility error findings, DMAS and DSS identified the need for substantial changes to the two information technology (IT) systems used by local caseworkers to process applications and enroll individuals into Medicaid: the Application Benefit Delivery Automation Project (ADAPT) and the Medicaid Management Information System (MMIS). ADAPT is maintained by DSS, and is designed to be a case management and eligibility determination system. MMIS is the enrollment and financial claims payment system used by DMAS. DMAS has noted that inadequacies in IT systems have resulted in errors in the calculation of income, a major cause of the errors notes in the PERM review discussed earlier in this chapter.

DMAS and DSS Need a Single Medicaid Eligibility IT System That Guides Eligibility Decision-Making. DMAS and DSS report that a single system that will determine Medicaid eligibility for all applications continues to be needed, a goal which the agencies have unsuccessfully pursued since 1995. Some Medicaid applications are processed in ADAPT, but others are processed manually. In particular, applications submitted by persons who may be eligible for Medicaid as Long-Term Care or Aged, Blind and Disabled recipients are processed by hand. This manual process introduces the risk of errors. In addition, the use of two separate IT systems also

results in Medicaid eligibility errors because all applications must also be manually entered into MMIS to complete the enrollment process.

DMAS and DSS also note that human errors could be reduced if an eligibility system were available to guide local department staff through the eligibility determination process and to automate some mathematical calculations and other transactions. As currently designed, ADAPT relies heavily on properly trained caseworkers to correctly determine how to apply complex Medicaid policies and enter the result of this determination into the correct system. This is because ADAPT does not automatically determine eligibility based on information entered into the system, nor does it guide decision-making by prompting the user to enter or consider information. Instead, caseworkers are required to manually make several important calculations and use their judgment when applying Medicaid policy. According to DMAS staff, other states have had automated, guided systems for almost 20 years.

Systems Improvements Currently Being Developed May Be Able to Address Eligibility Errors If They Are Successfully Implemented.

DMAS, DSS and the Department of Motor Vehicles (DMV) are developing new IT systems that will likely reduce eligibility errors, but their successful implementation depends upon several key factors that have hindered earlier systems development efforts. DMAS is developing a new eligibility system as part of a larger Medicaid Information Technology Architecture project that aims to harmonize and coordinate IT systems and data throughout the Secretariat of Health and Human Resources (HHR). This project is planned for implementation in two overlapping phases, beginning in 2011 and ending in 2016. The Phase I activities are designed to use the existing IT systems but to move toward their replacement by using a new customer website (or portal) under development by DSS that will automate some aspects of the application process. In addition, new data standards and data management policies will be introduced that are designed to assign certain State agencies the responsibility for maintaining key data that will be used by other agencies. A prominent example of these activities, which is already underway, is a DMV project that will create a single identifier for all Virginia residents. This will allow DSS to automate the process of verifying an applicant's identity at the time of application, by accessing Social Security Administration data, and not solely rely upon the individual to submit the correct documentation. In the second phase, a new eligibility system is planned that will automate routine, time-consuming activities and add case management capabilities for all Medicaid aid categories.

Although these efforts appear sufficient to address many of the errors noted by the PERM review, their successful implementation

depends upon the availability of State matching funds, the creation of a secretarial project management office that can guide these systems into the next administration, and the adoption of new data standards and management practices by State agencies. These efforts have not been attempted before, and represent a substantial shift from the existing practice wherein each agency maintains its own data and manages its own projects. Moreover, successful implementation requires the cooperation of agencies outside HHR that maintain key data, such as the Department of Taxation and the Virginia Employment Commission, and ongoing oversight by the Virginia Information Technologies Agency to ensure compliance with IT standards and the availability of needed IT hardware.

Increased Availability of Other Systems May Reduce Medicaid Recipient Eligibility Errors. Local department staff have also expressed concerns regarding the limited availability of two existing IT systems that could allow them to reduce eligibility errors and allow State staff to better assess the accuracy of local eligibility determinations. One commercial product, known as the Work Number system, allows local departments to verify the income of individuals during the application and redetermination processes, but its availability is limited. Currently, Work Number is the only system that reports up-to-date information on the income of Medicaid applicants and recipients. (A limitation is that the individual must work for an employer that submits payroll information to the Work Number vendor.) Although local departments can use other means of verifying income, such as data provided by the Virginia Employment Commission, these data are at least two quarters old by the time they are available to caseworkers. However, DSS has reduced the availability of the Work Number system because of increasing vendor charges. As a result, the system is only available for the first half of each month, or until that month's allotted number of income verifications are performed. Local staff indicate that some applicants are aware of the system's limited availability, and may apply toward the end of the month when the system is unavailable and their income is less likely to be verified. DSS staff report that the contract with the vendor currently costs the agency \$318,000 per year, and will increase to an annual cost of nearly \$400,000 over the next five years.

Local departments have also expressed an interest in expanding their use of a caseload tracking system that allows them to quickly identify and correct eligibility errors. The system, known as Rushmore, tracks the eligibility errors made by individual caseworkers, but State funding restrictions have limited its use to the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps). Because no comparable system exists for Medicaid, local departments can only calculate a locality error rate and thus

cannot identify the individual caseworkers who may need additional training or supervision. However, DMAS staff note that the system may not be needed because supervisors should already know which caseworkers are likely to commit errors and may need additional training. Yet the use of Rushmore would also benefit DSS and DMAS because it would allow these State agencies to have better insight into the errors that occur at local departments.

DSS staff report that it would cost \$130,000 to expand Rushmore to the Medicaid program, and \$15,000 per year afterward to operate it statewide. Although DSS staff believe the federal government will reimburse 50 percent of the cost of system implementation and operation as allowable administrative costs, DMAS staff report that additional research is needed to determine if matching funds could be used.

Recommendation (1). The Departments of Social Services (DSS) and Medical Assistance Services (DMAS) should identify and report the costs, benefits, and feasibility of expanding the Rushmore cases tracking system to the Medicaid program in order to allow local departments of social services to utilize its case management and oversight functions. DSS and DMAS should report to the House Appropriations and Senate Finance Committees before the start of the 2013 General Assembly Session on their conclusion. If the results indicate that Medicaid eligibility errors could be cost-effectively reduced, DSS or DMAS should request funding for the expansion of this system to the Medicaid program.

DSS and DMAS Should Also Develop Systems to Verify Financial and Real Property Assets Reported by Applicants. Local departments currently do not have access to automated IT systems that would allow caseworkers to verify the financial and real property assets reported by Medicaid applicants or recipients. Instead, caseworkers must rely on applicants and recipients' self-disclosed information, which may have significant bearing on their eligibility for Medicaid. This inability to verify information creates a gap in verification that likely results in the enrollment of ineligible individuals. In addition, these eligibility errors would not be detected through the current review processes, such as PERM, because the reviewers can only review information that is available in case files.

For example, local departments do not have a means of determining the number of bank accounts an individual has, or the amount of real property he or she own. Instead, the caseworker is wholly reliant upon the individual to fully and accurately disclose all financial accounts, and the subsequent cooperation of financial institutions. The Medicare Improvements for Patients and Providers Act will require Virginia to have a financial assets verification sys-

tem by 2013. DSS staff have stated that a financial assets verification system was piloted in three other states in 2008, but that no similar systems are being actively developed in Virginia. In addition, no system has been implemented by any state other than the pilot states, according to DMAS staff. At least one vendor has proposed financial and asset verification processes as components of a larger eligibility automation project proposal.

In addition, although local departments may have access to public real property records from some localities, they do not have access to information statewide. Currently, the Supreme Court of Virginia maintains a database of real property records for the majority of Virginia circuit court clerks. This database may allow for the automated verification of real property ownership in Virginia, an opportunity which should be explored by DSS.

Recommendation (2). The Department of Social Services (DSS) should develop and implement automated systems that allow caseworkers at local departments of social services to verify the financial and real property assets of Medicaid applicants, including records maintained by Virginia Circuit Courts. DSS should report to the House Appropriations and Senate Finance Committees before the start of the 2013 General Assembly Session on the cost and status of these systems.

Extent of Eligibility Errors Suggests Need for Ongoing Agency Efforts to Identify and Implement Program Improvements. The scale of eligibility error estimated by the PERM review suggests there should be an ongoing effort by DMAS, DSS, and local departments of social services to identify changes that could reduce eligibility errors. DMAS and DSS have collaborated through the Corrective Action Panel which is designed to implement a corrective action plan addressing PERM errors. In order to provide a more consistent means of considering ways to improve the accuracy of the Medicaid eligibility process, DMAS and DSS should continue to evaluate means to reduce Medicaid eligibility error rate. Additionally, the group should periodically report its findings to the General Assembly.

Recommendation (3). The Departments of Medical Assistance Services and Social Services should continue to evaluate means to reduce the Medicaid eligibility error rate, and annually report their findings to the Senate Finance and Rehabilitation and Social Services Committees, and the House Appropriations and Health, Welfare, and Institutions Committees.

DELAYS IN REDETERMINATIONS OF RECIPIENT ELIGIBILITY MAY RESULT IN IMPROPER PAYMENTS AND WASTED EFFORT

The eligibility redetermination process plays a role in minimizing improper payments because it is designed to ensure that only eligible recipients continue to receive Medicaid benefits. Continuing eligibility is established by re-verifying certain information that is likely to change over time (recipients' residency, household composition, and income and resources), using the same processes as for determining initial Medicaid eligibility.

However, local departments do not consistently redetermine the eligibility of Medicaid recipients every 12 months as required by federal law. Despite the importance of redetermining eligibility in a timely manner so as to avoid making improper payments on behalf of ineligible recipients, local departments are not penalized if delays occur. This accountability structure is different from that used with the SNAP program, for which errors result in federal sanctions for the social services system. Instead, only DMAS incurs the higher costs associated with any improper payments resulting from the continued enrollment of ineligible individuals. Also, unlike SNAP and other benefit programs, DSS lacks the authority under federal regulations to automatically terminate Medicaid benefits if a redetermination is overdue. Instead, DSS cannot take any action until the redetermination process has been initiated by a local department and the recipient has been found to be ineligible. Because local department decisions can cause delays in the redetermination process, the use of a partially automated administrative redetermination process may be needed to ensure redeterminations are completed in a timely manner.

Overdue Redeterminations May Have Resulted in Improper Medicaid Payments of \$5.2 Million in FY 2009

Staff at some local departments of social services interviewed by JLARC staff indicate that they have responded to an overall increase in applications for the benefit programs they administer by prioritizing the initial determination of eligibility over other activities. As a result, the annual redetermination of Medicaid eligibility is often delayed. This approach appears to reflect a desire to err on the side of ensuring that new applicants have access to all benefits for which they are eligible. However, as with other aspects of the Medicaid program discussed in this chapter, the decision by local departments to not comply with Medicaid policy cannot be effectively addressed by DSS.

Overdue Medicaid eligibility redeterminations pose a financial risk because they may result in expenditures for ineligible individuals who would have been disenrolled if redetermination had occurred in compliance with Medicaid policy. According to a JLARC staff

analysis of DSS and DMAS data, overdue redeterminations may have resulted in improper Medicaid payments of at least \$5.2 million during FY 2009. As defined by the Improper Payments Information Act of 2002, an improper payment is “any payment that should not have been made or that was made in an incorrect amount,” including “any payment to an ineligible recipient.”

JLARC staff calculated this estimate by determining the percentage of overdue redeterminations that would likely result in a cancellation of eligibility. This figure was multiplied by average annual Medicaid expenditures to determine the improper payment amount. This estimate likely represents a minimum amount because it only reflects recipients in the Families and Children aid category, which have, on average, the lowest annual Medicaid expenditures compared to other aid categories. This category was used because DSS and DMAS lack data for the Long-Term Care and Aged, Blind and Disabled aid categories that indicate the reason why recipients were disenrolled. If data were available that indicated the percentage of cancellations that resulted from the redetermination process, then the estimated costs of overdue renewals would likely increase because these recipients tend to incur higher medical expenses. A more detailed discussion of the methodology used to estimate the improper payments associated with overdue redeterminations can be found in Appendix B.

Inefficiencies in the Redetermination Process Also Appear to Lead to Wasted Effort

A JLARC staff analysis shows that recipients are most frequently disenrolled from Medicaid because they failed to return their redetermination forms on time. However, many individuals who are disenrolled subsequently re-enroll in Medicaid, and may have been eligible all along, according to DSS representatives. A JLARC staff analysis of data on individuals who were disenrolled in FY 2009 and FY 2010 for failing to complete paperwork on time indicates that 34 to 40 percent of these recipients, respectively, were re-enrolled in Medicaid by the start of FY 2011.

The fact that a large proportion of disenrolled recipients are ultimately re-enrolled suggests that waste exists in the redetermination process. When recipients disenroll and subsequently re-enroll, caseworkers must cancel the individual’s eligibility and then subsequently process a new Medicaid application. This represents a waste of time and effort because the amount of information that must be verified on an initial application is more extensive than the verifications required for a redetermination. In contrast, a new application entails the verification of all information, which can result in processing delays and reduces the time a caseworker has to ensure other applications are processed correctly.

Administrative Redetermination Process Could Increase Efficiency by Reducing Overdue Redeterminations

DSS and local department staff interviewed by JLARC staff have indicated that the implementation of an administrative redetermination process for Medicaid may improve both the timeliness and efficiency with which local departments complete Medicaid redeterminations. A similar process is used by DSS for SNAP and by DMAS for the Family Access to Medical Insurance Security program. Currently, recipients are required to fill out all financial and non-financial information before returning the redetermination form, even if no changes have occurred. DSS and local department staff suggested that recipients may not return the form because it is hard to understand. In addition, recipients may not realize that failure to return the form will result in the cancellation of Medicaid.

Instead of relying upon recipients to manually complete a form, the use of a pre-filled redetermination form could reduce waste in the redetermination process by addressing the concern that some recipients cannot understand the form. A recipient who has no changes to report would simply check the box indicating no changes occurred, sign the form to attest to its validity, and return it to the appropriate local department. A recipient who has changes to report would correct the form before returning it. While local departments would be required to verify the information on the form as they presently do with the manually completed forms, DSS staff have stated that there may be risks associated with implementation of administrative redeterminations.

DSS staff interviewed by JLARC staff stated that an administrative redetermination process would also reduce the workload of local eligibility staff because many clerical functions associated with eligibility redeterminations would be centralized and thereby increase the time available to caseworkers. It also appears that this process would allow DSS to ensure that all redeterminations have been initiated in a timely manner.

DSS staff indicated that they are preparing to implement an administrative redetermination process in the spring of 2012, and will allow some Medicaid recipients to complete the redetermination process by telephone on October 1, 2011. However, the new process will be limited to individuals in the Families and Children aid category because the financial assets of recipients in other aid categories must be verified during the redetermination process and DMAS and DSS lack an IT system that can be used for this purpose.

IMPROPER USE OF MEDICAID BY RECIPIENTS COULD BE REDUCED BY IMPROVING INTERAGENCY COORDINATION

In addition to recipient eligibility errors, another potential source of improper payments is the improper utilization (abuse or misuse) of medical services by recipients. Improper utilization is defined as the use of medical services in contravention of Medicaid policy or generally accepted medical necessity. This could include individuals who over-use services as well as people who under-use services by failing to seek preventative care, thereby resulting in higher costs at a later date. In the context of service provision, improper use is distinct from fraud, which represents an effort to seek payment for services that were not rendered. Improper use is also distinct from error, which usually denotes situations where services were properly provided but the provider inadvertently sought a payment that exceeded allowable limits.

DMAS Recipient Monitoring Unit Identifies Improper Utilization of Medical Services by Fee-for-Service Recipients

Following federal and State regulations, DMAS's Recipient Monitoring Unit (a component of the Program Integrity Division) monitors Medicaid recipients by conducting statistical analyses and responding to referrals submitted by providers and other DMAS units. Only the usage of certain services within the fee-for service program is monitored, because managed care organizations (MCOs) are responsible for monitoring their enrollees (as discussed below), and DMAS's Long-Term Care Division is responsible for monitoring long-term care recipients.

If any recipient is found to use an unusually high or low amount of medical services, based on the unit's further review, or if a recipient's usage violates specific criteria outlined in the *Virginia Administrative Code*, then DMAS closely manages that recipient's future use of services. Examples of improper utilization as defined in State regulations include excessive use of emergency room services or a pattern of visiting multiple physicians in a short period of time in order to receive identical medical services (i.e., doctor shopping). The following case study provides an example of outlier analysis involving the overuse of emergency room services.

Case Study

One type of outlier analysis creates profiles of fee-for-service recipients between 21 and 29 years of age who use emergency room services. State regulations require DMAS to review all recipients who visit the emergency room more than three times in three months. Between October and December of 2010, one individual visited the emergency room 12 times and was therefore subject to a full review.

DMAS Uses Federally-Required Lock-In Program to Manage Care Provided to Recipients Who Improperly Utilize Services

When the Recipient Monitoring Unit finds that a recipient's service utilization violates Medicaid policy, the individual is enrolled in the Client Medical Management (or "lock-in") program for at least 36 months to mitigate the risk of further misuse or abuse. Recipients in the lock-in program must designate a single primary care physician and pharmacy from which they will receive all medical services and prescriptions for the duration of their enrollment in the lock-in program. The usage patterns of enrolled recipients are then reviewed every six months to monitor compliance with Medicaid rules. Between FY 2008 and FY 2010, more than 500 Medicaid recipients were enrolled in the DMAS lock-in program at any given time. (This represented less than one percent of total enrollment in the fee-for service program.)

Lack of Coordination Between Fee-for-Service and MCO Lock-In Programs Could Hinder Recipient Utilization Management

Unlike the DMAS lock-in program, which began in 1983, the lock-in programs administered by the Medicaid MCOs first began in 2010. In part because the MCO programs are new, no steps have yet been taken to coordinate the MCO programs with each other or with the fee-for-service lock-in program. But coordination needs to occur in order to allow DMAS to address two factors that appear to diminish the overall effectiveness of the lock-in program.

First, DMAS and MCOs use different programmatic standards, including standards that define which services will be reviewed for improper utilization. These differences may result in a recipient's enrollment in one MCO's lock-in program for utilization patterns that would not result in enrollment in another MCO's program. For example, three of the five MCO lock-in programs focus only on abuse of prescription drugs and pharmacy services. This is far narrower than the scope of services reviewed by DMAS, which reviews the utilization levels of all medical services by Fee-for-Service recipients.

Second, recipients are not automatically re-enrolled in a lock-in program if they switch from their current Medicaid managed care plan during open enrollment periods. As a result, recipients that have a choice of managed care plans may be able to disenroll from a lock-in program by switching from one MCO to another, or by switching from managed care to fee-for-service. This lack of coordination may increase the risk of improper payments resulting from recipients improperly utilizing medical services.

Recommendation (4). The Department of Medical Assistance Services should develop process and policy changes to increase coordination between the department's Client Medical Management program and the recipient utilization monitoring programs administered by the Medicaid managed care organizations. Policy changes should focus on (1) increasing consistency of standards used to define appropriate levels of service utilization, and (2) ensuring recipients' utilization of medical services is subject to continued oversight when switching from the fee-for-service to managed care program or from one managed care organization to another.

GREATER INTERAGENCY COORDINATION APPEARS NEEDED TO MINIMIZE RECIPIENT ERROR AND FRAUD

As discussed in the JLARC interim report, although DMAS and local departments of social services share responsibility for addressing Medicaid recipient fraud and error, the degree of coordination and division of responsibilities between the agencies may not be optimal. In FY 2010, State and local agencies identified \$4.1 million in improper payments made on behalf of recipients, including \$3.0 million in error and \$1.1 million in fraud. Despite these successes, representatives of State and local agencies interviewed by JLARC staff indicated that responsibilities are fragmented and may not be assigned to the most appropriate party. State and local staff also indicated that variation in communication and coordination between DMAS and local departments of social services is hindering efforts to investigate and prosecute recipient fraud. Improved coordination, as well as changes in responsibilities for addressing fraud committed by recipients, may be needed.

Responsibility for Investigating Recipient-Related Error and Prosecuting Fraud Is Fragmented

DMAS and DSS share responsibility for investigating errors made by Medicaid recipients and forwarding cases of suspected fraud to Commonwealth's Attorneys for prosecution. Within DMAS, this responsibility is assigned to the Recipient Audit Unit, which is a component of the Program Integrity Division. If recipients err during the enrollment process by not disclosing all required information, they can be required to repay the funds expended for their care. In addition, a conviction of Medicaid fraud can also result in disqualification from the program for up to one year.

The responsibilities and processes related to investigating and prosecuting fraud committed by Medicaid recipients are fragmented, owing to the diversity of statutory, regulatory, and programmatic authorities. The result of this fragmentation is a system that does not appear to sufficiently mitigate Medicaid fraud and error. In particular, coordination is hindered by the lack of a direct relationship between DMAS and the local departments. Statute explic-

itly requires DSS to administer a statewide fraud program for all of the benefit programs it administers, including Medicaid. As a result, the fraud prevention programs at local departments are not overseen by DMAS, which must instead rely upon the efficacy of interagency agreements to coordinate recipient-related program integrity activities with DSS and local departments.

Investigatory Process May Be Improved and Streamlined by Increasing Communication and Reconsidering Each Agency's Fraud Responsibilities

Interviews with staff at local departments and DSS suggest that fraud investigations are not always conducted by the most appropriate agency. In addition, the working relationship between agencies may not be consistently satisfactory. A re-evaluation of recipient fraud responsibilities and improvements in the coordination of recipient fraud-related activities may increase the number of cases of identified Medicaid fraud.

DSS and Local Departments Contend That Some Recipient Fraud Investigations Are Better Handled Locally. The existing assignment of investigatory responsibilities results in investigations of Medicaid recipients by both DMAS and local departments. The interagency agreement assigns DMAS responsibility for investigating all cases of error and fraud that only involve Medicaid, but overlap exists regarding fraud investigations that involve Medicaid and another benefit program. Accordingly, DMAS investigates any case of Medicaid fraud where the recipient only received Medicaid. In addition, DMAS investigates the Medicaid portion of any case where the recipient also received SNAP benefits, and the local department investigates the SNAP portion of the cases. Local departments also investigate the Medicaid portion of any case that involves other programs, including Temporary Assistance to Needy Families (TANF) and Child Care.

Local fraud investigators interviewed by JLARC staff indicated that in some instances, the Medicaid portion of a SNAP investigation may be more effectively handled by local departments instead of DMAS. According to local fraud investigators, fraud committed against Medicaid and SNAP typically involves the same policy violations. In such cases, the current policy of requiring DMAS to investigate the Medicaid portion of the case while local departments focus on the SNAP portion represents a duplication of efforts. Local department staff also indicated that certain types of fraudulent activities, such as the presence of an unreported adult who contributes to the household's income, are more easily established by local staff because these cases often require at-home surveillance. According to DMAS staff, this kind of investigation cannot be performed by its staff, many of whom are located in Richmond, due to

a lack of resources. In its formal responses to this report, DSS expressed support for reconsidering fraud responsibilities, while DMAS does not agree that a realignment of Medicaid fraud investigation responsibilities is appropriate.

Recommendation (5). The Departments of Medical Assistance Services (DMAS) and Social Services should reconsider the nature and scope of responsibilities for the investigation of recipient fraud and error in public assistance programs assigned to DMAS and local departments of social services, and determine whether a realignment of responsibilities would more effectively promote the investigation of Medicaid recipient fraud and error.

Local Fraud Investigators Vary in Their Assessment of Working Relationship With DMAS. Representatives of local departments interviewed by JLARC staff varied greatly in their description of the working relationship they maintain with the Recipient Audit Unit at DMAS, but most expressed a desire for more formal avenues of communication. Local staff also stated that improvements to procedures would be beneficial, such as the establishment of standard timelines for the Recipient Audit Unit's response to referrals from local departments, and additional training on the nature and extent of information that should be contained in a referral. Currently, neither statute nor the DMAS-DSS interagency agreement provide guidance to the Recipient Audit Unit or local departments regarding the timeliness of communication, or the necessary components of case referrals. However, DMAS staff report the Recipient Audit Unit has implemented procedures to automatically notify local departments that a fraud referral has been received. DMAS staff also assert that the information presently available to local department staff about the required components and processing of referrals is sufficient.

USE OF ADMINISTRATIVE DISQUALIFICATION HEARINGS MAY REDUCE BARRIERS TO PROSECUTION OF RECIPIENT FRAUD

Many cases of potential Medicaid recipient fraud do not appear to be prosecuted because of two primary barriers. Although all cases are evaluated to determine if they merit prosecution, it appears to be difficult for fraud investigators to clearly establish the element of intent needed to support a fraud prosecution. In addition, Commonwealth's Attorneys vary in their willingness to accept a referral for prosecution. Currently, cases that are not accepted for prosecution are handled as errors in which restitution is sought but the recipient is not disqualified from receiving Medicaid. Implementation of an administrative disqualification hearing process may increase the ability of DMAS and local departments of social services to bar recipients from receiving Medicaid services in those cases where intent cannot be established "beyond a reasonable doubt" or

where Commonwealth's Attorney decline to accept the referral. This process would also result in a standard statewide process for addressing recipient fraud.

Difficulty Establishing Intent Beyond a Reasonable Doubt Limits Prosecution of Recipient Fraud

As part of the investigatory process established in its *Operating Procedures Manual*, Recipient Audit Unit investigators must evaluate each case, whether it results from a referral or detection by DMAS staff, to determine if it warrants referral to a Commonwealth's Attorney for prosecution as fraud. All cases that are not referred, or which are not accepted by the Commonwealth's Attorney, are treated as errors.

This determination is documented through the use of a form (the Criminal Prosecution Evaluation Worksheet) which must be completed for every case. This internal control records the reasons why a given investigator decided to treat a case as error instead of fraud. JLARC staff reviewed a statistically significant sample of worksheets (170) from the 1,705 Recipient Audit Unit case files for which an investigation was initiated in FY 2009. Of the 170 files reviewed, only two investigations were referred to a Commonwealth's Attorney for criminal prosecution. Most commonly, cases were not forwarded because (1) agency policy stipulated that the case be treated as an instance of recipient error (35 percent), (2) investigators had difficulty establishing intent to defraud Medicaid (29 percent), (3) the amounts in question were too low to merit prosecution (eight percent), and (4) the case involved agency errors and therefore could not be prosecuted (six percent).

Establishing Intent Is Difficult Even When a Violation of Medicaid Policy Is Clear. In order for a recipient to be convicted of fraud, investigators must establish that the individual intended to defraud the Medicaid program "beyond a reasonable doubt." DMAS and local department staff have offered two reasons why it is particularly difficult to reach this threshold of intent. First, if a recipient states that they did not understand program rules regarding reporting and disclosure of information, it is difficult to prove that they actually intended to violate those rules. Second, the complexity of Medicaid's eligibility and reporting rules makes it difficult for prosecutors to convince a jury that an intentional violation has occurred. One local investigator indicated that if a jury is unable to understand the Medicaid rule violated by the recipient, it is unlikely that the jury would then be willing to find that recipient guilty of fraud.

Case files reviewed by JLARC staff supported the assertion that cases are frequently not referred for prosecution because of the dif-

difficulty involved in establishing intent. Specifically, the worksheet lists two factors pertaining to the lack of evidence needed to clearly establish intent. Combined, these two factors were cited in 49 of the 170 case files reviewed (29 percent) as reasons for not pursuing criminal prosecution. The difficulty establishing intent is illustrated by the case example below, which shows that even when a recipient has clearly violated Medicaid policy, DMAS cannot necessarily refer the case for criminal prosecution.

Case Study

In October of 2008, a local department of social services forwarded a case to DMAS for investigation of excess resources. Upon review, DMAS determined that the recipient failed to report the sale of his home for nearly \$400,000, and was therefore retroactively ineligible for Medicaid for two and one-half years due to excess resources. The recipient's failure to report the sale of his home resulted in overpayments of approximately \$78,000 during the period of ineligibility. The DMAS investigator determined, through file reviews and interviews, that failure to report the home sale was a case of recipient error, and that the evidence indicated a lack of client understanding but did not support a charge of intent to defraud Medicaid. The case was subsequently handled through the administrative recovery process. Collections were initiated in February of 2009, and the balance was repaid by April 2009.

The outcomes of cases forwarded to and accepted for prosecution by Commonwealth's Attorneys also appear to indicate that it is difficult to establish intent. DMAS data show that between FY 2006 and FY 2010, of the 219 cases accepted for prosecution by Commonwealth's Attorneys, 126 (58 percent) resulted in conviction.

DMAS Policy Precludes Prosecution for Several Types of Recipient and Agency Errors. The most common reason for which potential fraud cases are not referred for prosecution is DMAS policy, which states that some cases must be treated as errors and not investigated for potential fraud. For example, cases involving a Medicaid recipient enrolled in multiple states are treated as errors for which an administrative recovery of funds is sought. This type of error comprised 26 of the 170 cases reviewed by JLARC staff. DSS and DMAS staff have stated it is infeasible to prosecute an individual who lives in another state. Most of the time, it appears that no actual fraud has occurred because the recipient either failed to notify both states that they had moved, or one state failed to disenroll the individual. In either scenario, if no improper payment occurred because of the dual enrollment, then there is no basis for an investigation.

Third Party Liability

Cases in which an insurance company other than Medicaid is responsible for covering Medicaid services.

Estate Recovery

Cases involving a deceased recipient only collect from the individual's estate.

Patient Pay Underpayment

Can occur as a result of agency error and may not involve recipient fraud.

Additionally, it is DMAS policy to treat all cases of third-party liability, estate recoveries, and patient pay underpayment as errors and to seek an administrative recovery of any improper payments. These findings occurred in 33 of the 170 case files reviewed (approximately 19 percent). Additionally, 10 of the cases reviewed were instances of agency error, for which the recipient was not liable for repayment.

In some cases, an apparent return-on-investment analysis was used to determine whether prosecution was warranted. In 14 of 170 cases (approximately eight percent), the case was not forwarded for prosecution because the investigator determined that prosecution was not cost-effective. Until recently, it was agency policy to treat all cases in which the potential improper payment was less than \$3,000 as an error and to seek an administrative recovery. Exceptions were made for cases of blatant fraud or where an infraction was committed by a repeat offender. This policy appears to have been the result of the reluctance by Commonwealth's Attorneys to accept cases that involve small improper payments, which is discussed in more detail in the following section.

Autonomy of Commonwealth's Attorneys Also Appears to Limit Prosecution of Medicaid Recipient Fraud

Although the Recipient Audit Unit has not established agreements with Commonwealth's Attorneys regarding the requirements a case must meet to warrant prosecution, local departments of social services are required to enter into such agreements as a condition of receiving State fraud control funding. Analysis of local fraud program plans shows that most agreements are informal, while a few take the form of more formal memoranda of understanding.

The plurality of agreements (36 of 104) reviewed by JLARC staff had no clear monetary threshold for accepting referrals, but rather indicated that referrals were considered on a case-by-case basis. However, many local departments stated that in practice Commonwealth's Attorneys use a monetary threshold to determine whether a case merits prosecution: the minimum thresholds range from a low of \$200 (seen in several localities) to a high of \$3,000. The variation in thresholds suggests that the definition of Medicaid recipient fraud effectively differs from one locality to another.

Despite some use of formal agreements and thresholds, staff at local departments, DSS, and the Recipient Audit Unit all stated that Commonwealth's Attorneys retain the authority to reject a referral, even if the conditions of the referral agreement have been met. Between FY 2006 and FY 2010, Commonwealth's Attorneys did not accept 48 (18 percent) of the 267 cases forwarded for prosecu-

tion by DMAS, based on JLARC staff analysis. Similar data for local department referrals are not tracked.

DSS and Local Departments Believe an Administrative Process May Reduce Barriers to Prosecution of Recipient Fraud

DMAS, DSS, and local departments of social services indicate that the creation of an administrative disqualification hearing (ADH) process for Medicaid may increase the State's ability to disqualify individuals from Medicaid who have committed fraud but who would otherwise not be prosecuted. An ADH process is already in use for SNAP and TANF, and if a similar Medicaid ADH process was adopted, it could provide a means of addressing cases that are not accepted by Commonwealth's Attorneys.

Presently, cases of suspected SNAP or TANF fraud that are not eligible for referral to a Commonwealth's Attorney because of criteria in the local department's agreement are addressed through the ADH process. Likewise, a Medicaid ADH process would provide an alternative for prosecuting cases where the local department or DMAS suspects fraud occurred but which are not accepted by a Commonwealth's Attorney. Within the SNAP and TANF process, the ADH hearing is conducted by a DSS hearing officer, who is responsible for determining whether the individual has committed fraud based upon the evidence submitted by the local department and individual. A Medicaid ADH process could operate in a similar manner.

Because it is an administrative process, the burden of proof is lower. Fraud prosecutions must establish intent beyond a reasonable doubt because conviction results in a criminal record in addition to disqualification from Medicaid. In contrast, an ADH process would use a lower standard of evidence ("clear and convincing") which reduces the burden of establishing whether a program violation was intentional. If the evidence indicates that intent exists, the recipient could be disqualified from receiving benefits for a period specified by program policy (typically, one year). As with SNAP and TANF cases, an individual would have the right to appeal an ADH decision by seeking a ruling in circuit court.

Although federal statute requires that DSS administer an ADH process for SNAP, DSS has proactively implemented similar processes for TANF and Child Care using the SNAP process as a model. Currently, DSS representatives interviewed by JLARC staff indicate that no federal laws or regulations appear to prohibit the creation of a Medicaid ADH process, although it does not appear that other states have adopted similar processes for their Medicaid programs. DMAS staff note, however, that additional research would be needed to determine if an ADH process is permit-

ted by federal laws and regulations, and that additional financial resources may be required to implement the process. A Medicaid ADH process would also establish a consistent, statewide standard for “prosecution” of recipient fraud cases, and would not rely upon the willingness of Commonwealth’s Attorneys to accept a case for prosecution.

Recommendation (6). The Departments of Medical Assistance Services (DMAS) and Social Services (DSS) should evaluate whether the implementation of an administrative disqualification hearing process would increase the State’s ability to disqualify individuals from Medicaid who have committed fraud but who would otherwise not be prosecuted. This evaluation should include an assessment of the potential financial resources needed to implement this process, and a determination regarding whether this process is permitted by federal and State laws and regulations. If the results indicate that additional individuals could be cost-effectively disqualified, DSS or DMAS should request funding for use of the administrative disqualification hearing process in the Medicaid program.

Improvements Needed to Further Improve and Sustain DMAS' Strong Performance of Provider Review Activities

In Summary

While Medicaid provider review activities successfully prevented and detected most improper payments based on a 2009 federal review, several improvements should be made to further minimize the risk of improper payments created by provider claims payments and to help maintain a consistent level of high performance. Information obtained during enrollment could be better used to identify providers that may present a risk of future improper payments and, in turn, subject their claims to closer review. Based on a review of effective practices used by managed care organizations, DMAS should also add pre-payment audits to its preventative tools. Although a federal review of claims paid by DMAS indicates nearly all improper payments are identified, shortcomings in the plans and other documentation used in the post-claims audit process could undermine DMAS's ability to sustain this successful performance in an efficient manner. A prominent shortcoming is the lack of an apparent relationship between the risk scores assigned to each type of provider and the number of audits conducted by agency staff and their contractors. Furthermore, there is inadequate documentation to substantiate why planned audits are not consistently conducted. In addition, DMAS should improve its process for evaluating the outcomes of audits to ensure resources are effectively and efficiently used and all cases of suspected provider fraud are referred to the Medicaid Fraud Control Unit.

In FY 2009, the Department of Medical Assistance Services (DMAS) processed approximately 28 million reimbursement claims for medical services, submitted by more than 30,000 providers, at a total cost of about \$3.6 billion. In order to minimize the risk of making improper payments to providers, DMAS screens providers to ensure they are eligible to enroll in Medicaid and also audits claims after providers have been paid in order to increase the total amount of improper payments detected. While the department has experienced successes with both program integrity activities, especially as measured by a federal review, several improvements could be made to further reduce the risk of improper payments and ensure that its strong performance can be sustained. Greater coordination and sharing of information between provider enrollment and program integrity functions should help DMAS better target its efforts toward providers that present more risk. In addition, creating a single, comprehensive audit plan for all provider audit activities could help ensure that all sources of improper payment risk are addressed. Moreover, additional analysis of audit outcomes could help DMAS allocate resources more efficiently and more clearly ascertain whether existing audit activities cost-effectively minimize the risk of improper payments.

Payment Error Rate Measurement Review

The Centers for Medicare and Medicaid Services conducts Payment Error Rate Measurement (PERM) reviews of state Medicaid programs on a rotating three-year cycle. The most recent review of Virginia's Medicaid program was conducted in federal FY 2009 (October 2008 through September 2009), and the next review is scheduled to occur in federal FY 2012.

FEDERAL REVIEW INDICATES LESS THAN ONE PERCENT OF PAID CLAIMS CONTAIN ERRORS

A review conducted by the federal government indicates that only 0.7 percent of paid Medicaid claims contain errors. As discussed in Chapter 2, the Centers for Medicare and Medicaid Services (CMS) conducts Payment Error Rate Measurement (PERM) reviews in each state. The goal of these reviews is to determine the nature and scope of errors.

PERM Review Indicates More Than 99 Percent of Claims Paid to Fee-for-Service Providers Are Processed Correctly

CMS reviewed a sample of fee-for-service claims paid by DMAS during federal fiscal year (FFY) 2009 to determine if any were paid in error. Each claim in the sample was examined to determine if it was accurately processed and paid based on the information provided as part of the claim. Based on this examination, PERM estimated that DMAS paid only 0.7 percent of all fee-for-service Medicaid claims in error, which the federal government estimated had a potential cost of \$32 million. Virginia's error rate was well below the national error rate of 1.9 percent. Virginia's low error rate reflects the performance of all program integrity activities that took place before claims were paid, including prepayment review and system edits, and indicates that these activities are more effective than those in many other states.

PERM Review Indicates 99 Percent of Capitation Payments to MCOs Are Processed Correctly

The federal PERM review also indicates that DMAS made very few errors when processing capitation payments to MCOs. As indicated in Chapter 1, MCOs receive a monthly capitation payment for each person enrolled in their plan. The processing of these payments was reviewed for potential errors such as payment for an ineligible recipient or duplicate payments. Only one error was identified, resulting in an error rate of 0.01 percent, well below the national error rate of 0.13 percent for capitation payments.

It should be noted that accuracy in the processing of capitated payments is not related to the adequacy of the process used to set accurate capitated rates. The PERM review did not assess the accuracy of the data used to set rates or the adequacy of the rate-setting process itself.

DMAS SHOULD USE INFORMATION OBTAINED DURING ENROLLMENT TO IDENTIFY POTENTIALLY HIGH-RISK PROVIDERS WHO MAY SUBMIT IMPROPER CLAIMS

While the provider enrollment process offers DMAS its first opportunity to scrutinize providers, the process has not been fully uti-

lized to identify providers who may pose a financial risk. DMAS's Program Operations Division is responsible for enrolling roughly 13,000 new fee-for-service providers each year. These providers can be individual physicians, nurses, and licensed social workers, facilities such as hospitals, clinics, and nursing homes, or suppliers of medical equipment. The risk of improper payments to these providers can be mitigated by using all available information to ensure providers that do not meet program requirements are kept out of the program. In addition, information obtained from enrollment screenings, such as site visits or criminal background checks, can be used to identify high-risk providers for further scrutiny. To date, few providers have been excluded from the fee-for-service program and screenings have not been used to identify high-risk providers. Additional coordination among DMAS divisions could increase the utility of information obtained during the enrollment process.

DMAS Program Operations Enrolls Fee-for-Service Providers While Managed Care Organizations Enroll Their Providers

To participate in the Medicaid fee-for-service program, an individual provider or a group of providers enrolling as an organization must submit a complete application and several federally required disclosures, such as the names of any individuals with five percent ownership in the organization (when applicable). If providers submit a complete application, have all required licenses, have not been convicted of a felony, and have not been barred by the federal government from participating in Medicaid, they are generally enrolled by DMAS as a provider to serve recipients in the fee-for-service program.

List of Excluded Individuals/Entities (LEIE)

The LEIE is a database maintained by the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG) that lists all providers banned from Medicare and Medicaid by the OIG. CMS will not reimburse DMAS for Medicaid services delivered by providers listed in the LEIE. As of 2010, 1,080 providers in Virginia were listed on the LEIE. Most of the exclusions resulted from license suspension or revocation or convictions for crimes related to Medicare or Medicaid.

The provider enrollment unit within DMAS's Program Operations Division is responsible for enrolling providers, and uses a contractor to conduct many enrollment activities. The contractor reviews applications and performs checks to ensure that providers meet program requirements, including verifying that they hold a valid license. The contractor also reviews the U.S. Office of Inspector General's List of Excluded Individuals and Entities (LEIE) to determine whether the provider and individuals disclosed as owners or managing employees have been barred from participating in Medicaid (managing employees include general managers, business managers, administrators, or directors). Once providers are enrolled, DMAS does not require them to re-enroll, but the contractor performs ongoing licensure and LEIE checks of all enrolled providers (although managing employees and disclosed individuals who own more than five percent of the organization are only screened during the initial enrollment).

In contrast, the Program Operations Division does not have a role in overseeing enrollment of providers into managed care networks. Instead, managed care organizations (MCO) are responsible for enrolling their providers, including verifying their licensure and ensuring that providers do not appear on the LEIE. In addition to these verifications, MCOs use a credentialing process, guided by National Committee for Quality Assurance (a non-profit organization which accredits and certifies a wide range of health care organizations) standards, that is more extensive than the process used to enroll providers into the fee-for-service program. As of June 2010, the combined provider network enrollment of the five MCOs was over 60,000.

Few Providers Are Excluded From Participating in Medicaid Fee-for-Service

The Program Operations Division could mitigate the risk of improper payments by conducting additional screenings, before and after enrollment, to identify providers that may potentially pose a financial risk and by excluding those providers. However, DMAS has not used all available screening methods and has excluded and terminated few providers from the fee-for-service program, primarily due to a lack of statutory authority and limited resources. Moreover, while provider enrollment staff acknowledged that all divisions play a role in ensuring program integrity, their primary focus has been to minimize the health and safety risks to recipients.

DMAS staff report that because most providers meet program requirements, few are either turned away or removed from the fee-for-service network. Since FY 2006, 75 providers have been terminated due to sanctions or program violations, such as license revocation, felony convictions, or inclusion on the LEIE; another 41 were terminated due to expired licenses or accreditation. DMAS staff suggest that low numbers of provider terminations may reflect an effective front-end process of excluding providers that do not meet program requirements. Nonetheless, three MCOs, which reportedly have more stringent front-end credentialing processes, terminated 25 enrolled providers for suspended licenses in just one fiscal year (FY 2010).

DMAS staff indicate that the principal reason they exclude few providers is their limited statutory authority. Statute authorizes DMAS to exclude providers that have been convicted of a felony or banned from Medicaid, as indicated by their inclusion on the LEIE. DMAS staff noted that they have tried to exclude providers that have been determined to pose a risk to the health, safety, or welfare of recipients, but those decisions typically have not withstood provider appeals. Moreover, DMAS staff report that staff in

Other States Use Additional Provider Enrollment Screenings

A 2004 report by the U.S. Government Accountability Office (GAO) found that states often target their program integrity procedures to those provider types that pose the greatest financial risk to their Medicaid programs. The review found that 33 states used one or more of the following enrollment measures for high-risk provider types: on-site inspections of the applicant's facility prior to enrollment, criminal background checks, and time limited enrollment.

the Office of the Attorney General have verbally offered their opinion that DMAS must promulgate regulations stipulating the specific reasons why a provider should be denied enrollment in order to demonstrate that a denial is not arbitrary. The difficulty of outlining each specific circumstance that could warrant exclusion has prevented DMAS from promulgating those regulations.

A shortage of resources has also reportedly limited DMAS's use of available screening tools to exclude providers. For instance, DMAS has not conducted criminal background checks to identify providers with felony convictions in large part because the agency lacks the funding needed to reimburse the Virginia State Police for performing these checks. Instead, DMAS relies on providers to self-disclose felony convictions on their applications. As a result, DMAS cannot ensure that all providers that have felony convictions are kept out of the program. According to a 2004 report by the U. S. Government Accountability Office (GAO), at that time 13 states used criminal background checks to screen provider types considered high risk for inappropriate billing. DMAS estimated that conducting criminal background checks for all enrolled Medicaid providers in FY 2012 would cost an estimated \$2.5 million.

Provider Enrollment Could Play a Greater Role in Prevention of Improper Payments

While the provider enrollment process offers DMAS an opportunity to identify providers that could potentially commit fraud, DMAS has not historically used this information to improve audit activities. Although its ability to exclude high-risk providers from the program may be limited, DMAS could use the information obtained during the enrollment process to subject those providers to intensified claims review or auditing, or targeted provider education. According to the GAO, the majority of states reported using one or more of these approaches for high-risk providers in 2004. As health care reform is implemented under current law, the magnitude of required enrollment activities will increase substantially and DMAS will need to identify ways to effectively utilize the information collected.

New Site Visit Program May Help DMAS Identify Potentially High-Risk Providers. Since the publication of the 2010 JLARC report *Interim Report: Fraud and Error in Virginia's Medicaid Program*, the provider enrollment unit has begun to expand its role in program integrity. Staff have conducted nine unannounced site visits as part of a pilot meant to assess the effectiveness of using random site visits as a means of identifying high-risk providers. Problems uncovered during the site visits could be referred to the Program Integrity Division (PID) to initiate an investigation. While DMAS staff indicated that they had some concerns about one provider

they visited, they did not ultimately refer any of the providers to PID. Staff also indicated that the pilot program has helped them prepare to implement provisions of health care reform.

Health Care Reform Increases the Amount of Information Obtained During Provider Enrollment. The federal regulations promulgated in March 2011 pursuant to health care reform greatly expand the scope of required activities related to enrolling providers in Medicaid. For instance:

- All providers have to re-enroll in the Medicaid program every five years.
- All managing employees and owners must be screened against the LEIE every month (rather than only during initial enrollment).
- DMAS has to conduct additional licensure and database checks for all provider types, as well as site visits, criminal background checks and fingerprinting for provider types deemed by either the Centers for Medicare and Medicaid Services (CMS) or DMAS as posing a moderate or high risk to Medicaid. (CMS has designated the risk level for provider types that participate in Medicare and DMAS will be responsible for assigning a risk level to all other provider types) These additional responsibilities are shown in Table 2.

According to DMAS staff, Virginia and other states are awaiting additional guidance from CMS before implementing the required provisions. Staff have also stated the need to secure significant additional resources through the state budget process. Provider application fees authorized by health care reform could be used to cover a portion of the costs of the screenings.

Table 2: Health Care Reform Requires Additional Provider Enrollment Screenings

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

^a The Excluded Parties List System (EPLS) lists all individuals and firms excluded by the federal government from receiving federal contracts.

Source: Patient Protection and Affordable Care Act Final Rules, March 2011.

After health care reform is implemented, the provider enrollment unit is likely to obtain more information about providers who enroll and will be in a better position to identify those who may pose a risk to the program. Although the regulations promulgated by CMS as part of health care reform outline what additional screenings are required, they do not specify how states must use the information they obtain. Because the provider enrollment unit may lack authority to use the information it obtains to keep high-risk providers out of the program, DMAS will need to develop effective policies for sharing this information with other divisions that can potentially use it to mitigate the risk of improper payments. Provider enrollment staff indicate that they already share available provider enrollment information with PID. Staff should expand upon this coordination by identifying and referring providers that pose the greatest financial risk to the Medicaid program to PID for additional review.

Information About MCO Provider Terminations Could Also Improve Program Integrity in the Fee-for-Service Program. Given that MCOs have extensive provider networks, information they gather about providers that are terminated from their networks could be used to identify fee-for-service providers that are wrongfully enrolled or pose a risk to the program. While DMAS should not take action against a provider solely on the basis of an infraction in an MCO plan, this information could be used to identify providers and, if warranted, subject them to additional pre- or post-claims reviews, or terminate them from the fee-for-service program (if there is evidence of a program violation).

Based on detailed information about providers terminated from the provider networks of three MCOs responding to a data request, JLARC staff identified nearly 800 providers that were terminated from one or more managed care networks from FY 2008 to FY 2010 that are currently enrolled in the fee-for-service program. Many of these providers were terminated for reasons that would not necessarily affect fee-for-service enrollment, such as movement out of a managed care network area. However, 73 of the nearly 800 providers were terminated for reasons which could also affect their enrollment in the fee-for-service program, such as being retired or deceased, or having their businesses closed or their licenses suspended. Given this discrepancy, it appears that this information could provide a basis for investigation or follow-up by the Program Operations Division or PID.

Although DMAS provider enrollment staff report occasionally receiving notifications about providers terminated by MCOs, more comprehensive reporting could be used to better identify providers that may pose a risk to the fee-for-service program. To date, the

Health Care Services Division, which oversees DMAS's contracts with MCOs, has not required them to report all provider terminations to DMAS. MCOs are required to "report quarterly those providers who have failed to meet accreditation/credentialing standards," as well as any actions that seriously impact quality of care for recipients and may result in termination or suspension of a provider's license. However, they are not required to report all providers that are terminated from their networks after completing the credentialing process.

DMAS should amend future contracts with MCOs to require them to report information about providers terminated from their networks, along with the reasons for termination. MCOs could report data on all terminated providers, or DMAS and the MCOs could collaborate to identify the termination reasons that are most relevant to the fee-for-service program. This information should be shared with the provider enrollment unit and PID for potential follow-up.

Recommendation (7). The Department of Medical Assistance Services (DMAS) should revise future contracts with managed care organizations (MCOs) starting in FY 2013 to require MCOs to report data on providers terminated from their networks on at least a quarterly basis. Data should include the provider name, unique identification number, and reason for termination. DMAS should use this information to identify providers that should not be enrolled in the fee-for-service program or that may pose a risk to the program.

Recommendation (8). The Department of Medical Assistance Services (DMAS) should establish policies for ensuring that information collected as part of the fee-for-service provider enrollment and managed care credentialing and termination processes are shared among all DMAS divisions responsible for program integrity activities. Information obtained during the enrollment or termination processes should be used to identify potentially high-risk providers for further scrutiny, which could include intensified claims reviews, audits, site visits, or education.

DMAS SUCCESSFULLY USES PRE-PAYMENT CLAIMS REVIEWS TO PREVENT IMPROPER PAYMENTS, BUT ADDITIONAL OPPORTUNITIES EXIST

While DMAS has focused many of its program integrity efforts on the detection of improper payments after they have been made, it has also successfully prevented many improper payments by blocking them before or during claims processing. As suggested by the federal PERM review, existing prepayment tools appear to prevent the vast majority of errors. However, as more claims are processed due to federal health care reform, the risk of additional and differ-

ent errors will likely grow. Generally speaking, these and other pre-payment activities are superior to post-payment audits because they prevent improper claims from ever being paid. However, it appears that additional pre-payment methods could be used to better prevent these payments from occurring. Virginia's MCOs appear to use more stringent pre-payment reviews and more enhanced analytical tools than DMAS.

DMAS Used Pre-Payment Program Integrity Activities to Block \$50 Million in Improper Payments in FY 2009

As discussed more fully in the interim report, *Interim Report: Fraud and Error in Virginia's Medicaid Program*, DMAS uses a prior authorization process and extensive claims processing to prevent improper payments. Up to \$50.3 million in potential fraud or error was prevented in FY 2009 through the use of front-end controls that blocked or reduced improper claims before they were paid. This includes \$25.6 million in services blocked by DMAS' prior authorization process because the requested services were deemed to not be medically necessary. It also includes \$11.8 million in reduced claims identified by DMAS' claims processing system. These reductions occur as a result of the system identifying improperly-filed claims and reducing them to the proper, lower reimbursement level. Lastly, up to \$13 million in managed care premiums were avoided by dis-enrolling individuals who were no longer eligible for Medicaid. These avoided costs are likely underestimated because DMAS does not estimate the value of claims that are entirely blocked, only the amount of the reduction in payment for claims determined to be too high.

DMAS Should Evaluate Use of Pre-Payment Audits

Although DMAS does successfully use pre-payment program integrity activities, Virginia's MCOs appear to use additional methods to prevent improper payments. Notably, the MCOs use prepayment auditing to identify improper payments by requiring certain providers to submit medical documentation before claims are paid. This kind of pre-payment review thereby avoids the "pay and chase" situation created when an audit identifies an improper payment after a claim has been paid. According to Virginia's MCOs, which use this practice widely, pre-payment audits that include a review of medical documentation also deters providers from billing for inappropriate services in the future.

DMAS could perform this type of pre-payment auditing in the same manner as it presently conducts post-payment audits, as discussed in the next section of this chapter. It is important to note that adopting this process may require new staff or the transfer of resources from post-claims auditing. In addition, DMAS staff believe that implementing such a program would require an exemp-

tion from Virginia's statutory prompt payment requirements, which mandate payment for services rendered within 30 days. If needed, DMAS should seek this exemption.

Recommendation (9). The Department of Medical Assistance Services (DMAS) should evaluate the implementation of a pre-payment audit process for those services, individual providers, and provider types that present a high risk of improper payments. This evaluation should include a determination of the resources necessary to perform these activities and their potential benefits, and whether any statutory changes, such as an exemption from the Virginia Public Procurement Act, are required. DMAS should report the results of its evaluation to the House Appropriation and Senate Finance Committees before the start of the 2013 General Assembly Session. If the results indicate that improper payments could be cost-effectively reduced, DMAS should request any funding or statutory changes needed to implement pre-payment audits.

Medicaid Fraud and Abuse Detection System Could Identify More Improper Payments Before Claims Are Paid

Although DMAS already conducts data analysis to identify potential improper payments, the agency has noted that these activities could be improved through the use of commercially available Medicaid fraud and abuse detection systems which provide a more robust form of analysis. These systems could give DMAS new capabilities to identify potential fraud and abuse by making data more accessible and by providing access to new analytical techniques. Alternatively, DMAS could develop this type of analytical capability through staff resources. DMAS examined options for use of such systems in a 2010 report to the General Assembly, *Options for Enhancing Fraud and Abuse Deterrence in the Virginia Medicaid Program*.

Two of Virginia's MCOs use these systems and report substantial savings, although only one was able to report documented savings. While piloting one of these systems with only 75 cases in Georgia, one MCO identified improper payments of \$1.25 million in FY 2010. In addition, as a result of identifying improper practices and implementing controls to prevent them in the future, that MCO estimates they avoided costs of between \$11 and \$17 million.

This type of data analysis, whether done internally or by an external vendor, could be used either to identify providers on whom to focus post-claim auditing activities, or as a method to focus pre-payment claims review, if that practice was implemented. According to DMAS staff, the agency is issuing a request for proposals for a Medicaid fraud and abuse detection system and implementation of this system should be pursued.

IMPROVEMENTS IN PROVIDER AUDIT ACTIVITIES NEEDED TO SUSTAIN STRONG PERFORMANCE AND ENSURE EFFECIENCY

Although the PERM review of claims indicates that DMAS identifies 91 percent of all improperly paid claims in the fee-for-service program, several shortcomings should be addressed to sustain these efforts in a cost-effective manner and better indicate to policy-makers that audit goals are achieved. DMAS uses many types of program integrity activities to prevent and detect improper payments by determining whether providers have acted in accordance with federal and State regulations and Medicaid policy. Some of these activities involve audits of providers by the Program Integrity Division (PID) after claims are paid to detect improper payments. This and other program integrity activities must be effectively coordinated between divisions to ensure the risk of improper payments is minimized. It is equally important to ensure activities within PID are coordinated. To ensure this coordination occurs, and that improper payments are fully addressed in a cost-effective manner, several shortcomings in the audit process should be addressed. This includes the adoption of a unified audit plan that fully coordinates the activities of PID's constituent units as well as third-party contract auditors and clearly indicates how the risk of improper payments is addressed by each of these audit activities. Moreover, additional analysis of audit outcomes could help PID ensure the division does not miss opportunities to identify improper payments. Addressing these shortcomings would also allow PID to ensure it continues to be successful in identifying improper payments and to better demonstrate this success to policymakers.

Program Integrity Division Conducts Provider Audits to Identify Improper Payments After Claims Have Been Paid

PID is responsible for ensuring that DMAS complies with federal regulations directing state Medicaid agencies to conduct program integrity activities, including maintaining programs to detect and investigate fraud and controlling the improper utilization of Medicaid services. In particular, division staff look for improper payments made in paid claims by investigating referrals and complaints, and conducting planned audits of providers who are selected for review through the use of data analysis.

Three Units Within PID Conduct Some Provider Audits, but Reliance on Contract Audit Firms Has Been Increasing. Responsibility for auditing fee-for-service providers is assigned to three units within PID, but the division has also increasingly relied upon contract auditors. The units within PID generally focus on particular types of providers:

- Mental Health Utilization Review focuses solely on the six provider types who bill for community mental health and

PID Uses Contract Auditors

DMAS contracts with national auditing firms to assist with provider review activities.

Clifton Gunderson, LLP conducts several types of audits, including hospice, physician, home health, pharmacy, and durable medical equipment (DME).

ACS Heritage conducts DME and pharmacy audits.

Health Management Systems conducts two distinct types of audits: Diagnostic Resource Group and mental health audits.

residential treatment services. This amounts to a total of 1,199 providers who bill for these types of services.

- Hospital Utilization Review focuses solely on the 114 licensed hospitals.
- Provider Review is responsible for investigating the remaining 31,000 providers who bill Medicaid, including auditing some of the same providers reviewed by Mental Health Utilization Review for services not audited by that unit. Provider Review accounts for 63 percent of all audits conducted by PID staff.

The division's current organization and duties resulted from a reorganization effort in FY 2006 which was intended to centralize and streamline DMAS's program integrity efforts into a single division. Previously, program integrity activities had been dispersed throughout DMAS's administrative structure. The creation of a single program integrity division has been noted by CMS as a best practice for state Medicaid programs.

In addition to using its own staff, PID contracts with three outside audit firms. In combination, PID and its contract auditors identified more than \$29 million in improper payments in FY 2010 (Table 3), which accounted for 38 percent of all improper payments identified from FY 2006 through FY 2010. PID relied heavily on contract auditors in FY 2010, which conducted 60 percent of audits and identified 79 percent of improper payments.

Table 3: Audits by Contractors and PID Staff Identified Over \$29 Million in Improper Payments in FY 2010

Auditor	Total Audits	Percent of Total Audits	Identified Overpayments	Percent of Identified Overpayments
ACS Heritage	79	10%	\$1,420,562	5%
Clifton Gunderson, LLP	241	32	10,370,173	33
Health Management Systems	89	12	3,260,599	10
Health Management Systems Mental Health	44	6	7,887,917	32
Contractor Total	453	60%	\$22,939,252	79%
Hospital Utilization Review	50	7	1,263,273	6
Mental Health Utilization Review	61	8	4,416,471	13
Provider Review Unit	191	25	580,714	2
Program Integrity Division Total	302	40%	\$6,260,458	21%
Grand Total	755	100%	\$29,199,710	100%

Note: Identified overpayment amounts reflect reductions in initial amounts following the appeals process.

Source: JLARC staff analysis of DMAS data on audit outcomes.

Federal Regulations Govern the Process Used to Conduct Provider Audits, Which Result From Referrals or Planned Audits. Federal regulations require DMAS to investigate a provider whenever it receives a referral or identifies any questionable practices. The process must continue until one of three outcomes is achieved:

- The investigation is closed because of insufficient evidence.
- Appropriate legal action is initiated. In Virginia, legal action is initiated when PID refers the case to the Medicaid Fraud Control Unit (MFCU).
- The matter is resolved between the agency and the provider. This resolution may involve a warning letter to the provider, suspending or terminating the provider from the Medicaid program, recovering improper payments, or imposing other sanctions.

In accordance with these requirements, PID investigates providers by conducting audits in response to a referral and as part of a planned audit process. Although 40 percent of the audits conducted by PID staff typically result from referrals, this type of audit takes precedence over planned audits. Planned audits result from an “outlier” analysis that identifies providers whose submitted reimbursement claims indicate questionable practices characterized by substantial deviation from other providers within their specialty. The following is an example of a provider who billed for an abnormally large number of high-level emergency room services, which are reimbursed at a higher rate than non-emergency services.

Case Study

One provider was audited because 43 percent of his claims were billed as high-level emergency room services, in comparison to an average of 20 percent for other providers in his peer group. Although this analysis suggests that the provider may have been billing at a higher reimbursement code than was warranted for the actual services provided, confirmation required an audit of medical records.

In FY 2010, 66 percent of audits conducted by PID’s Provider Review Unit resulted in a finding that an improper payment occurred. Another 12 percent of audits resulted in provider education letters, and 14 percent resulted in findings that no abuse or error occurred. The remaining eight percent were cases that either remained open, or for which the outcome was not noted in the data.

Federal Review of Claims Paid by DMAS Indicates PID Identifies More than 90 Percent of All Improper Payments.

As discussed previously, CMS conducted a PERM review of a sample of fee-for-service claims paid by DMAS during FFY 2009 to determine if any were paid in error. This review also examined the supporting medical records for 87 percent of the sampled claims, using a process similar to PID's provider audits. However, the claims reviewed by PERM would not yet have been subject to a PID audit.

The federal government estimated that the 0.7 percent claims payment error rate found by the PERM review is equivalent to an improper payment amount of \$32 million. CMS calculated this amount by extrapolating the payment errors detected by the PERM review into an annual amount. The extrapolated annual amount of improper payments (\$32 million) is close to the amount of improper payments identified (\$29 million) by PID in the following fiscal year. This suggests that PID identified approximately 91 percent of all improperly paid claims in that year.

PERM also demonstrates that medical record audits are needed, whether they occur before or after payment is made, because about half of the improper payments detected were only identified by conducting a review of medical records.

Changes Made to PID's Audit Process Have Partially Addressed Concerns Previously Raised by Auditor of Public Accounts

While PID has improved its audit process in response to concerns raised by the Auditor of Public Accounts (APA), some shortcomings remain that could preclude the division from detecting the highest possible level of improper payments on a consistent basis. In particular, a lack of adequate documentation of the unit's planned and completed activities, and how those derive from prior audit findings, hinders an assessment by agency management or policymakers regarding the extent to which the unit has achieved its goals.

The Provider Review Unit accounts for more than 60 percent of all audits conducted by PID staff. Provider Review plays another key role within PID because the unit is responsible for overseeing the creation of an audit plan that determines the potential risk of improper payments posed by each provider type and plans audits for those provider types that present the highest risk. Because these planned audits will be conducted by two other units in PID and by contract auditors, Provider Review must ensure that a robust audit planning process is used. Otherwise, gaps in audit coverage could allow improper payments to go undetected, as noted by the APA.

The APA noted that "if one or more of the units...does not work as intended, it creates a gap within the Medicaid program where unnecessary utilization and/or fraud can occur and go undetected."

Ten Risk Factors Are Used to Calculate Provider Type Risk Scores

- 1) Size of the provider type (number of recipients served and/or dollar amount of claims)
- 2) Average value per claim
- 3) Complexity of operations (extent of specialization)
- 4) Changes in operational (regulatory) requirements
- 5) Extent of government regulation
- 6) Impact of adverse publicity on provider (deterrent effect)
- 7) Level of claims processing sophistication (use of electronic submission)
- 8) History of fraud
- 9) Experience level of management
- 10) Elapsed time since last audit

Earlier APA Review of DMAS's Audit Process Identified Gaps That Could Lead to Improper Payment Risks. In FY 2005, the APA reviewed the DMAS units that conduct program integrity activities, including those within PID. The APA noted that "if one or more of the units...does not work as intended, it creates a gap within the Medicaid program where unnecessary utilization and/or fraud can occur and go undetected." The review examined how the units planned their audit schedule, allocated resources, selected providers for audit, and prepared and analyzed documentation of audit outcomes.

The APA's review found weaknesses in internal controls that required corrective action. Specifically, the review found that the program integrity units did not have sufficient resources to complete their planned audits due to changing priorities, and that some of the audit plans and other documentation "did not contain sufficient information to determine what work the units performed." To address these deficiencies, the APA recommended that DMAS establish performance measures to evaluate the effectiveness of the units, and use a risk-based process to guide its audit activities. Doing so would help ensure that audits were targeted at riskier provider types and that shortcomings in the ability to meet audit goals would be identified and addressed in future audit plans.

Provider Review Audit Plan Partially Addresses APA Findings by Prioritizing Planned Audits Based on Risk of Improper Payments.

DMAS concurred with the APA's findings and adopted several changes to improve its audit process. A key aspect of the changes included the creation in FY 2007 of an annual Provider Review audit plan that assigns a risk score to each provider type. As stated in the plan, these risk scores will be used to establish which provider types "will be prioritized for review on an annual basis," and to permit an efficient allocation of limited resources. The plan accomplishes this by using the risk scores to rank provider types; those with a score exceeding 400 are deemed to pose the highest risk and must be audited. (These risk scores are based upon ten risk factors, such the size of the provider type as a percentage of all providers who submit claims.) Within these provider types, individual providers are selected for audit using the outlier analyses discussed earlier in this chapter. DMAS also stated it would address the APA's findings about the failure to complete planned audits by outsourcing some audits to third-party contract auditors.

Despite Improvements, Shortcomings Persist That Could Create Gaps in the Audit Process

JLARC staff's review of the audit process used by PID and Provider Review indicates that additional steps are needed to eliminate gaps in the process that could result in improper payments, includ-

ing those gaps identified in the APA review. These steps are needed in part to ensure PID can maintain the degree of success indicated by the PERM review. In addition, audit plans, procedure and policy manuals, and data collectively create a system of “internal controls” that provide assurance that PID’s activities are repeatable, sustainable, and meet the goals established by agency management and policymakers. As noted by the GAO in *Standards for Internal Control in the Federal Government*, agencies need to “compare actual performance to planned or expected results throughout the organization and analyze significant differences.” Internal controls provide a means of ensuring that this occurs, and that “management’s directives are carried out.”

As discussed in greater detail in the following sections, PID should take the following steps to address existing shortcomings:

- Develop and follow a single audit plan for all of PID and its contract auditors that describes the number and type of audits planned for the upcoming year, and the units and contractors to which these audits will be assigned. These planned audits should be based upon an objective measure of risk, such as the risk scores presently used. Audits of individual provider types that do not directly result from a risk-based methodology, such as special project or referral-based audits, should be clearly indicated and distinguished from other audits. A clear indication should also be given as to which types of audits are counted toward completion of planned audit goals. A formal planning process with these components is needed to ensure that the rationale for selecting the number of audits, and the provider types that will be audited, is objective and documented.
- Adopt a more complete series of controls in the form of adequately documented procedure and policy manuals, and data that measure the status of all referrals received by the unit, the outcomes of all audits, and the rationale for these outcomes. These controls are needed to ensure that no gaps exist and that decisions are made in an objective manner.
- Formally analyze all data on the outcomes of audit activities in a coordinated manner to measure their overall effectiveness as a means of identifying improper payments. This analysis is needed to allow PID to adjust future audit plans to account for past results.

Shortcomings in Provider Review Unit’s Audit Plan May Lead to Unaddressed Improper Payment Risks

Although the Provider Review Unit’s audit plan creates a constructive framework for evaluating risk and focusing resources, short-

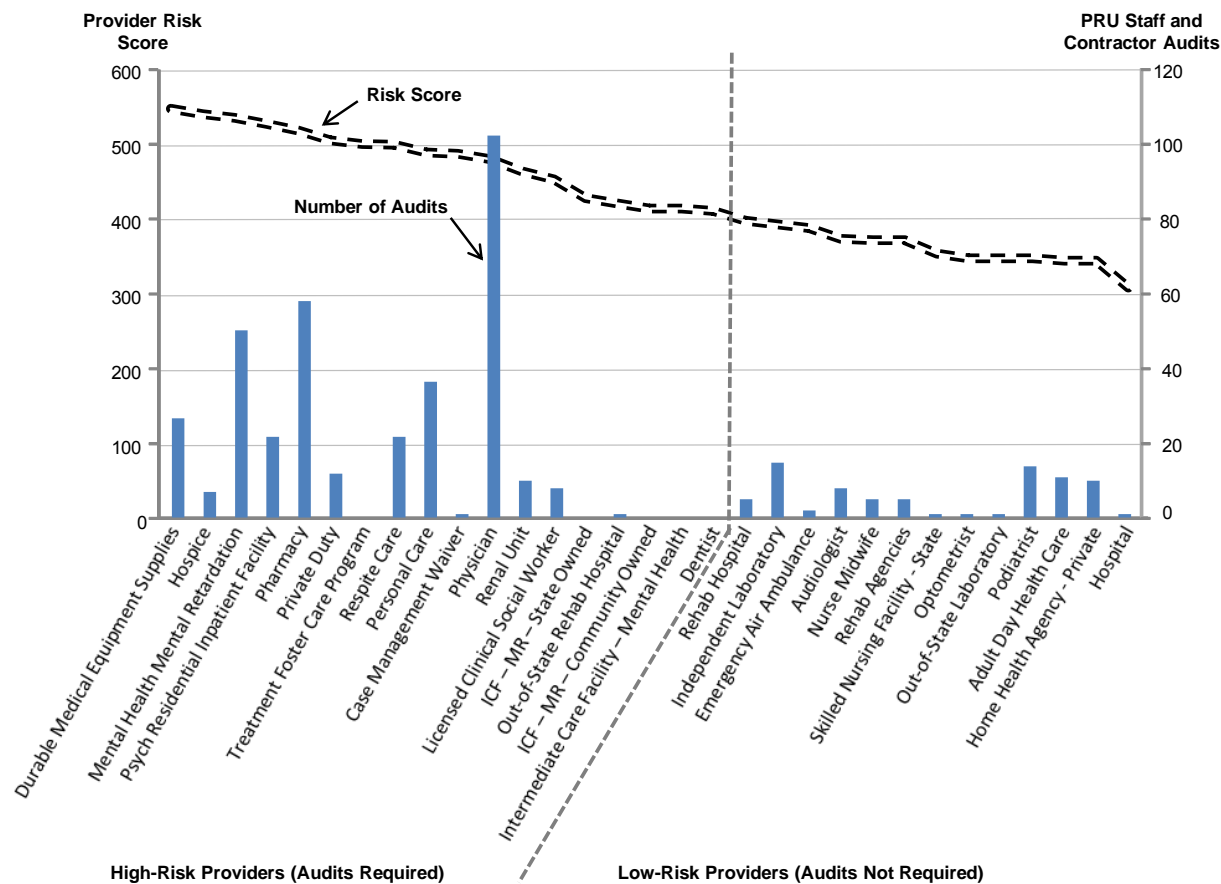
comings in the implementation of this plan leave an apparent gap in the program integrity process. The potential for this gap is evidenced by the lack of a clear relationship between the risk scores assigned to provider types and the actual number of audits to which each provider type is subjected. This gap appears to result from two major shortcomings in the plan. First, the plan does not include audits that contract auditors are expected to complete, although the unit relies on contractors to conduct most of its audits. Second, the lack of adequate documentation used to indicate why actual audits conducted by Provider Review staff deviate from their planned audits hinders an assessment of the relationship between actual audits and risk scores.

Lack of Clear Relationship Between Risk Score and Actual Audits Indicates a Gap in the Audit Planning Process. The actual number of audits completed for each provider type deviates substantially from the number of audits that would be expected given their risk score. Although some of this deviation appears to occur because of audits that result from referrals, the audit plan does not clearly indicate whether a referral-based audit is equivalent to a risk-based audit. In contrast to risk-based audits, referrals may not be substantiated. Because the volume and type of referrals is outside of PID's control, the analysis of audit planning and in this chapter focuses on audits that do not result from referrals.

The deviation between planned audits and completed audits based on risk raises concerns about the extent to which the unit's audit plan is truly risk-based and whether internal and contract resources are allocated toward the greatest risk of improper payments. As seen in Figure 5, the deviation between risk score and actual audits takes three forms:

- High-risk provider types that were audited at a lower level than would be indicated by their risk score rankings, such as case management waiver providers.
- High-risk provider types that have far more audits conducted of them than would be indicated by their risk score, such as physicians.
- Low-risk provider types that have a substantially higher number of audits than would be indicated by their risk score, such as podiatrists and adult day health care providers.

Figure 5: Number of Provider Review Unit Staff and Contractor Audits Does Not Appear Related to Risk Score of Each Provider Type (FY 2010)



Note: ICF-MR, Intermediate care facility for the mentally retarded (intellectually disabled).
Dashed line delineates providers with risk scores above and below 400. Audit counts do not include referrals, and reflect only the number of audits completed in response to planned audits based upon a risk score.

Source: JLARC staff analysis of Provider Review Unit audit plans and audit outcomes.

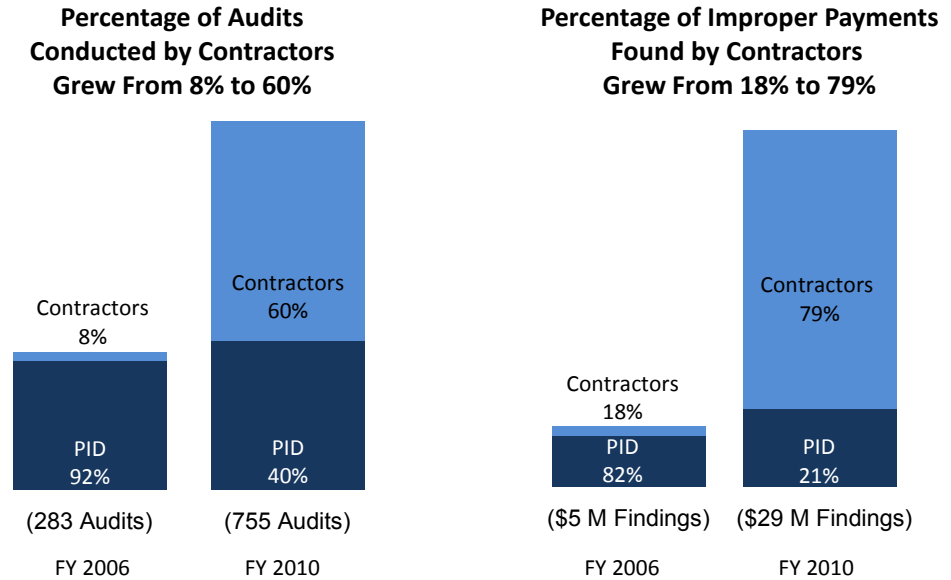
Gap in Audit Planning Process Results in Part From Exclusion of Contract Auditors From the Provider Review Unit's Audit Plan.

As mentioned earlier in this chapter, a large proportion of provider auditing is currently conducted by contract auditors, which reflects a change in PID's approach to auditing since the audit plan was initially developed. As seen in Figure 6, PID has greatly increased its reliance on contract auditors since FY 2006. In FY 2006, contractors conducted only eight percent of all audits and identified only 18 percent of all improper payments.

However, by FY 2010 contract auditors conducted 60 percent of audits and identified 79 percent of improper payments. PID staff auditing increased over this time period as well, albeit to a lesser degree. The number of audits increased from 260 to 302 and find-

ings of improper payments increased from \$4.1 million to \$6.3 million.

Figure 6: Use of Contract Auditors Increased Substantially From FY 2006 to FY 2010



Source: JLARC staff analysis of PID and contractor audit outcomes.

While the use of contract auditors has grown substantially, the Provider Review Unit’s audit plan does not integrate the number of audits that contractors are expected to complete for each provider type. Instead, the audit plan currently captures only audits that internal staff plan to conduct. As a result, the audit plan is incomplete, and it cannot be used to ensure that the total number of planned audits is related to the risk presented by each provider type.

Because the use of contract auditors was more limited when the audit plan was first created in FY 2006, the absence of contract auditors from the plan did not create a substantial gap. However, by FY 2010 contractors were responsible for nearly three-quarters of all Provider Review audit activity, including 13 of the 18 high-risk provider types.

The absence of contract auditors from the Unit’s audit plan has been partially corrected in the unit’s FY 2012 audit plan, which notes which contract auditor will be assigned to each high-risk provider type. However, the plan remains incomplete because it does not specify the number of audits assigned to each contractor. Instead, DMAS indicates that they defer to the expertise of contract auditors in determining the number of audits to be conduct-

ed. Although this situation does not in itself indicate that the unit failed to address all improper payments risks, it creates a gap in internal controls that hinders an assessment of whether all components of the unit are collectively following a risk-based audit process. In order to address this shortcoming, the unit should actively incorporate contractor audits into the audit plan to ensure that improper payment risks are effectively addressed.

Recommendation (10). The Department of Medical Assistance Services Program Integrity Division should create a central audit plan, based on the current risk-based Provider Review Unit audit plan, which addresses the audit activities of all contracted auditors as well as all units within the Program Integrity Division in order to coordinate all audit activities. This plan should include a discussion of the number of audits to be conducted per provider type and an explanation of how any factors other than the risk score modify the number of planned audits indicated by the risk score alone.

Provider Review Staff Do Not Adequately Document the Reasons for Deviating From the Number of Planned Audits. An additional gap in the audit process occurs because Provider Review staff do adequately document the reasons why actual audits deviate from planned audits. Overall, in FY 2010 Provider Review staff conducted fewer audits based on the risk score than were planned, and the degree of variation differed substantially between provider types. For example, some provider types, such as physicians, appear to be consistently audited in excess of the planned number of audits, as illustrated in Table 4. That said, PRU actually exceeded their overall planned reviews for FY 2010 as a result of expanded special projects and re-reviews of providers who required follow-up audits.

One of the reasons why Provider Review staff have often deviated from the number of planned audits is because resources were used to respond to referrals and changing agency priorities. As a result, some improper payments that could have been identified during deferred audits may have remained undetected. The following case study illustrates a case in which planned audits were not completed and may have resulted in undetected improper payments involves case management waiver services.

Case Study

Despite planning to conduct 23 audits of case management waiver providers in FY 2009 and FY 2010, all of these planned audits were deferred to address other audit priorities. Although the planned audits were deferred, the unit and its contractors conducted three audits of these providers as a result of referrals, which uncovered average improper payments of \$54,236. This indicates that substantial im-

proper payments may have been uncovered if the 23 planned audits had been conducted. Despite the fact that none of these planned audits had been conducted, and that audits based on referrals found improper payments, the number of planned case management waiver audits decreased to eight in FY 2011.

Table 4: Count of Actual Audits Conducted by Provider Review Unit (PRU) Staff Deviates From Planned Audits (FY 2010)

Provider Type	Risk Score	PRU Planned Audits	PRU Actual Audits	Difference Between Planned and Actual Audits
Mental Health/Mental Retardation Services	534	12	14	+2
Personal Care	488	0	5	+5
Case Management Waiver	486	11	0	-11
Physician	479	11	35	+24
Renal Unit	463	11	10	-1
Licensed Clinical Social Worker	452	10	8	-2
Dentist	410	9	0	-9
RISK SCORE THRESHOLD		400		
Prosthetic Services	398	9	0	-9
Independent Laboratory	392	9	6	-3
Emergency Air Ambulance	387	9	2	-7
Audiologist	373	9	8	-1
Family Caregiver Training	371	8	0	-8
Nurse Midwife	371	8	5	-3
Podiatrist	347	8	14	+6
Chiropractor	347	8	0	-8
Adult Day Health Care	344	8	11	+3
Total		140	118	-22

Note: Conducted audit counts do not include referrals, but inclusion of referrals does not alter overall findings.

Source: JLARC staff analysis of DMAS data on audit outcomes.

These deviations suggest that DMAS has not fully addressed the APA's concern about inadequate planning for situations where insufficient resources or changing priorities affect the ability to complete planned audits. In addition, the rationale for why this type of deviation occurred and whether these deferred audits would be addressed in the future is not adequately documented. Although deviation from the plan is reasonable, limitations in the documentation maintained by Provider Review hinder an assessment of their performance in meeting planned audit goals. Therefore, it is unclear whether deviations represent a deficiency in the unit's audit activities or whether the deviations were justified and future audit plans should be adjusted.

An additional shortcoming with the audit plan and other documentation is the apparent fact that the plan has not accurately represented the activities that Provider Review expected to perform. Specifically, the audit plans for FY 2007 through FY 2010 included

audits of dentists and chiropractors, but other documentation (discussed below) indicates these audits were never intended to be completed. Because the number of planned audits for each provider type is derived from an estimate of the total number of audits the unit will be able to conduct, the continued inclusion of provider types that will not be audited skews the number of planned audits for other provider types. This results in an audit plan that inaccurately projects the allocation of staff resources. These issues need to be either addressed within the audit plan itself or in a subsequent audit plan, as appropriate, to ensure the visibility of these deviations and in turn, identify opportunities for corrective action in future years.

Provider Review staff were able to provide some documentation to indicate why planned audits did not occur, but the information does not adequately indicate the rationale for all deviations. As a result, the documentation provided by Provider Review during the course of this study is insufficient to ensure a reasonable basis for these deviations exists. For example, the sole indication of why dentists and chiropractors were not audited in FY 2010 consists of this statement: “Dentist: performed by Doral; Chiropractor: limited services.” However, additional documentation provided after DMAS’ review of a draft copy of this report elaborated upon these reasons. For dentists, DMAS noted that the agency director determined program integrity activities would be conducted by the contractor. For chiropractors, DMAS noted that only \$12,000 in claims was paid during the last fiscal year, thus management determined no audits were needed. This additional information substantially improves the ability to assess the rationale for the deviation, and should have been maintained by Provider Review staff initially.

In those cases where additional audits are planned beyond those included in the audit plan, the documentation maintained by Provider Review also does not indicate the methodology used to determine the additional number of audits. As noted above, physicians appear to be consistently audited in excess of the planned number of audits. Although the documentation provided by Provider Review staff does not indicate why additional audits are needed, it was reported to JLARC staff that the number of actual physician audits results in part from the large number of physicians, who make up 62 percent of all providers who bill Medicaid in Virginia. However, this fact was known prior to the fiscal year. Moreover, this excess occurred over several years. As a result, the additional number of physician audits should have been accounted for in earlier audit plans, as the unit began doing in FY 2011. In response to a request for clarification regarding the methodology used to determine the additional number of physician audits, Provider Review staff were unable to provide a methodology but in-

stead stated that the additional physician audits occurred as a result of “special projects” undertaken during the year. The need for special projects is reasonable, but the documentation provided to JLARC staff does not indicate the types of providers reviewed as part of a special project.

As a result of this and other deviations, the actual audit efforts of the Provider Review Unit staff may not be fully risk-based even if the *planned* audits were perfectly aligned with provider type risk scores. Moreover, the absence of this information hinders the value of the plan as an internal control, because agency management is not able to use the audit plan to determine whether the unit is adequately meeting its audit goals. To ensure that its efforts are risk-based, the Provider Review Unit needs to fully document why deviations were necessary. In those cases where the deviation results in the performance of fewer audits than were planned, the documentation needs to distinguish between situations where staff determined that fewer audits were needed (and why) and situations where other program integrity activities in DMAS were determined to reduce the number of audits needed, and the basis for that determination.

Recommendation (11). The Program Integrity Division of the Department of Medical Assistance Services should include in the annual audit plan a formal assessment of whether actual audits met, fell short of, or exceeded planned audit goals for the previous year. This assessment should document the reasons for deviation from planned audits, evaluate the effect of these deviations, and indicate whether these deviations necessitate a change in audit activities to better meet audit goals or an adjustment of planned audit goals to better reflect the goals of the division.

Provider Review Unit Lacks Certain Controls Needed to Ensure All Referrals Are Reviewed

Although referrals accounted for 40 percent of the Provider Review Unit’s audit activity between FY 2006 and FY 2010, the unit does not formally track the outcomes of all referrals. While unit staff indicate that managers evaluate the status of referrals at weekly meetings, the lack of a robust control, in the form of a formal and consistently applied tracking mechanism, makes it difficult to ensure that all referrals are evaluated. The only data collected by the unit on the disposition of referrals is a list of all referrals that indicates which resulted in audits. For FY 2010, this list indicates that 46 percent of the 190 referrals resulted in an audit. However, no data are maintained to indicate whether the remaining 103 referrals were determined to not warrant an investigation or whether they have yet to be evaluated. In contrast, another unit in PID, Mental Health Utilization Review, maintains data that clearly

identify which referrals have been evaluated, which have yet to be reviewed, and the outcome of the review. These data elements indicate which referrals have resulted in audits, and which referrals were evaluated but determined to not warrant an audit.

Recommendation (12). The Program Integrity Division of the Department of Medical Assistance Services should institute a formal mechanism for tracking the disposition of all referrals to ensure that they are evaluated consistently and that appropriate action is taken.

Program Integrity Division Needs to Improve Its Assessment of the Outcomes and Effectiveness of Audits

In addition to improving certain controls within its units, PID needs to improve the process it uses to assess the effectiveness of its activities. Presently, it is not clear to what extent PID effectively analyses existing data to determine whether staff and contractor audit activities effectively identify improper payments and efficiently allocate resources. However, shortcomings in this process appear to have resulted in missed opportunities to improve the focus of its audits.

It Is Unclear to What Extent PID Adequately Uses Data on Audit Outcomes to Focus Future Audits. Documentation provided by PID after their review of a draft copy of this report suggests that its staff and the contract auditors analyze the results of prior audits to improve the effectiveness of future audits. Although contract auditors provide annual reports to DMAS on the outcomes of their audits, the level of this analysis is not consistent and one contract auditor provided no analysis in their annual report. Additionally, no documentation has been provided to indicate how planned audits have been adjusted in response to this analysis. This is because the audit plans used by PID staff and their contract auditors do not discuss how the results of prior data analysis has been used, although they do indicate it is considered. Although the plans may incorporate this analysis, and procedures exist for its consideration, the documentation should be improved to more clearly establish this link. Otherwise, the agency's institutional knowledge resides only within the memories of the individuals presently working there.

Because of these limitations in the documentation, it is unclear to what extent PID uses data on audit outcomes to identify areas where audits consistently uncover substantial improper payments. For example, PID should analyze the percentage of audits that identify improper payments for each provider type. This kind of analysis would allow the unit to focus its efforts on provider types that have a proven history of posing an improper payment risk. Although it is not clear to what extent this kind of analysis is performed, it appears that shortcomings in this area have resulted in

at least one missed opportunity to identify improper payments. This is illustrated by PID's history of auditing durable medical equipment providers. From FY 2006 to FY 2010, 93 percent of the audits of durable medical equipment providers uncovered improper payments, with an average identified amount of \$38,408. However, PID decreased the number of these audits from 64 in FY 2007 to 27 in FY 2010 without documenting why the reduction occurred.

PID Does Not Appear to Formally Assess Results of Audits Overturned or Reduced Because of Provider Appeals. After an audit is conducted by PID staff or contract auditors, the preliminary improper payment amount is reported to the provider who was audited. The provider can then submit additional documentation as part of a reconsideration phase, which could reduce the preliminary improper payment amount. The provider is then officially notified by letter of the established improper payment amount, which the provider can appeal through a multi-step appeals process.

An analysis of DMAS data by JLARC staff indicates that the reconsideration phase and the appeals process often lead to substantial reductions in improper payment findings. From FY 2006 to FY 2010, preliminary findings were reduced by 21 percent during the reconsideration phase. Subsequently, the appeals process reduced these established improper payment amounts by another eight percent.

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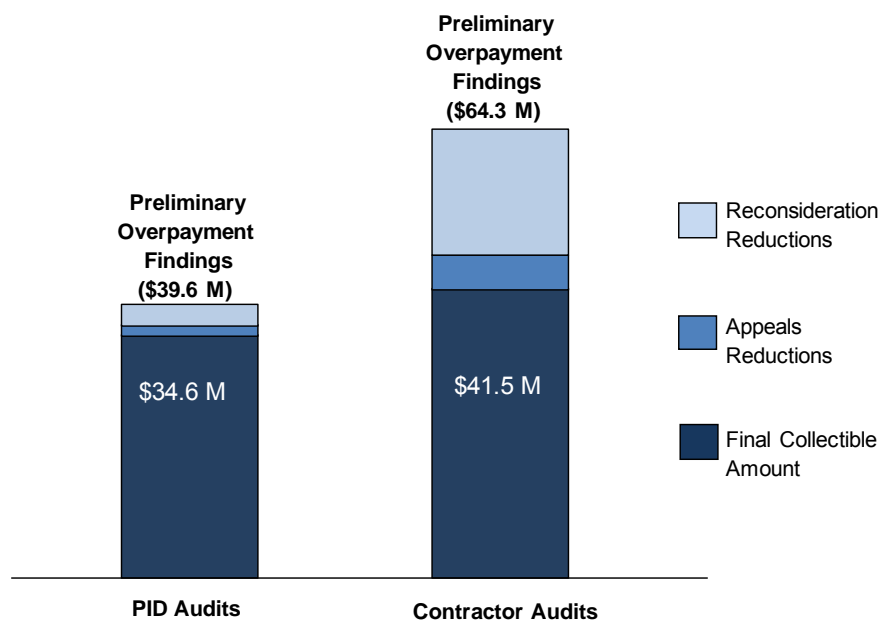
Because substantial reductions in initial findings of improper payments through the reconsideration and appeals process may reflect shortcomings in the audit process, it is important to assess these results to improve the effectiveness of future audits. Yet PID does not appear to formally document and track why those reductions occurred. Instead, PID staff manually store all appeal decisions and assert that these manual records are routinely reviewed for opportunities to improve the audit program. Because no analysis or database exists, PID staff cannot validate their assertion that reductions frequently occur because providers submitted additional documentation during the appeals process. Another potential reason for appeals reductions is that the auditors may have erred in their use of the applicable audit standard, or the audit standard (typically the relevant provider manual) may have been ambiguous, as subsequently pointed out by providers during appeal.

The lack of a formal tracking process makes it difficult to determine the extent to which any single factor led to a reduction in the initial improper payments amount. DMAS staff state that the agency is developing a master database to track appeal data across each of the agency's divisions. PID should use this opportunity to

record the outcomes of all appeals including the reasons why audit findings were adjusted or subsequently reduced. These data should be regularly reviewed to determine if PID needs to modify future audit activities or take corrective action with its staff or contract auditors. These data may also indicate that DMAS policies need to be updated or clarified to respond to any weakness in the provider manuals or other audit standards that are uncovered during the appeals process. This kind of corrective action would limit the need to adjust initial findings and improve efficiency for both DMAS and providers.

An evaluation of appeals outcomes may be particularly important as a means of overseeing contract auditors and responding to concerns by providers about the degree to which DMAS effectively oversees contract auditors. As shown in Figure 7, the initial amount of improper payment findings by contract auditors was reduced to a much larger degree than the improper payment amounts identified by PID. Preliminary findings reported by contract auditors were reduced by 28 percent during the reconsideration period, while preliminary findings reported by PID staff were reduced by only nine percent. Likewise, the improper payments reported by contract auditors were reduced by ten percent during the appeals process, while the amounts reported by PID were reduced by only five percent. A better understanding of the reasons

Figure 7: Contract Auditor Findings Were Reduced to a Greater Degree Than Findings From Audits Conducted by DMAS Staff (FY 2006–FY 2010, \$ in Millions)



Source: JLARC staff analysis of DMAS data on audit findings adjusted due to appeals.

for these reductions could allow PID to identify whether issues exist with the manner in which contractors conduct audits and address those issues through education or clarification.

Because the type of auditor is only one potential factor that could result in differences in reductions from appeals, DMAS should take steps to more fully analyze the effect of the most likely reasons. Another likely factor, noted by DMAS staff, is the type of provider being audited. As seen in Table 5, the effects of reconsideration and appeals on identified improper payments vary by provider type as well. For example, although pharmacy and physician audits were appealed at a similar rate, pharmacy audits resulted in a much higher reduction in initial improper payments amounts.

Table 5: Appeals of Provider Review Unit Audits Have Outcomes That Vary by Provider Type (FY 2006–2010)

Provider Type	Total Audits	Percentage of Audits Appealed	Reduction in Initial Improper Payments
General Hospital (in-state)	10	10%	77%
Pharmacy	122	17	52
Licensed Clinical Social Worker	23	9	47
Respite Care	10	20	40
Nurse Practitioner	10	40	39
Skilled Nursing Home Non Mental Health	10	20	37
Renal Unit	20	5	30
Physician	407	19	21
Transportation	25	4	15
Independent Laboratory	22	5	12
Personal Care	24	17	10

Note: Includes only provider types for which reduction in initial improper payment was at least ten percent.

Source: JLARC staff analysis of DMAS data on FY 2006–2010 Provider Review Unit audit outcomes and appeals.

Recommendation (13). The Program Integrity Division of the Department of Medical Assistance Services should create a mechanism for tracking all identified improper payment reductions due to retractions that occur during the reconsideration and appeals stages, including the reasons for those retractions. This information should be utilized to identify any shortcomings in contractor or staff auditing practices, as well as agency policies, and to guide the implementation of any needed corrective action.

PID Does Not Evaluate the Return on Investment From Its Audits. One means of improving the division’s audit process is through an evaluation of the return on investment (ROI) from audit activity, as measured by the amount of improper payments identified relative to the cost of an audit. By using this measure in conjunction with other performance measures and agency objectives, PID could determine if resources are effectively allocated. While PID staff in-

dicade they informally evaluate whether contract auditors identify a sufficient amount of improper payments to cover the cost of the contract, this does not appear to be done regularly, nor is it done based on post-appeals overpayment amounts.

While data limitations preclude a more sophisticated analysis of ROI, an examination of the relative returns of PID and their contractors indicates notable variation. As seen in Table 6, measuring the relative ROI from different auditors provides greater insight than simply determining whether identified improper payment are sufficient to cover audit costs. For example, Health Management Systems has an ROI of 2.3, meaning that these auditors identify \$2.30 in improper payments (post-appeals) for every dollar they are paid, while the other two contractors have an ROI of only 1.6. While all of these contractors have positive ROIs, the return on the Health Management Systems contract is 44 percent greater than on the other two contracts.

Table 6: Return on Investment (ROI) Varies Between Auditors and Is Reduced Due to Appeals (FY 2009)

Auditor	Expenditures (A)	Established Improper Payments (B)	Initial ROI (B/A)	Improper Payments After Appeals (C)	Post- Appeals ROI (C/A)
ACS Heritage	\$622,468	\$1,147,275	1.8	\$977,309	1.6
Clifton Gunderson, LLP	2,138,170	3,983,972	1.9	3,313,752	1.6
Health Management Systems	1,082,890	2,482,793	2.3	2,482,793	2.3
Program Integrity Division	2,980,653	7,422,905	2.5	7,176,962	2.4
Total of All Audit Activities	\$6,824,181	\$15,036,945	2.2	\$13,950,817	2.0

Source: JLARC staff analysis of DMAS and contractor audit outcomes, appeals results, and expenditures for FY 2009.

In addition, identified overpayments are often reduced due to appeals, as discussed in the previous section. Because these reductions affect the amount that can be collected as a result of the audit, an accurate ROI calculation should be based on audit results after the appeals process has concluded. As shown in Table 6, appeals reductions impact each auditor's ROI to varying degrees, in some cases reducing ROI by 12 to 17 percent. To some extent, these differences in ROI reflect the size and complexity of the claims submitted by different provider types, rather than the performance of the contract auditor. But persistent differences in ROI should be evaluated to determine whether the contract auditor is underperforming, or if PID should focus its contract resources on more productive contracts.

Differences in ROI between provider types or audit types could also be used to assess the need to reallocate resources. However, PID does not track its cost of performing individual audits, in terms of staff resources expended. In addition, because contracts with out-

side auditors do not require reporting of the cost of individual audits or types of providers, PID only knows of the overall cost of the contract with each auditor. Collecting information on PID's internal audit costs and requiring contractors to report this additional detail within the contract would allow PID to evaluate the ROI from an individual audit, from a type of audit, or from a type of provider. For example, one contractor audits both durable medical equipment providers and pharmacies, but the durable medical equipment audits identify overpayments that are on average 12 times higher than pharmacy audits (\$56,831 vs. \$4,795). However, the costs of performing each audit are not disclosed to DMAS. With information on costs and identified overpayments for all contract auditors and internal staff audits, PID could more accurately determine if audit resources are directed in a manner which yields the greatest ROI. While maximizing ROI should not be the sole factor that informs audit activity, audit planning should be informed by and address such metrics.

Recommendation (14). The Program Integrity Division of the Department of Medical Assistance Services should assess the return on investment for all contract and staff audit resources as part of a centralized audit plan to evaluate whether existing resources are being used efficiently and effectively so as to identify the maximum amount of improper payments. In order to calculate returns effectively, the division should track staff hours spent on each audit and redesign their contracts with outside auditors to enable calculation of the average cost of each type of audit. To ensure accurate representation of identified overpayments, this return on investment should be based on audit results after all appeals have concluded.

INCREASE IN DMAS REFERRALS TO MFCU SUGGESTS IMPROVED COORDINATION, BUT OPPORTUNITIES REMAIN

PID must comply with federal requirements that DMAS forward cases of suspected provider fraud to the Attorney General's Medicaid Fraud Control Unit (MFCU) for prosecution. The referral process involves an initial determination by PID of whether a case has sufficient intent to warrant referral. As defined by an interagency agreement between DMAS and the MFCU, the MFCU has a defined period of time to decide whether to accept a case for prosecution. Although PID's referrals to the MFCU increased sharply in FY 2010, it is not possible to assess whether all potential fraud is addressed due to shortcomings in the controls used to determine why a case merits a referral.

PID Is Responsible for Identifying Potential Fraud

Both PID and the MFCU play a role in the prevention of provider fraud, and their respective responsibilities are governed by federal regulations and an interagency agreement between DMAS and the

MFCU. Federal regulations assign responsibility for the initial determination of potential provider fraud to DMAS, stating that if an investigation gives the state Medicaid agency reason to believe that fraud has occurred, the agency must refer the case to the MFCU in accordance with the interagency agreement. In fact, the agreement further notes that DMAS will, “at the earliest practical moment,” advise the MFCU of any matter in which there is “any suspicion of fraud.” Although PID is responsible for determining which cases to refer, the agreement also notes that the MFCU exists “for the express purpose of providing a completely independent review of possible provider fraud in the Medicaid program.”

DMAS Referrals to MFCU Have Increased in Recent Years

PID referred 51 cases of suspected provider fraud in FY 2010. Although this figure represents only seven percent of all audits conducted by PID in that year, it is substantially higher than the approximately ten cases PID referred each year from FY 2006 to FY 2009 (Table 7).

This increase may partly result from the use of bimonthly interagency meetings. At these meetings, DMAS staff discuss the reasons why these cases are suspected to contain fraud and MFCU staff discuss what evidence will likely be needed. MFCU has recently expanded their staff by adding additional investigators to respond to a backlog created by increased referrals from DMAS.

Table 7: PID Referrals to MFCU Increased Substantially in FY 2010

Year	Total PID Referrals	Accepted by MFCU	Declined by MFCU	Pending MFCU Review
FY 2006	6	5	1	0
FY 2007	15	13	2	0
FY 2008	15	8	7	0
FY 2009	7	6	1	0
FY 2010	51	13	5	33
Total	94	45	16	33

Source: JLARC staff analysis of DMAS data on referrals to MFCU.

PID Lacks the Controls Needed to Verify Whether All Investigations Are Reviewed for Potential Fraud

Although the number of referrals to the MFCU has markedly increased, PID lacks the controls needed to ensure all instances of suspected fraud are being referred to the MFCU. As a result, it is not possible to assess whether PID is both fulfilling its responsibilities in a reasonable manner and allowing the MFCU to fulfill its role of providing a completely independent review.

Some of the control inadequacies involve insufficient documentation. Of the three provider audit units, only one includes fraud review and referral procedures in its policy and procedure manual. Despite the lack of procedural documentation, PID staff state that the outcome of every case is reviewed by a supervisor or manager to determine if potential fraud exists.

However, the provider audit units also lack the kinds of controls needed to ensure that policies about which cases to refer are followed. Specifically, the division has not adopted a consistent practice of defining specific criteria for determining if a provider audit should be referred to the MFCU, nor do all units in PID maintain data that could be reviewed to ensure these criteria are consistently and reasonably applied. In contrast, another unit in PID (the Recipient Audit Unit), has formal criteria that define which factors will be used to decide whether a case merits prosecution, and documentation is maintained that records the use of these criteria by individual auditors, which is then reviewed for consistency.

Because the provider audit units within PID lack the necessary controls, it is impossible to determine whether every case has been reviewed for potential fraud, or whether the case is still pending review. This also hinders an assessment of whether cases are being referred in a timely manner. Moreover, the lack of defined criteria that indicate which cases warrant prosecution limits the ability of agency management or the MFCU to ensure that the selection of cases for referral is reasonable.

Recommendation (15). The Program Integrity Division of the Department of Medical Assistance Services should institute a formal, documented mechanism of evaluating the outcomes of all staff and contractor audits to determine if potential fraud exists and ensure that all cases of potential fraud are referred to the Medicaid Fraud Control Unit.

DMAS Collects Majority of Improper Payments but Process Could Be Improved

In Summary

Although DMAS has recovered 69 percent (\$19.8 million) of 2009 improper payments resulting from provider and recipient errors and fraud, there are opportunities to improve the collection process. To date, DMAS has collected nearly three-quarters of what is owed by providers but only a quarter of what is owed by recipients, based on a JLARC staff review of invoices created for FY 2009 improper payments. Collection rates are also lower for improper payments resulting from recipient fraud and provider criminal fraud than amounts due to errors. Further, approximately \$0.8 million in improper payments that were identified through audits has not been collected because invoices were never created and, as a result, collection efforts were never pursued. To improve the collection process, DMAS should develop clearer policies for sharing information about improper payments across departments, establish better controls to ensure invoices are created, and improve its accounts receivable system to enable better reporting.

The effectiveness of Medicaid program integrity efforts largely depends upon the percentage of improper payments that is collected, and many of the program integrity activities described in Chapters 2 and 3 of this report result in improper payments which should be collected. Improper payments that are identified but never collected neither reduce program costs nor serve as an effective deterrent against future error and fraud. However, DMAS staff have not routinely analyzed and reported accurate collection rates for their program integrity activities.

DMAS FISCAL DIVISION IS RESPONSIBLE FOR COLLECTING IMPROPER PAYMENTS

According to the Virginia Debt Collection Act, agencies must take “all appropriate and cost effective actions to aggressively collect all accounts receivable,” and the Fiscal Division within DMAS has primary responsibility for collecting improper Medicaid payments. To begin the collection process, the Fiscal Division creates an invoice (or “receivable”) for providers and recipients in an accounts receivable system. Invoices are based upon improper payment information provided by the Program Integrity Division (PID) and other DMAS divisions, and the Medicaid Fraud Control Unit (MFCU). Fiscal Division staff report that the information about improper payments they receive from PID varies, but typically includes a form with supporting documentation and a letter of notification to the recipient or provider. For provider fraud cases, DMAS receives court restitution orders from the MFCU.

Once an invoice has been created, the Fiscal Division takes several steps to begin collections. They first send a collection letter to the provider or recipient referencing the initial notice outlining the results of an audit or review performed by the agency or its contractors. The letter from the Fiscal Division gives the provider or recipient 30 days from the date of the initial letter to submit payment in full. If amounts owed by providers are not collected in the timeframe, DMAS will offset future payments through its claims processing system, the Medicaid Management Information System (MMIS). Offsets through MMIS do not apply to recipient receivables. A repayment plan is an option for both providers and recipients if they can demonstrate that payment in full creates a financial hardship. If these methods fail, DMAS can use several other options (the Setoff Debt Collection program administered by the Departments of Taxation and Accounts, the Office of the Attorney General's Division of Debt Collection, or a private collection agency) but these methods accounted for less than one percent of total provider and recipient collections in FY 2010.

COLLECTION PROCESS RECOVERED MOST IMPROPER PAYMENTS FROM PROVIDERS BUT FEW FROM RECIPIENTS

Overall, DMAS has collected the majority of improper payments made to providers and recipients in FY 2009 (excluding improper payments resulting from errors made by State or local agency staff). The total value of the invoices created for improper payments in that year equaled \$28.7 million. (This amount is net of any adjustments such as reductions due to appeals.) Of this amount, \$19.8 million (68.8 percent) had been collected by May 2011. However, the collection rates were much higher for providers than recipients, and higher for cases of error than fraud.

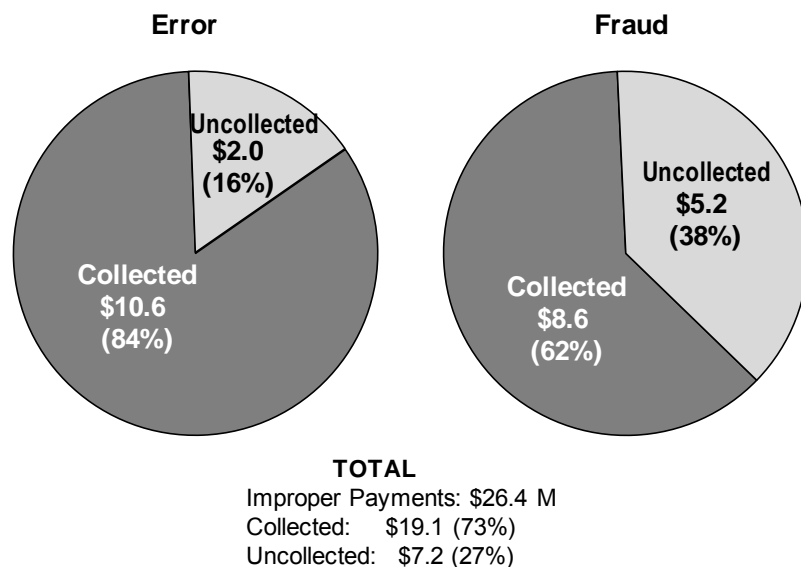
In order to calculate collection rates, JLARC staff matched accounts receivable data with improper payment data from PID and the MFCU. JLARC staff analyzed the collection rates for FY 2009 improper payments because DMAS has had ample time to collect the amounts owed (between about two and three years), except for cases involving lengthy appeals. Due to the substantial effort required to calculate accurate collection rates, JLARC staff were unable to calculate reliable collection rates for other fiscal years, although less robust analyses suggest that the overall collection rate, and the more specific rates described below, are indicative of other years. Appendix B contains additional information about the methodology used to calculate collection rates.

DMAS Has Collected 73 Percent of FY 2009 Provider Improper Payments

Overall, DMAS has collected 73 percent (\$19.1 million) of the \$26.4 million in improper payments made to providers in FY 2009, but

the collection rate is higher for improper payments resulting from errors than fraud (Figure 8). Of the \$10.6 million owed by providers because they received payment in error, 84 percent has been collected. (In fact, 93 percent of all provider invoices were collected in full.) DMAS's ability to withhold future payments from providers contributes to the high collection rate: over half of the funds collected as a result of provider errors were withheld through MMIS. In contrast, DMAS has collected 62 percent (\$8.6 million) of the improper payments resulting from provider fraud.

Figure 8: Most FY 2009 Improper Payments to Providers Have Been Collected, but Fewer of Those Due to Fraud (\$ in Millions)

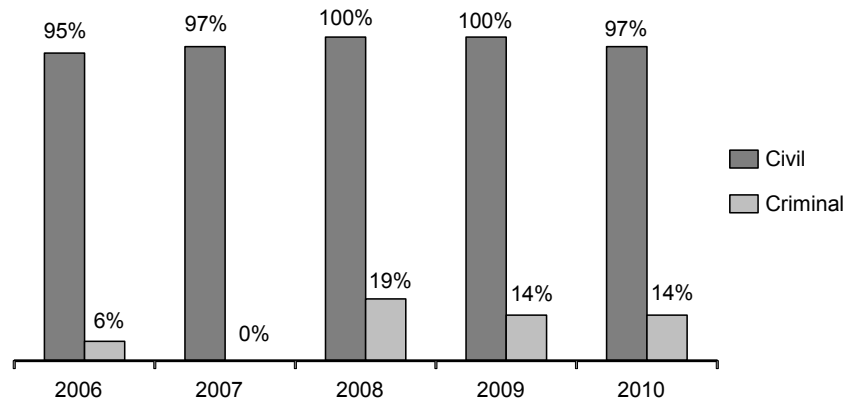


Source: JLARC staff analysis of accounts receivable data from DMAS's Fiscal Division and improper payment data from DMAS's Program Integrity Division and MFCU.

The lower collection rate for provider fraud cases is due primarily to the difficulty collecting funds resulting from criminal fraud convictions. While DMAS has collected 100 percent (\$7.7 million) of what was owed for civil convictions in FY 2009, it has collected only 14 percent of the criminal conviction amounts for that year. As illustrated in Figure 9, this difference in civil and criminal collection rates has been consistent over the past five years.

According to MFCU staff, collection rates are higher for civil cases because they typically involve large pharmaceutical companies that have significant resources, whereas criminal cases typically involve an individual or facility with few resources with which to make restitution. In addition, criminal cases are more likely to result in incarceration, thereby reducing the collection rate.

Figure 9: Collection Rates for Provider Civil Convictions Greatly Exceed the Rate for Criminal Convictions



Source: JLARC staff analysis of DMAS accounts receivable data and MFCU data.

Additional analysis of provider fraud collections by JLARC staff indicates that the funds returned to DMAS from cases prosecuted by the MFCU are substantially lower than the recoveries reported by the MFCU in its annual reports. (MFCU staff state that the annual report uses the term “recoveries” in response to federal direction.) Owing to the MFCU’s success in jointly prosecuting cases of provider fraud with the federal government and other states, only \$61 million of the \$720 million reported as recoveries in the MFCU’s annual reports is attributable to improper Medicaid payments in Virginia (Table 8). However, the MFCU appears to be reporting all restitution, forfeiture, penalties, and other awards ordered by courts in cases in which the MFCU participated. MFCU staff state that the annual report uses the term “recoveries” in response to federal direction that defines recoveries more broadly. Of this \$61 million, \$44 million has been collected by DMAS.

Table 8: DMAS Collections From MFCU Cases Are Lower Than Recoveries Reported by MFCU (FY 2006–FY 2010)

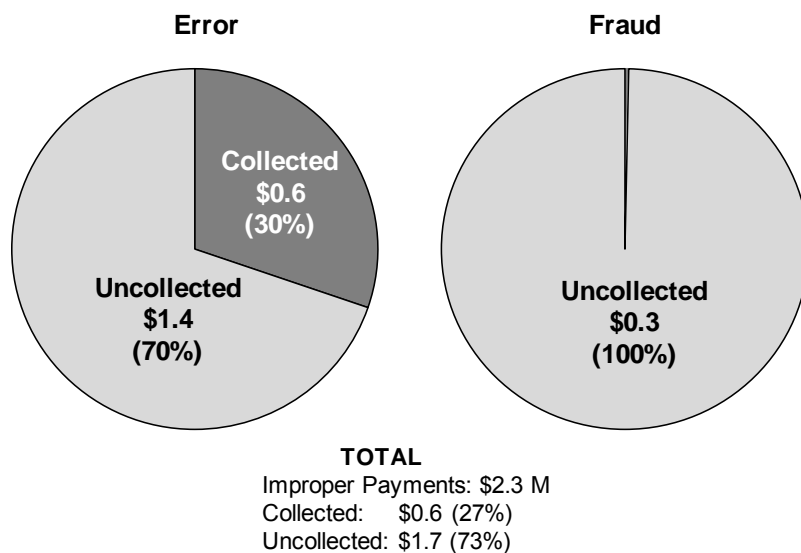
Year	Recoveries From MFCU Annual Report	DMAS Invoiced Amount for MFCU Cases	DMAS Actual Collections From MFCU Cases
FY 2006	\$9,071,043	\$7,785,089	\$2,161,828
FY 2007	117,704,247	9,192,523	4,909,776
FY 2008	541,099,617	15,133,428	14,240,187
FY 2009	27,607,670	13,789,303	8,553,020
FY 2010	25,390,467	13,252,557	12,561,245
Total	\$720,873,044	\$60,737,740	\$43,687,033

Source: JLARC staff analysis of MFCU case data and DMAS collections data.

DMAS Has Collected 27 Percent of FY 2009 Recipient Improper Payments

Overall, DMAS has collected 27 percent (\$0.6 million) of the \$2.3 million in improper payments made to recipients in FY 2009. As shown in Figure 10, DMAS has collected a larger portion of the improper payments resulting from error (30 percent) than fraud (less than one percent). According to DMAS, these collection rates are low because most recipients are indigent and some may be in jail.

Figure 10: Less Than One Third of All FY 2009 Improper Payments to Recipients Have Been Collected, and Almost None of Those Due to Fraud (\$ in Millions)



Source: JLARC staff analysis of accounts receivable data from DMAS's Fiscal Division and improper payment data from DMAS's Program Integrity Division.

The effects of incarceration on the ability of a recipient to fully re-pay Medicaid are illustrated by the following case study:

Case Study

In FY 2009, an individual was convicted of fraud for lying about being paralyzed in order to avoid going to prison for violating probation. As part of the scheme, the individual received medical services paid for by Medicaid. The individual was sentenced to 16 years in prison and ordered to pay restitution of over \$200,000 to DMAS.

A payment plan outlined by the court required monthly payments of \$25 during imprisonment. While an invoice was established by DMAS and a notification letter was sent to

the individual demanding payment, no payments have been made to date. Further, even if monthly payments were made, DMAS would only recover \$4,800 during the 16-year prison sentence.

SOME IMPROPER PAYMENTS ARE NOT COLLECTED BECAUSE INVOICES WERE NOT CREATED

Some improper payments made to providers and recipients in FY 2009 have not been collected because invoices were never created. Improper payments identified by DMAS and its partner agencies in FY 2009 totaled \$30.6 million after appeals, but invoices for those payments totaled only \$28.7 million. According to DMAS, approximately \$867,000 in FY 2009 improper payments is pending action by the courts or MFCU and therefore cannot be pursued for collection. Most of the remaining amount—over \$840,000—reflects improper payments that should have been collected but were never invoiced. Improved communication and internal controls are needed to ensure invoices are always created. (Appendix B contains additional information about the remaining discrepancies).

Invoices Have Not Been Created to Collect Over \$840,000 in FY 2009 Improper Payments

JLARC staff identified over \$840,000 in improper payments which have not been collected because invoices were never created (Table 9). This amount resulted from 41 audits or convictions in FY 2009. While this reflects less than five percent of provider and recipient improper payments for that year, analysis by JLARC staff suggests that this occurs to some extent each year, although the full magnitude of the issue could not be determined. For example, in addition to the two cases in Table 9, JLARC staff identified another 13 MFCU fraud cases from FY 2006 to 2010 that have not been invoiced, resulting in an additional \$2.5 million in improper payments that are not being collected.

Table 9: Invoices Have Not Been Created to Collect Over \$840,000 in FY 2009 Improper Payments

Type	Number of Cases	Total Improper Payments
Provider error	31	\$385,017
Provider fraud	2	413,003
Recipient error	7	42,280
Recipient fraud	1	368
Total	41	\$840,668

Note: This table excludes improper payments that were not forwarded to the Fiscal Division because they are pending court action or because they were below a certain threshold (recipient improper payments less than \$300 were not forwarded for collection prior to December, 2010).

Source: JLARC staff analysis of DMAS accounts receivable data, DMAS Program Integrity data, and MFCU data.

Not creating invoices for all improper payments represents a missed opportunity to recover misspent funds. It is highly likely that most of the uninvoiced improper payments resulting from provider errors could have been collected. This is illustrated by the fact that 27 of the 31 providers that were not invoiced subsequently received payments from DMAS that exceeded the amount they owed DMAS for improper payments. Therefore, DMAS could have fully recouped the amount of improper payments owed by these 27 providers by withholding payments.

Identified Improper Payments That Do Not Result in Invoices Suggest a Lack of Communication and Internal Controls

The exact reasons why improper payments were not invoiced for collection are unclear. DMAS and MFCU staff were asked to explain why invoices were not created for each of the identified improper payments included in Table 9. In certain cases, RAU and PID contractor staff reported that the appropriate information was forwarded to the Fiscal Division. This suggests that the Fiscal Division needs to establish better internal controls to ensure invoices are always created.

In other cases, however, it is not clear whether PID staff appropriately conveyed information about improper payments to the Fiscal Division. A similar concern was noted in a 2005 Auditor of Public Accounts report which examined DMAS records of improper payments from another division to determine if invoices had been created, and found that “four of the six cases involving improper payments [were] not communicated to the Fiscal Division.” A 2007 review by DMAS’s Internal Audit Division concluded that the Fiscal Division should take steps to “develop a standardized overpayment form or process that can ultimately be used by all divisions and contractors.”

According to DMAS staff, the department established a receipt confirmation process in response to the APA’s report; however, the effectiveness of that system is unclear. The department’s use of that system was first brought to JLARC staff’s attention after a draft report was reviewed by DMAS, and not during extensive prior discussions about the issue. In addition, while such a system would provide DMAS with records of cases that were forwarded for collection, it is not clear how it would ensure that all improper payments are actually forwarded to the Fiscal Division.

MFCU staff did not provide any explanation about why the provider fraud cases have not been invoiced, but DMAS staff suggested that communication between the two agencies could be improved. According to a 2005 memorandum of understanding between DMAS and MFCU, the two agencies will “coordinate their activi-

ties whenever necessary to ensure that . . . overpayments will be expeditiously recovered.” It further states that the agencies will agree on a “procedure for collection of such overpayment.” However, it does not appear that a formal agreement exists, and the Fiscal Division’s policies and procedures manual does not explicitly outline procedures for establishing invoices for MFCU fraud cases.

In addition, a lack of controls makes it difficult to determine which cases with findings have been recovered. Of the 106 cases reported by MFCU with funds due to DMAS, JLARC staff were only able to match 91 to invoices created by DMAS. This apparent discrepancy may, in part, exist because DMAS and MFCU do not consistently use a unique identifier for cases that are referred between the agencies. Because of this missing control, it is unclear whether invoices were not created or if the name on the DMAS invoice did not match the name on the MFCU case. DMAS and the MFCU should use a single identifier for these cases, such as the PID case identifier, to act as a control that would indicate whether invoices were created for all cases referred by the MFCU to DMAS for collection.

In order to increase collection of improper payments, DMAS should ensure that the Fiscal Division collaborates with PID and other divisions in DMAS as well as the MFCU to improve and standardize information sharing. In addition, DMAS should identify which division should be responsible for periodically comparing improper payment data with accounts receivable data to ensure that invoices have been created for all improper payments. Assigning each error and fraud investigation a case number could assist in tracking whether invoices have been created. DMAS should also update its fiscal policies and procedures to reflect the improved processes, including coordination with the MFCU.

Recommendation (16). The Department of Medical Assistance Services (DMAS) and the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General should develop a single unique identifier to be used by both agencies for each individual case. This unique case identifier should be used to track the status of referrals to the MFCU as well as to create invoices at DMAS for completed prosecutions.

Recommendation (17). The Department of Medical Assistance Services (DMAS) should develop and implement a plan to improve and standardize the process of sharing information about improper payments between divisions and agencies, and develop a process to track and review whether invoices are created for each identified improper payment. Representatives from DMAS’s Fiscal and Program Integrity Divisions, other divisions within the agency, and the Medicaid Fraud Control Unit should work together to achieve these objectives.

COLLECTION RATES COULD HELP BETTER ASSESS EFFECTIVENESS OF PROGRAM INTEGRITY ACTIVITIES

To date, DMAS has not calculated collection rates for its program integrity activities and has instead focused on the magnitude of improper payments, rather than the amounts collected, as the measure of the effectiveness of its activities. The calculation of a collection rate for program integrity activities would allow DMAS to allocate resources to those activities that are most effective.

In part, the agency's ability to calculate a collection rate has been limited by shortcomings in its accounts receivable system. Currently, the data needed to calculate collection rates for specific activities resides in different divisions and agencies and is difficult and time-consuming to aggregate. Further, some useful information is contained in the accounts receivable system but cannot be easily accessed (such as appeals amounts). Adding a few key variables to the accounts receivable system (such as auditor, type of audit, and type of provider) would enable the Fiscal Division to more efficiently analyze collection rates on an ongoing basis. Fiscal Division staff agree that their system should be updated to improve its utility, and they should collaborate with other units in DMAS to identify what information should be captured to improve their assessment and reporting capabilities.

Recommendation (18). The Department of Medical Assistance Services' Fiscal Division should collaborate with the agency's Program Integrity Division to identify information that should be captured in the accounts receivable system to readily calculate collection rates. Information that should be captured includes fields that identify the auditor, type of audit, and type of provider that was audited. Adjustment amounts due to appeals should also be clearly identified.

More Oversight of Managed Care Is Needed to Ensure Rates Exclude Improper Payments

In Summary

Oversight of managed care organizations (MCOs) by DMAS is insufficient to ensure that the monthly capitated rates paid to MCOs are not inflated because of undetected improper payments. The capitated rates paid to MCOs are calculated based on claim expenditures and other data MCOs report to DMAS. If these data contain undetected improper payments, the rates calculated will be too high. To date, DMAS has largely relied on the MCOs to detect improper payments within their provider networks, and to report accurate data. However, audits conducted by MCOs appear less robust than in the Medicaid fee-for-service program, and inadequate reporting has prevented DMAS from fully assessing the effectiveness of the MCOs' program integrity activities. Further, discrepancies between the claims data that MCOs submit to DMAS for rate setting and the claims data submitted strictly for reporting purposes raise concerns about the accuracy of expenditure information. Consequently, DMAS should increase its oversight of MCO program integrity activities and require independent verification of claims and other expenditure data used to set rates.

Payments made to Medicaid managed care organizations (MCOs) can result in improper payments, as is the case with any service contractor or provider paid by DMAS. MCOs receive a flat (capitated) monthly payment for each recipient enrolled in their plan. MCOs then pay the providers within their networks and submit these expenditure data to the Department of Medical Assistance Services (DMAS). The expenditure data are used by DMAS, along with administrative costs reported by the MCOs, to set future capitated rates. Because MCO rates are based on data reported by MCOs, any improper payments contained in those data can lead to inflated rates. This can occur if MCOs (1) do not detect or recover all improper payments from providers within their networks, or (2) submit inaccurate expenditure data to DMAS.

Because of the magnitude of capitation payments to MCOs (\$2 billion in FY 2011) even a small percentage of improper payments could have a substantial financial impact on the State. The importance of preventing improper payments in managed care is acknowledged by DMAS, as indicated by the contract it executes with MCOs which requires each organization to prevent fraud and abuse. Although this report focuses on mitigating improper payments and does not assess the effectiveness of managed care, DMAS notes that managed care offers a number of benefits. These include health education, chronic care management, provider credentialing, and better health outcomes.

IMPROPER PAYMENTS IN CAPITATED RATES PRESENT A GROWING RISK REQUIRING EFFECTIVE OVERSIGHT

Since its initial adoption by DMAS in 1991, the role of managed care has grown. The managed care program discussed in this chapter, known as Medallion II, was first implemented in 1996 as a means of improving care and controlling costs. Today, five MCOs have contracts with DMAS and their provider networks cover most of the State and serve the majority of Medicaid recipients. In FY 2011, about 64 percent of Medicaid recipients were enrolled in managed care. Following planned expansions to the program, DMAS staff expect managed care will eventually account for 75 percent of all Medicaid recipients.

Despite a growing reliance on MCOs to provide Medicaid services, DMAS still has primary responsibility to ensure the fiscal integrity of the Medicaid program. This responsibility was identified by the Health Care Financing Administration (the predecessor to the Centers for Medicare and Medicaid Services) in 2000, when the agency published *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*. The report stated that “the primary responsibility for program integrity in the Medicaid program lies with the State and federal governments, *regardless of what service delivery system is used* [emphasis added].” To reduce this risk, the *Guidelines* contain certain practices that state Medicaid agencies should use, including oversight of MCO program integrity activities and expenditure data. To date, two divisions in DMAS—Health Care Services and Provider Reimbursement—have shared the responsibility for overseeing managed care by monitoring MCOs’ activities and reimbursement. This oversight will become increasingly important as managed care expands in Virginia.

MCOs Are Paid a Capitated Rate to Provide Services to Recipients in Their Plan

Capitated Rates Vary

While MCOs are paid a monthly capitated rate for each person enrolled in their plans, the rates vary based on the recipient’s eligibility group, region, and demographic group. They also vary by MCO based on variations in the health status of their enrollees.

In exchange for capitated payments, each MCO agrees to coordinate and pay for a range of services for the recipients in their plan, regardless of the actual cost. Each MCO enrolls medical providers within their managed care network to deliver these services, and these providers submit reimbursement claims to the MCO. If an MCO can keep its payments to providers and other administrative costs below the total amount of capitated payments it receives, the organization can keep a portion of the difference as profit (the amount MCOs can keep is contractually limited to eight percent). However, if the MCO’s costs exceed its capitated payments, the organization is not entitled to any additional payment. In other words, MCOs assume the financial risk of unknown future costs.

Capitated rates are based on expenditure data submitted by MCOs. MCOs submit two years of provider claims and other ex-

penditure data to DMAS' actuary. Under the direction of the Provider Reimbursement Division, the actuary analyzes the data and makes adjustments based on assumptions about future utilization and other factors. Accordingly, the capitated rates are prospective because they are set in advance and then paid to the MCOs over the next year (the term of the MCO contract).

Incentives of Capitated Payment Structure Do Not Eliminate the Risk of Improper Payments

DMAS' Provider Reimbursement staff have stated that the use of a capitated payment structure minimizes the risk of fraud and abuse in managed care because MCOs have an incentive to keep their costs below the flat amount they receive from DMAS. Because the capitated rate is based on average expenditures reported by all five MCOs, if one MCO's expenditures are higher than average because of improper payments to their providers, its expenditures will exceed the capitation payments and result in a loss. This rate structure is thought to create an incentive for each MCO to identify improper payments in order to ensure that its expenditures never exceed the capitated rate.

However, the capitated rate structure does not fully shield the State from the effects of improper payments because the average expenditures reported by all MCOs will still likely be inflated to some degree by any undetected improper payments in their claims data. In addition, if MCOs know that improper payments will not be detected in the data they submit, they will not face a strong incentive to prevent improper payments because the costs can be passed on to the State in the form of higher capitated rates.

Furthermore, an MCO does not have to rely on the identification of improper payments as the only means of reducing its expenditures. If an MCO can reduce its expenditures through other means, such as negotiating lower reimbursement rates with providers or conducting more effective health management (such as promotion of preventative care), it could lower its costs below the average while still making improper payments. As a result, the profit motive alone may not be a sufficient inducement for MCOs to conduct program integrity activities.

Concerns about fraud and abuse in managed care have been documented since at least the late 1990s, when the National Association of Medicaid Fraud Control Units noted:

While many proponents of managed care believe that the very nature of the system prevents fraud, the experience of the fraud control units proves otherwise. . . no health plan

is immune from fraud, but rather that fraud will simply take different forms.

Likewise, the Health Care Financing Administration's (HCFA) *Guidelines* observed that:

The original thinking of many within the industry was that fraud did not exist in managed care. However, experience has proven that fraud does, in fact, exist in many ways within a managed care environment.

Undetected Improper Payments in Managed Care Expenditure Data Can Potentially Inflate Rates

The HCFA's *Guidelines* identified claims submission as one of the six potential fraud and abuse risk areas in managed care. The report noted at least two ways in which fraudulent claims data could inflate the capitated rates. While the report focused on the risk of fraud, similar improper payments could result from errors.

First, the HCFA observed that "claims and billing fraud could be perpetrated by either providers or subcontractors who manipulate the claims submitted to MCOs." This could occur if providers in an MCO's network charge more for the services they provided than is allowed, or bill for services that were never provided, resulting in improper payments to these providers by the MCO. This could also occur if network providers erroneously engage in these same activities, and the MCO fails to detect these errors.

Second, the report added that MCOs could commit claims or billing fraud by "submitting false claims to the State or other purchasers of health care *in the hope that future capitation payments will be based upon inflated service records* [emphasis added]." This could occur if MCOs report administrative expenditures that were not incurred as part of their Medicaid line of business, or that are not considered allowable expenses for Medicaid rate setting. It could also occur if MCOs fail to reduce the expenditures reported on their claims data to reflect the funds they collect, such as improper payments recovered from providers in their network or payments from third-party insurance companies (Medicaid is intended to be the payer of last resort).

Federal Government Has Recommended Certain Measures to Reduce Improper Payment Risks in Managed Care

The responsibility of state agencies to reduce improper payments in Medicaid managed care has been clearly recognized by the federal government although it does not appear that specific requirements have been promulgated. Instead, the federal government has issued several best practices for addressing the risk of improv-

er payments. For instance, the HCFA's *Guidelines* indicate that states should incorporate explicit fraud and abuse measures into their MCO contracts. In addition, HCFA noted that state Medicaid agencies should engage in several specific activities, including the adoption of an MCO monitoring program that consists of

- audits and contract reviews to assess compliance with fraud and abuse requirements and procedures,
- the timely recovery of mis-spent funds when irregularities are identified, and
- use of third-party quality assurance reviews, specifically External Quality Review Organization (EQRO) reports, to then “analyze ERQO data to identify potential managed care fraud and abuse” and inform the MCO.

Need for Robust Oversight of MCOs Will Increase as Managed Care Expands

As will be discussed below, the measures DMAS has adopted to oversee MCOs appear to fall short of the responsibilities identified by the federal government. Yet the need to ensure MCOs engage in robust program integrity activities and submit accurate expenditure data will increase as managed care continues to expand.

The 2011 Appropriation Act directs DMAS to expand managed care to cover all parts of the State, with a specific focus on expanding managed care to the Roanoke and far Southwest Virginia areas no later than July 2012. DMAS is also expanding managed care to cover more member groups, such as foster care children and individuals receiving home and community-based waiver services. In addition, the federal Patient Protection and Affordable Care Act will result in an estimated 270,000 to 425,000 new enrollees in Virginia Medicaid by January 2014, many of whom will be covered through managed care. As the number of claims processed by MCOs increase, the risk for fraud, error, and abuse will also increase.

DMAS OVERSIGHT OF MCO PROGRAM INTEGRITY ACTIVITIES IS INSUFFICIENT TO MINIMIZE RISK OF IMPROPER PAYMENTS

Because the State is not fully shielded from improper payments within managed care, DMAS must exercise sufficient oversight to ensure MCOs fulfill their contractual program integrity obligations. Oversight of MCOs is largely conducted by the Health Care Services Division, which is responsible for administering DMAS' contract with each organization. The contracts contain requirements related to program integrity planning and reporting activities. Although MCOs are not required to report all of this data to DMAS, they are contractually required to maintain records of all

program integrity activities and outcomes to allow for evaluation of the success of these efforts.

To date, however, DMAS' oversight appears to have been insufficient to fully assess the effectiveness of MCO program integrity activities and ensure that the risk of improper payments is minimized. The Health Care Services Division has focused on ensuring the quality and availability of managed care services and has placed less emphasis on minimizing the risk of improper payments. Consequently, MCO reporting and compliance with contractual requirements related to program integrity has been insufficient. As a result, DMAS appears to lack the information that would be needed to assess the degree to which MCOs detect and recover improper payments. In fact, some data provided by MCOs suggests that their efforts may not be sufficient to protect the State from the effect of improper payments on capitated rates.

DMAS Oversight of Managed Care Is Focused on Quality and Availability of Care Instead of Program Integrity Activities

The Health Care Services Division focuses primarily on ensuring that the quality and availability of care provided by MCOs are reasonable. This attention appears to be warranted because the under-provision of services by MCOs is considered a potential risk which is inherent in capitated managed care programs. This risk exists because the use of a capitated rate creates a potential incentive for MCOs to limit the quality or amount of services they provide in exchange for these fixed payments so as to lower costs and increase profits.

The internal oversight activities undertaken by division staff include efforts to improve patient satisfaction and health outcomes, such as provision of a helpline that recipients can use to enroll in managed care and report concerns regarding the quality and availability of care. Division staff also ensure consistent application of Medicaid policy by investigating recipient complaints and addressing these concerns with the MCOs, in part through quarterly meetings with each MCO.

The agency also relies on two external third-party reviews to supplement internal oversight:

- EQRO evaluations conducted by an outside consultant every three years to ensure MCOs attain certain health outcomes and maintain grievance systems that allow recipients to challenge service denials
- National Committee for Quality Assurance (NCQA) accreditation which assesses patient access to care, quali-

ty and adequacy of the provider network, and achievement of patient health outcomes

DMAS requires all of its MCOs to achieve NCQA accreditation and four of the five MCOs have achieved the highest level of NCQA accreditation. As with DMAS' internal review activities, the external reviews focus on quality of care and health outcomes rather than compliance by the MCOs with contractual program integrity requirements.

Some MCOs Do Not Fully Comply With Contractual Requirement to Maintain Program Integrity Plans

Although the Health Care Services Division oversees MCOs to ensure they fulfill their contractual obligations relating to the quality of and access to care, a similar level of scrutiny is not given to the MCOs' contractual obligation to maintain program integrity plans. These plans are required to include policies, schedules of activities, and reports that document the MCOs' efforts to minimize improper payments. These plans provide the basis for determining whether the MCOs are adequately preventing, detecting, and collecting improper payments within their provider networks.

Documentation Required as Part of MCO Program Integrity Plans

MCOs are contractually required to maintain three types of documentation as part of an overall program integrity plan: (1) an audit schedule, specific to their Virginia Medicaid line of business, which outlines all program integrity activities for the calendar year and indicates how that plan addresses identified risk; (2) a standard audit report for each audit that includes, at a minimum, purpose, methodology, findings, and recommendations; and (3) quarterly and annual summary reports of any findings of fraud and abuse.

MCOs Comply With Basic Contractual Requirements Regarding Program Integrity Policies and Procedures. JLARC staff's review of documentation submitted by each MCO suggests that the organizations generally comply with basic contractual requirements to maintain written policies and procedures for preventing and detecting improper payments. These basic requirements include

- designating a compliance officer, who is accountable to senior management, and a compliance committee,
- providing a means (such as a fraud hotline) for individuals to report incidents of potential fraud and abuse, and
- having procedures for identifying, correcting, and documenting potential and actual improper payments, including a process for the timely reporting of violations to DMAS.

Inadequate Compliance With Contractual Requirements for Planning, Documenting, and Reporting Hinders Assessment of MCO Program Integrity Activities. In addition to these basic procedural requirements, MCOs are contractually required to maintain certain auditing documents, including a schedule of planned audits and other monitoring activities, as well as reports on the conduct and outcomes of these activities. MCOs are not required to submit these documents to DMAS. A JLARC staff review of these documents, which were requested from each MCO, indicates that many

of these contractually-required elements are missing or incomplete. These shortcomings hinder DMAS' ability to evaluate the adequacy of MCO program integrity efforts.

Each MCO is contractually required to maintain an audit schedule that lists the program integrity monitoring and auditing activities it plans for the calendar year. These audit schedules are required to be specific to the MCO's Virginia Medicaid program, as opposed to other lines of business. These schedules are intended to allow the MCO to determine which risk areas will most likely affect their organization, and to prioritize their monitoring and audit strategy accordingly. In addition, the audit schedule allows each MCO's compliance officer to assess whether these program integrity activities will address identified risks.

JLARC staff found a lack of compliance with this requirement. Two MCOs indicated that they do not maintain an annual audit schedule. In addition, of the three MCOs that were able to provide an audit schedule, only one MCO provided a schedule that was both specific to Virginia Medicaid and clearly identified how risk was evaluated and addressed. Although MCOs are not required to provide these schedules to DMAS, their absence would hinder any evaluation of the sufficiency of an MCO's program integrity activities.

In addition to a schedule of planned activities, the contract requires the MCOs to maintain records of all completed activities and their findings, including a standard report for each audit. JLARC staff requested 20 audit reports (four from each MCO), and a review of the 17 audit reports provided by MCOs indicates that they often lacked contractually required information. Specifically, not all reports included information on the audit methods, the amount of improper payments identified, the amount of funds recovered, or an indication of whether any follow-up activities were planned. For example, some audit reports indicated that a provider was determined to have billed the MCO incorrectly, but the report failed to identify the amount of those improper payments.

Furthermore, not all MCOs appear to comply with the requirement to report to DMAS all improper payments found as a result of program integrity activities. On a quarterly basis, each MCO is required to report any "findings of fraud and abuse." These quarterly reports are followed by an annual report on all program integrity activities conducted and their outcomes. However, a review of the reports submitted by MCOs to DMAS showed that not all improper payment amounts and types are reported. This appears to partly result from the fact that, until recently, DMAS did not require MCOs to use a standard format when reporting improper payments. In addition, there does not appear to have been a consistent

understanding of what should be reported. Although the contract requires MCOs to report all “findings of fraud and abuse,” some MCOs have interpreted this narrowly and did not report improper payments resulting from errors. This lack of clarity has resulted in wide variation in what each MCO reported. For example, while one large MCO reported almost \$1.5 million in improper payments for a single quarter, two other MCOs reported no identified overpayments or recoveries for an entire year. Another MCO told JLARC staff they had an “informal understanding” that only improper payments that exceeded \$10,000 had to be reported, and only for cases that involve fraud or patient abuse, not just error.

MCOs Do Not Appear to Consistently Detect or Recover Improper Payments

In order to assess the effectiveness of MCO program integrity efforts, JLARC staff requested a variety of data from MCOs that are not reported to DMAS. An analysis of these data raises concerns about the adequacy of MCO program integrity activities.

MCOs Do Not Appear to Adequately Audit Their Provider Network or Report on the Outcomes of Those Audits. A review of data and other information provided by MCOs to JLARC staff indicates that, relative to DMAS fee-for-service program, MCOs engage in limited auditing of claims and recover very few improper payments. As shown in Table 10, MCOs conduct fewer audits of their network providers (on a per dollar basis) than DMAS with its fee-for-service providers. In addition, one of the larger MCOs (#3) reported that none of its audits resulted in any identified improper payments. Another MCO (#4) was unable to report any audit activities or recoveries specific to Virginia Medicaid. This is because the MCO was unable to distinguish between the program integrity activities it conducts on Medicaid claims and those it conducts on its other (non-Medicaid) lines of business. This may violate the contractual

Table 10: MCOs Appear to Conduct Fewer Audits Than DMAS (FY 2010)

	Audits Conducted	Audits per \$10 Million in Medical Expenditures
DMAS	757	2.00
MCO #2	35	0.68
MCO #5	10	0.28
MCO #1	3	0.54
MCO #3	3	0.56
MCO #4 ^a	n/a	n/a

^a Unable to provide JLARC staff with audit or recovery data specific to Medicaid.

Source: JLARC staff analysis of DMAS data on audit outcomes and data provided by the five Virginia Medicaid MCOs.

requirement to develop a “program integrity plan *specific* to its Virginia Medicaid program [emphasis added].”

Although the number of reported audits appears to indicate a lower level of scrutiny than DMAS imposes on fee-for-service providers, DMAS notes that certain aspects of MCOs differ from the fee-for-service program that could partially mitigate the need for post-claims audits. First, MCOs have greater latitude in selecting which providers they enroll. While that may reduce their risk of enrolling providers who are intent on defrauding the program, it does not eliminate the need for audits to detect improper payments, especially those resulting from errors. Second, each MCO stated that their use of ongoing utilization management and prepayment auditing limited their need to conduct audits. Nevertheless, none of the MCOs were able to provide data that fully substantiated this assertion. Only three MCOs were able to report data to document the savings that resulted from the use of ongoing utilization management and prepayment reviews, and those savings ranged from \$10,553 to \$44,894 per MCO in FY 2010.

Few MCOs Collect Any Identified Improper Payments From Audit Activities. Even within the limited audits conducted, MCOs do not always collect improper payments, either because the provider does not repay the funds or because the MCO chooses to provide education in lieu of pursuing collection. This practice has implications for whether the capitated rates paid by the State are overstated. All MCOs reported to JLARC staff that improper payments are included in the claims data provided to DMAS for rate setting unless the MCO successfully collects them. Therefore, claims data likely includes claims expenditures that the MCO identified as improper, but which the MCO either chose not to collect or failed to collect. A lack of data precludes DMAS from assessing the extent, appropriateness, and costs of alternative approaches used by MCOs in lieu of collecting misspent funds.

Based on a JLARC staff analysis of reports on the outcomes of 17 audits submitted by MCOs, the organizations collectively identified a total of \$152,733 in improper payments, of which only \$26,737 was collected (Table 11). Because not all of these improper payments were collected, the remaining \$125,996 in uncollected improper payments remained in the claims data used for rate-setting.

It is important to note that this analysis represents only a small sample of all audits and is not intended to be representative of all MCO audits. However, even though JLARC staff specifically asked each MCO to provide two audit reports where improper payments were ultimately collected, and two reports showing some other outcome such as provider education, only one MCO was able to com-

ply and provide audits that resulted in the collection of improper payments.

Table 11: Sample of 17 MCO Audit Reports Indicates Limited Collection of Identified Improper Payments (FY 2010)

	Total Improper Payments Identified	Total Improper Payments Collected
MCO #1	\$70,904	\$26,737
MCO #2	7,530	0
MCO #3 ^a	23,787	0
MCO #4	42,944	0
MCO #5	7,568	0
Total	\$152,733	\$26,737

^a Identified improper payments include one audit for which no standard audit report was submitted.

Source: JLARC staff analysis of MCO Audit Reports.

This outcome suggests that at least some identified improper payments are not collected and are therefore included in the claims data used for rate-setting. However, the lack of adequate reporting on the findings of MCO audits prevents any assessment of the magnitude of these identified but uncollected improper payments, which are certainly larger than the \$126,000 identified in this sample.

DMAS Needs to Coordinate With and Oversee MCO Program Integrity Activities

In response to a 2005 review by the Auditor of Public Accounts (APA) that found shortcomings in DMAS' coordination of program integrity activities, DMAS stated it would work with the MCOs to refine its audit plans and coordinate program integrity activities across both the fee-for-service and managed care programs. However, DMAS first initiated its efforts to coordinate with MCOs earlier this year. In addition, HCFA's *Guidelines* stated that Medicaid agencies should conduct "audits and contract reviews to assess compliance with fraud and abuse requirements and procedures," but DMAS does not appear to have audited MCOs nor does the existing degree of oversight appear to be sufficient. These shortcomings raise concern regarding whether MCOs are doing enough to prevent, detect, and collect improper payments made to providers within their network. To ensure MCOs comply with contractual provisions, and to gauge the effectiveness of their activities, DMAS needs to exercise greater oversight over the MCOs through audits and compliance reviews. These oversight efforts will provide greater assurance that the coordination of fee-for-service and managed care program integrity activities address any gaps in the overall Medicaid program integrity process.

DMAS recently began to coordinate its program integrity activities with those conducted by the MCOs by instituting quarterly meeting between Program Integrity Division staff and MCO program integrity staff to discuss best practices and areas of potential collaboration. While these efforts present an excellent first step in improving overall Medicaid program integrity in Virginia, some MCOs have raised the concern that these meetings would result in the dissemination of activities that are thought to represent confidential business practices. To ensure Medicaid funds are properly expended, DMAS must ensure each MCO is willing to share needed information on how it performs program integrity and the results of these activities.

DMAS has also begun to improve its oversight of MCOs, and the Program Integrity Division is currently organizing a new unit within the division that will review MCO program integrity activities. Based on JLARC staff's assessment, the unit's efforts would initially be best spent in the following activities:

- Determining whether MCOs are fulfilling their contractual requirements for program integrity and following their stated audit plans. This would include ensuring that MCOs have adequate audit plans, sufficient program integrity policies and procedures, and accurate and complete reporting on the outcomes of their audit activities.
- Comparing the outcomes of MCO audit activities to determine if the program integrity activities of some MCOs are inadequate

The results of these reviews should be reported to the Health Care Services Division so that appropriate adjustments in contractual terms and requirements can be made. The unit should also assess whether medical record audits of a sample of MCO claims are needed to further assess the adequacy of MCO program integrity activities.

While DMAS could use internal resources such as Program Integrity staff to ensure that these contractual requirements are met, some states use external reviews to assess MCO program integrity activities as recommended by HCFA's *Guidelines*. Doing so affords the Medicaid agencies in those states the opportunity to identify potential shortcomings and to compare MCOs to ensure adequate program integrity activities occur in each organization. For example, Wisconsin's EQRO reviews have identified the need for corrective action from MCOs that lacked adequate program integrity controls. In addition to its EQRO reviews, Missouri also conducts annual evaluations to assess the adequacy of MCO program integ-

rity policies and procedures, as well as the accuracy and completeness of MCO reports on audit outcomes. Finally, Maryland's EQRO reviews include an evaluation of each MCO's compliance with state program integrity requirements, which allows for an identification of opportunities for improvement.

Recommendation (19). The Department of Medical Assistance Services should establish a unit within the Program Integrity Division to evaluate the program integrity activities of managed care organizations (MCOs). The new unit should, at a minimum, assess whether MCOs are meeting their contractual requirements to have adequate audit plans, sufficient program integrity policies and procedures, and complete reporting on program integrity outcomes. In addition, the unit should examine the outcomes of MCO audits to determine if they are meeting their planned audit goals and if their activities are adequately minimizing improper payments. The results of this review should be documented and provided to the Health Care Services Division.

Recommendation (20). The Department of Medical Assistance Services should take necessary steps to ensure that all requirements of the managed care contract regarding program integrity planning and reporting are fulfilled by each of the managed care organizations. The Health Care Services Division should use information provided by the Program Integrity Division to annually evaluate the adequacy of the managed care organizations' efforts to prevent, detect and recover improper payments within their networks and make all needed adjustments to contractual requirements.

Recommendation (21). The Department of Medical Assistance Services should formally evaluate the benefits of using their External Quality Review Organization to periodically assess the degree to which managed care organizations comply with contractual requirements regarding program integrity planning, executing, and reporting.

DMAS OVERSIGHT OF MCO EXPENDITURE DATA IS INSUFFICIENT TO ENSURE IMPROPER PAYMENTS DO NOT INFLATE CAPITATED RATES

In addition to overseeing MCO program integrity activities, DMAS also has to ensure that the data MCOs submit are accurate and complete. Capitated rates could be inflated if MCOs do not detect or recover all improper payments from their providers, as discussed above, but also if they purposefully or inadvertently submit inaccurate expenditure data to DMAS. Despite the importance of using complete and accurate data for setting rates, DMAS has performed little validation of the expenditure data submitted by

MCOs received \$2 billion in capitation payments in FY 2009 that were based largely on expenditure data that had not been independently verified by DMAS.

MCOs. While MCO data submitted for reporting purposes, known as “encounter data,” are rigorously processed by DMAS for potential errors, data submitted for rate setting are only minimally reviewed for reasonableness by DMAS’ actuary. As a result, MCOs received \$2 billion in capitation payments in FY 2011 that were based largely on expenditure data that had not been independently verified by DMAS. The lack of consistent validation and auditing prevents an assessment of the magnitude of improper payments in rate-setting data. Nonetheless, evidence suggests that greater oversight of this data is warranted. As previously discussed in this chapter, DMAS’ oversight of MCO program integrity activities has not provided sufficient assurance that these data do not contain improper payments. Moreover, discrepancies between rate-setting data and encounter data, and problems identified during prior audits of managed care data, suggest that MCO data used to set rates may not be as accurate as should reasonably be expected.

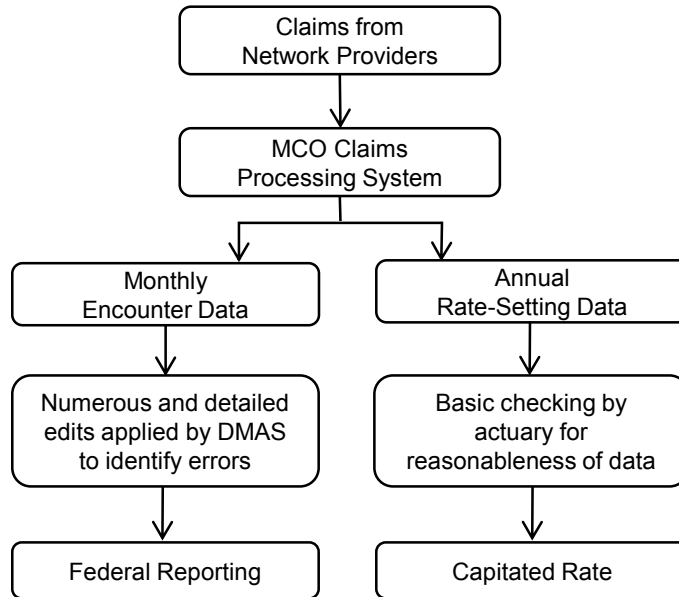
MCOs Submit Separate Data for Rate-Setting and Reporting Purposes

In calendar year 2010, MCOs submitted data for over 20 million claims they paid to network providers, a volume which was roughly comparable to the 28 million fee-for-service claims DMAS processed in FY 2009. These data were submitted by MCOs in two different formats and were used for two different purposes: setting rates and reporting to the federal government. The process used by MCOs to process and report data to DMAS is illustrated in Figure 11. Although MCOs must submit claims data, they are not directly reimbursed for their claims expenditures. Instead, this information is used by State and federal governments to monitor the utilization and cost of managed care services.

As seen in the figure, MCOs receive claims from providers in their network, which account for the vast majority of their expenditures, and process these claims using their claims processing systems. Like DMAS’ Medicaid Management Information System (MMIS), these systems are designed to identify problems and prevent payment for unauthorized or inappropriate services. Once MCOs pay these claims, the data is submitted to DMAS and its actuary in two different formats:

- “Encounter” data are submitted to DMAS on at least a monthly basis and edits are applied by MMIS to assess the validity of the data. Edits are designed to detect problems such as missing or invalid diagnoses and procedure codes. Encounter data are more detailed than rate-setting data and must be reported to the federal government.

Figure 11: Managed Care Organizations Submit Separate Claims Data for Federal Reporting and Rate Setting



Source: JLARC staff interpretation of *Medallion II Data Book and Capitation Rates, Encounter Data Submission Manual for Managed Care Organizations*, and interviews with MCO and DMAS staff.

MCOs Have Various Payment Arrangements With Their Network Providers

Some providers in an MCO network are compensated on a fee-for-service basis and others are compensated using a sub-capitated rate. In Virginia, the vast majority of managed care services are paid under a fee-for-service arrangement.

- Rate-setting data are submitted to DMAS' actuary on a yearly basis. The actuary performs certain basic checks before using the data to set rates.

In addition to claims data, MCOs also submit information about subcontractor and administrative costs to DMAS' actuary. Under the direction of DMAS' Provider Reimbursement Division, the actuary analyzes the claims, subcontractor, and administrative cost data and uses it to develop capitated rates for the following year (the contract period).

Magnitude of Improper Payments in Rate-Setting Data Is Unknown, but Concerns Exist

Because DMAS does not systematically process and audit managed care expenditure data for errors and potential abuse, it is difficult to assess the magnitude of improper payments in the data used to set rates. Nonetheless, discrepancies between the rate-setting and encounter data raise concerns about the accuracy of either or both datasets and, in turn, the rates paid to MCOs. Furthermore, the outcomes of several audits indicate that when DMAS has audited this data, problems have been identified.

System Edits

MMIS applies a series of automated reviews to each claim to ensure that claims comply with Medicaid policies and rules and are only submitted for valid recipients. If a claim is blocked by an edit, the system will generate an error message and the problem will have to be reviewed or corrected.

Rate-Setting Data Are Not Systematically Processed by DMAS to Detect Errors.

After MCOs submit encounter data to DMAS, the data are processed and edited by MMIS in much the same way as DMAS processes fee-for-service claims (Figure 11). Specifically, MMIS applies over 500 automatic checks (“edits”) to encounter data that are designed to detect problems such as missing or invalid procedure or diagnoses codes. They are also used to detect more complex billing irregularities, such as procedure or diagnoses codes that are inappropriate based on the recipient’s gender or age.

DMAS has designated a subset of 153 crucial MMIS edits as “fatal errors,” meaning that encounter data which fail to pass the edits should be corrected by the MCOs. Examples of fatal errors include

- enrollees who were not eligible on the date of service,
- diagnoses that do not agree with the age or sex of the recipient,
- primary diagnosis code that is invalid or missing,
- procedure code that is invalid or missing,
- enrollee identification that is invalid or missing, and
- zip code or location that is invalid.

In calendar year 2010, MMIS detected fatal errors in over six percent of the individual encounters, which is equivalent to 1.3 million encounters.

DMAS staff noted that not all MMIS edits are appropriate for use with managed care claims, in part because these edits were initially designed to process fee-for-service claims and are not always applicable to managed care encounters. Staff explained that there are “many identified but outstanding systems issues that presently lack resources and time to fix.” Consequently, not all fatal errors indicate claims that should not have been paid by the MCO. Still, fatal edits were designed to identify situations where there is insufficient information for DMAS to pay a claim. This raises concerns about the accuracy or completeness of the claims data submitted to the actuary for rate-setting purposes, which are not subject to any such edits.

In contrast, the State’s actuary applies a small number of basic checks to the annual rate-setting data, such as making sure that recipients were enrolled in managed care and eligible for Medicaid on the date of service. The actuary also compares aggregate data with prior data submissions to identify inconsistencies. While useful, these checks are less extensive than MMIS edits. In addition, according to the Office of Management and Budget, when MCO data is not subjected to MMIS edits, but rather validated by an out-

side source such as the actuary, “the eligibility checking may not be as intense as that done within MMIS.” As a result, rates may be based on inaccurate or incomplete data, and could be overstated with the costs of inappropriate services, such as those that could be detected by MMIS edits.

Discrepancies Between Rate-Setting and Encounter Data Raise Concerns About the Accuracy of Rates. Because rate-setting and encounter data both come from the same MCO claims processing systems, there should theoretically be no difference between the two. However, DMAS has expressed concerns about discrepancies between the two datasets. On multiple occasions, DMAS staff have identified problems when attempting to reconcile the two types of data. For example, DMAS has found differences in the *aggregate* dollar amounts reported in the claims submitted to the actuary versus the encounter data processed through MMIS:

- In FY 2008, pharmacy claim amounts submitted to the actuary were 4.7 percent, or \$11.6 million, higher than encounter data claim amounts.
- During the last six months of FY 2010, the dollar amount of claims submitted to the actuary by one MCO were 8.0 percent higher than their encounter data claims.

In addition, when DMAS has tried to match *individual* claims in the two datasets, they have found even greater discrepancies:

- Twelve percent of the FY 2008 pharmacy claims submitted to the actuary could not be matched to individual claims in the encounter data.
- For the MCO reviewed in FY 2010, only 36 percent of claims submitted to the actuary had matching individual claims in the encounter data.

DMAS staff noted that they do not fully understand the causes of the discrepancies and, consequently, do not know which data are more accurate. MCOs could be over- or under-reporting claims in either set of data, or the discrepancies could result from the different ways in which rate-setting and encounter data are formatted and processed by MCOs and DMAS. DMAS staff noted that a lack of unique claim numbers has likely limited their ability to match claims in both datasets. As a result, they recently asked MCOs to include a unique claim number for all encounter claims submitted. Although resolving this problem is unlikely to eliminate all discrepancies, it will help DMAS to pinpoint and resolve the source of some issues. Nevertheless, the discrepancies are concerning be-

cause DMAS does not know which data are more accurate for setting rates or other purposes.

DMAS staff report that their use of an alternative set of data for setting capitated rates does not violate CMS's requirement that rates must be actuarially sound. States must submit their rate-setting methodology and rates to CMS for review and approval and an actuary must certify that the rates are sound. These requirements help ensure that Medicaid spending for managed care is appropriate.

However, meeting these requirements does not ensure that the data used to set rates is accurate or complete. While actuaries are expected to review the data for reasonableness, as is the case in Virginia, they are not responsible for ensuring the accuracy and completeness of the data. In fact, DMAS' actuary noted that they "performed no independent verification and take no responsibility as to the accuracy of these data." Further, CMS focuses on the appropriateness of the data for rate setting rather than its quality or reliability. As stated by a Government Accountability Office report in 2010, "with limited information on the quality of data used to set rates, CMS cannot ensure that states' managed care rates are appropriate and risks misspending billions of federal and state dollars." The report also noted that states have "the primary responsibility for ensuring the quality of the data used to set rates."

Rate-Setting Data Do Not Include Information Necessary to Ensure the State Receives Credit for All Funds Recovered by MCOs. Compared to the claims data submitted for rate setting, encounter data are submitted on a monthly rather than a yearly basis and contain more detailed information. In addition, if a claim is subsequently adjusted for any reason, a new encounter reflecting the adjusted claim must be submitted to DMAS. MCOs adjust claim amounts for a variety of reasons, such as when an improper payment is recovered from a provider. Therefore, a single claim could be in the encounter data submitted to DMAS in multiple months and for different amounts. By contrast, claims submitted to the actuary are "final adjudicated" claims, meaning they reflect the final amount paid by the MCO to their network providers for the contract year, net of any adjustments.

As discussed previously in this report, MCOs that recover improper payments from providers or third party insurance payments should reduce the expenditures reported in their claims data to reflect these collections. If this does not occur, capitated rates will be based on overstated expenditures. In response to a JLARC staff request, four MCOs reported that improper payments and third party liability payments in excess of \$6.2 million were collected in

FY 2010. The MCOs also reported that claims were adjusted to remove these amounts from expenditure data (Table 12).

Table 12: Four MCOs Reported Reducing FY 2010 Claims by a Total of \$6.2 Million to Reflect Collected Improper Payments

	Claims Adjustments	Total Claims Expenditures	Percentage of Claims
MCO #1	\$1,410,834	\$55,717,090	2.5%
MCO #2	1,240,439	489,574,039	0.3
MCO #3	322,098	53,240,666	0.6
MCO #4 ^a	n/a	318,763,788	n/a
MCO #5	3,258,800	352,726,288	0.9
TOTAL	\$6,232,172	\$1,270,021,870	0.5%

^a Unable to provide JLARC staff with any dollar amounts for claims adjustments.

Source: JLARC staff analysis of MCO data on claims adjustments.

Although MCOs indicate that they reduce expenditure data for those improper payments that they collect from providers and for third party insurance payments, DMAS cannot effectively ensure that this occurs. Because the claims data used by the actuary to set rates reflect the MCOs' final payments, net any adjustments, the data do not contain sufficient detail to allow DMAS to assess whether they are receiving credit for all MCO recoveries. In other words, DMAS cannot validate that the \$6 million that MCOs indicated they collected in 2010 has been backed out of the data they submitted for setting rates. If the rate-setting data contained information on adjustments made to claims, that information could be compared to recovered amounts reported by MCOs, as well as MCOs' audited financial data, to make sure all amounts match.

DMAS staff also report concerns about the degree to which MCOs accurately report recovered amounts. Beginning with the most recent rate-setting process, DMAS requested additional information about the amounts MCOs have collected from providers and third party insurers. DMAS concluded that they "believe the amounts reported by the MCOs are understated, but that accurate amounts would still be immaterial." However, without additional auditing it appears that DMAS cannot know the extent to which these amounts are understated, and if they actually are immaterial.

Previous Audits Suggest Managed Care Data Are Not Always Accurate. DMAS has not consistently audited data submitted by MCOs. Nonetheless, when DMAS has conducted audits, these have revealed a number of concerns about the accuracy of managed care expenditure data.

From 2005 to 2007, DMAS contracted with Thomson Reuters to validate the encounter data submitted by MCOs. The audit found

that MCOs were not adequately testing or editing the data they received from subcontractors to ensure its completeness. It found that none of the MCOs performed detailed edits on claims data submitted by subcontractors, and concluded that this data “should be a primary focus for data quality improvement efforts.” As a result of that audit, DMAS added a contractual requirement for MCOs to apply system edits to subcontractor data. In addition, the “Encounter Data Submission Manual” states that each MCO is responsible for verifying the accuracy of its subcontractor data, “particularly with respect to those edits it would apply if the data were received directly from the provider rather than through a subcontractor.”

However, it appears that instead of applying comprehensive system edits to validate the accuracy and completeness of the data, MCOs primarily check that the data is in the proper format and that key fields are not missing. Staff at one MCO reported to JLARC staff that their subcontractor data is simply passed along to DMAS without validation, and staff at two MCOs noted that providers receiving capitated payments do not always have an incentive to report complete encounter data to the MCO because it does not affect their payments. DMAS staff indicated that they have not reviewed MCO compliance with the contractual requirement. As a result, no entity is rigorously checking the validity or completeness of the subcontractor data.

Incomplete data on services provided by subcontractors limits the ability of MCOs and DMAS to assess the reasonableness of the rates paid to those subcontractors. While DMAS staff report that their actuary reviews encounter level data for all of the major categories of subcontracted services, the actuary noted that they “cannot confirm that all encounters are reported and measures such as utilization rates and cost per unit for these services may not be accurate.” DMAS staff noted that because they use MCOs’ capitated payments rather than paid claims as the basis for setting rates, incomplete encounter data does not impact rates. However, absent complete records about subcontractor services, DMAS cannot adequately assess the reasonableness of MCOs’ subcontracted rates.

Outcomes from a more recent review by DMAS Internal Audit Division of the non-emergency transportation contractor, LogistiCare, also exposed problems with encounter data. Like MCOs, LogistiCare is paid on a capitated basis and must submit encounter data for transportation services that were provided. When DMAS audited LogistiCare in 2010, it found instances of incomplete and inaccurate data, missing data, and duplicate data. The review also found that LogistiCare staff did not always detect errors or abnormal billing patterns.

Audits have also revealed problems with managed care expenditure data. In fiscal years 2006 and 2007, DMAS hired a contractor to audit administrative costs reported by MCOs to the Bureau of Insurance (BOI) because that data was being used by DMAS to set rates. The contractor found that the data contained between \$4.5 and \$13.3 million in administrative expenses that were not allowable for the purposes of Medicaid rate setting, including lobbying expenses and charitable contributions. This led DMAS staff to adjust the administrative factor used during rate setting. The LogistiCare audit found similar concerns in how administrative costs were reported. The audit recommended that DMAS perform an annual review of the contractor's financial records to ensure all income and expenses are reported and classified correctly.

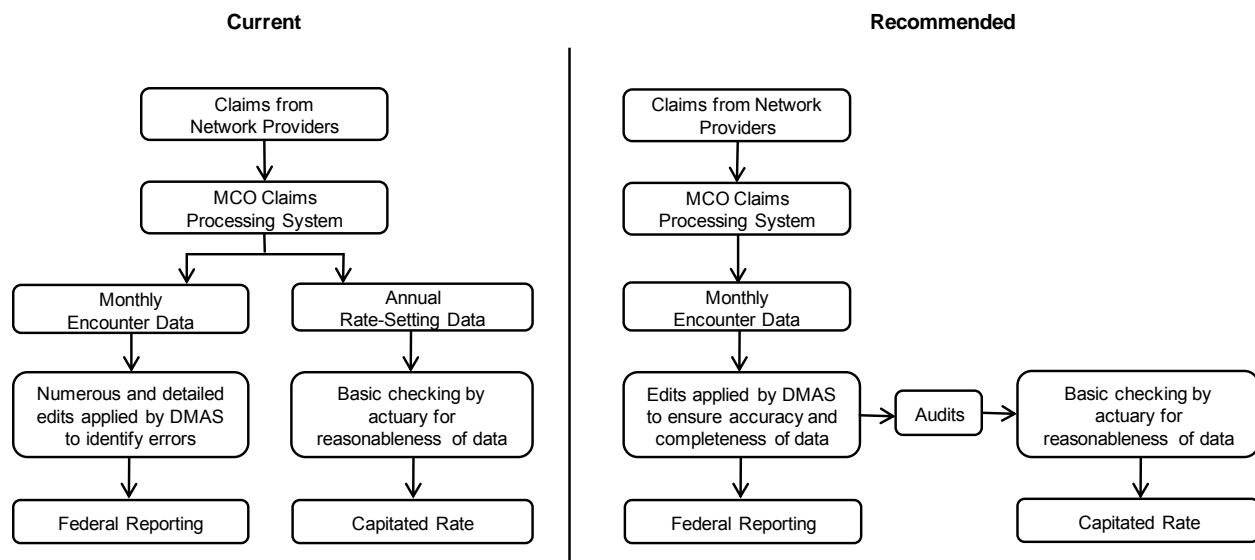
Recommendation (22). The Department of Medical Assistance Services should enforce contractual requirements for managed care organizations, including the requirement to apply key edits to subcontractor data to ensure accuracy and completeness.

Managed Care Data Used to Set Rates Should Be Subjected to More Rigorous Review and Audited to Prevent Improper Payments

Concerns about the accuracy of expenditure data used to set rates suggest that greater oversight is warranted. Figure 12 outlines one approach that could be used to validate the accuracy and completeness of MCO claims data. As shown, the recommended approach differs from the current approach in that monthly encounter data submitted by MCOs would be edited and audited for accuracy and completeness before being used to set rates. Other expenditure data submitted by MCOs, including administrative and subcontractor costs, should also be audited periodically before being used to set rates.

Data Used to Set Rates Should Be Systematically Processed for Errors. The use of system edits, as presently applied only to encounter data, can detect a variety of problems. Basic and complex system edits were recommended in the 2000 *Guidelines* published by HCFA as a means of detecting and preventing fraud and abuse in managed care. According to the *Guidelines*, system edits can be used in conjunction with other strategies to ensure data completeness, such as a comparison of data across plans and to national data, client surveys, quality improvement studies, and medical record reviews (discussed below). When used effectively, edits can prevent rates from being set on inaccurate, incomplete, or inappropriate payments.

Figure 12: MCO Encounter Data Should Be Edited for Accuracy and Completeness, Audited, and Used to Set Rates



Source: JLARC staff interpretation of *Medallion II Data Book and Capitation Rates*, *Encounter Data Submission Manual for Managed Care Organizations*, and interviews with MCO and DMAS staff.

While system edits can help ensure the validity and completeness of encounter data, the purpose and effectiveness of MMIS edits as currently applied is unclear. First, rate-setting data are not subject to these edits, in part due to DMAS' concerns about the accuracy and appropriateness of MMIS edits that were originally designed to verify fee-for-service data. Second, DMAS is not effectively utilizing "fatal errors" to identify problems which must be corrected by MCOs. HCFA's guidelines recommend that encounters which do not pass system edits should be rejected by the Medicaid agency and corrected by the MCOs. According to the MCO contract, encounter data submissions that have a five percent fatal error rate will be rejected by DMAS and should be corrected by the MCOs. However, DMAS staff report that they no longer have the system capability to reject encounter submissions that contain too many fatal errors. DMAS should fix MMIS edits or design an alternative system to process and verify MCO encounter data.

Encounter Data Should Be Used to Set Rates and Monitor Utilization. The use of separate data for setting rates has likely reduced the incentive for MCOs and DMAS to make necessary improvements to encounter data. As stated by both Thomson Reuters and DMAS staff, encounter data will only get better by being used. In their 2008 assessment of Virginia's encounter data, Thomson Reuters concluded that "MCOs need to understand that the data they submit to MMIS are used to make decisions about their performance and payment rates."

Out of 40 states that had capitated Medicaid managed care programs in 2009, Virginia was one of only seven that reported not using encounter data to set rates.

The use of encounter data to set rates is reportedly a common practice in other states. According to a U.S. Department of Health and Human Services Office of Inspector General report, out of 40 states that had capitated Medicaid managed care programs in 2009, Virginia was one of only seven that reported not using encounter data to set rates. The Office of Inspector General obtained this information through structured phone interviews with state Medicaid agency staff. The interviews focused on why states did or did not comply with requirements to submit encounter data to CMS and the extent to which states were using encounter data for rate-setting and other purposes.

During interviews with JLARC staff, DMAS staff acknowledged the need to improve encounter data accuracy in order to use these data to set rates. DMAS staff believe that utilizing one set of data as the basis for both rate setting and evaluating MCO performance will take several years and will require significant resources, including (1) DMAS encounter support staffing, (2) MCO process improvements and staffing for resolution of errors, and (3) systems resources to implement continuous fixes and enhancements. They have indicated that several options could be considered to resolve the current problems, but a consultant will be needed to identify the most efficient option.

Recommendation (23). The Department of Medical Assistance Services should develop a plan for using encounter data which has been edited for completeness and accuracy as the basis for setting capitated rates and other reporting purposes.

Managed Care Data Should Be Audited to Ensure Completeness and Accuracy. System edits are an efficient and necessary means of detecting potential problems with encounter data, but they are insufficient to ensure that MCOs are not over- or under-reporting claims costs to DMAS. To identify whether MCOs are reporting accurate and complete data, encounter data should be audited and compared to medical records by an independent party. This approach has been suggested by federal guidelines. For example, HCFA's *Guidelines* include the use of medical record reviews as a component of ensuring encounter data completeness, along with client surveys, comparison to national data, and external quality reviews.

Third-party studies, such as the EQRO reviews discussed earlier, can also be used to validate the accuracy of encounter data. In 2002, the Office of Management and Budget developed a protocol for validating encounter data through EQRO activities, which included a medical record review component. JLARC staff have also identified several states that include encounter data validation as a component of their required EQRO studies. These reviews have

identified a variety of concerns related to encounter data, including the submission by MCOs of data that are incomplete or inaccurate when compared to the medical records. In New Mexico, for example, the EQRO recommended that the “encounter data [used] for rate setting and policy development should be adjusted to reflect” the rates of over-reporting, under-reporting, and errors identified during the review.

Other information submitted by MCOs for use in rate setting, such as administrative costs, should also be periodically audited. These audits are needed to ensure that all expenditure data submitted by MCOs reflect appropriate costs that were actually incurred by the MCOs as part of their Medicaid program instead of another line of business. These audits can also be used to assess the extent to which amounts recovered by MCOs from providers or third-party payers are reflected in reductions in their claims data.

Since the 2010 JLARC report *Interim Report: Fraud and Error in Virginia’s Medicaid Program*, DMAS has taken an additional step to improve its oversight of MCO data. DMAS has begun requiring MCOs to submit a reconciliation of their submitted claims data with the financial statements submitted to the Bureau of Insurance. The objective of this requirement is to assess whether rate-setting data are consistent with expenditure data reported in their financial statements. While this provides a useful check on the accuracy of rate-setting data, it does not substitute for an audit because a comparison of claims data to financial statements does not demonstrate whether the services or expenditures were appropriate. Furthermore, although the Bureau of Insurance reviews these statements, bureau staff report that they do not independently compare the financial statements to original records to verify that reported expenditures and revenues actually occurred.

Recommendation (24). The Department of Medical Assistance Services should evaluate alternatives and select a process for managed care encounter data to be audited against medical records.

Recommendation (25). The Department of Medical Assistance Services should evaluate alternatives and select a process for how all managed care expenditure data used to set rates should be independently audited.

Comprehensive Changes Needed to Meaningfully Reduce the Risk of Improper Payments

In Summary

Many of the program integrity weaknesses identified in this report are widespread and span multiple divisions of DMAS and other agencies. Specifically, JLARC staff identified systemic concerns related to a lack of internal controls, inadequate information technology, limited analysis of data, insufficient coordination between divisions and agencies, and inadequate oversight of compliance with Medicaid policies. To meaningfully reduce the risk of improper payments, each of these concerns should be addressed as part of a comprehensive improvement plan that includes all agencies comprising the Medicaid system. Otherwise, program integrity gaps could persist that allow improper payments to be made. A special interagency task force appears needed to evaluate how to best address systemic concerns in a comprehensive manner across the entire Medicaid system.

Collectively, the findings in this report indicate that comprehensive changes are needed in several areas to adequately address program integrity weaknesses within Virginia's Medicaid system. Presently, these weaknesses may translate into improper payments, particularly with respect to eligibility determination errors that are estimated to have resulted in potentially unnecessary State general fund costs of between \$18 million and \$263 million in federal fiscal year 2009. Improvements in any single area will partially reduce the risk of improper payments, but changes must be comprehensive to close gaps in the program integrity process as a whole.

PROGRAM INTEGRITY IMPROVEMENTS ARE REQUIRED IN FIVE AREAS TO ADDRESS SYSTEMIC CONCERNS

Although State and local agencies identified improper payments of over \$31.6 million in FY 2010, there are still individual weaknesses in program integrity activities. To address them, recommendations have been presented throughout previous chapters. However, a review of individual weaknesses and recommendations reveals several recurring themes that warrant a more comprehensive approach. As shown in Exhibit 2, improvements are needed in five areas in order to address systemic concerns that often span multiple divisions in the Department of Medical Assistance Services (DMAS) and other agencies.

Exhibit 2: Addressing Systemic Concerns in Medicaid Program Integrity Activities Requires Improvements in Five Areas

1. Additional internal controls of program integrity activities are needed to ensure accountability and effectiveness.
2. New information technology and data are needed to improve internal controls and increase performance measurement.
3. The Departments of Medical Assistance Services (DMAS) and Social Services (DSS) need to increase the use of data analysis to measure operational effectiveness and efficiency.
4. Improved coordination is needed to enable a more systematic approach to program integrity.
5. DSS and DMAS need to improve oversight of local departments and MCOs to ensure compliance with Medicaid policies.

Source: JLARC staff.

Additional Internal Controls of Program Integrity Activities Are Needed to Ensure Accountability and Effectiveness

Generally speaking, internal controls are intended to ensure accountability, increase operational effectiveness, and improve efficiency. In the context of program integrity, internal controls take the form of plans, policies, procedures, and data that allow management to assess the outcomes of audits and other reviews. Robust internal controls also help agencies respond to changing priorities and resources. As agencies modify organizational practices and goals, management must continually assess and evaluate its internal controls to ensure they remain effective.

This report has identified several areas within DMAS' Program Integrity Division (PID) in which improvements to internal controls are needed to ensure the risk of improper payments is minimized. Specifically, PID needs enhanced controls to ensure

- all referrals of potential error and fraud received by PID are investigated in a timely manner,
- all audits follow a risk-based methodology that is adjusted over time,
- responsibility for investigating and auditing all provider types with a high risk of improper payments is assigned to a specific unit,
- all investigations and audits are assessed for potential referral for prosecution,

- all cases referred to the Medicaid Fraud Control Unit (MFCU), and all audits with improper payment amounts that are forwarded to the Fiscal Division for collection, contain a unique identifier that can be used to share information between the two units, and
- all cases referred to the Fiscal Division are tracked such that PID can ensure collections are initiated on all improper payments identified by PID.

New Information Technology and Data Are Needed to Address Control Weaknesses and Increase Performance Measurement

Internal controls are intended to clarify responsibilities and provide a defined set of criteria for assessing performance relative to operational goals and requirements. However, successful implementation of these controls often depends upon the availability of information technology (IT) systems that generate the data needed to gauge performance relative to the defined controls. This report has identified several areas in which efforts to reduce improper payments have been hindered by inadequate IT, including areas in which existing systems lack needed controls and the absence of needed performance and outcome data. In particular, some of the verification and caseload management systems could provide a relatively inexpensive means of quickly reducing eligibility errors, which create the greatest risk of improper payments for the State. IT improvements that are needed include

- successful implementation of the federally-funded eligibility system discussed in Chapter 2 which will verify information reported by Medicaid applicants, provide a consistent application process for all categories of Medicaid, and guide eligibility workers through each step of the application process;
- verification systems that improve the ability of eligibility workers to verify income and real property assets, and case management systems that allow local departments to track errors made by individual eligibility workers;
- new means of verifying data submitted by managed care organizations (MCO), either by fixing existing “edits” in DMAS’ Medicaid Management Information System or development of an alternative system; and
- improvements to the accounts receivable system to allow for more effective analysis of collection rates.

DMAS and DSS Need to Use Additional Data Analysis to Measure Effectiveness and Efficiency of Program Integrity Activities

The usefulness of internal controls and IT systems is somewhat limited unless the resulting data are analyzed to assess and im-

prove performance. In many cases, State agencies generate data but do not analyze them in order to assess operational effectiveness and efficiency. In particular, this review has identified several areas in which DMAS should expand the use of data analysis, including the

- calculation of accurate collection rates to assess the effectiveness of audit activities,
- analysis of audit outcomes, including the outcomes of the appeals process, to identify opportunities to improve the audit process,
- evaluation of a return on investment from audits to assess the performance of contract auditors, and
- review of providers terminated from MCO networks to identify providers in the fee-for-service program that may present a risk of improper payments.

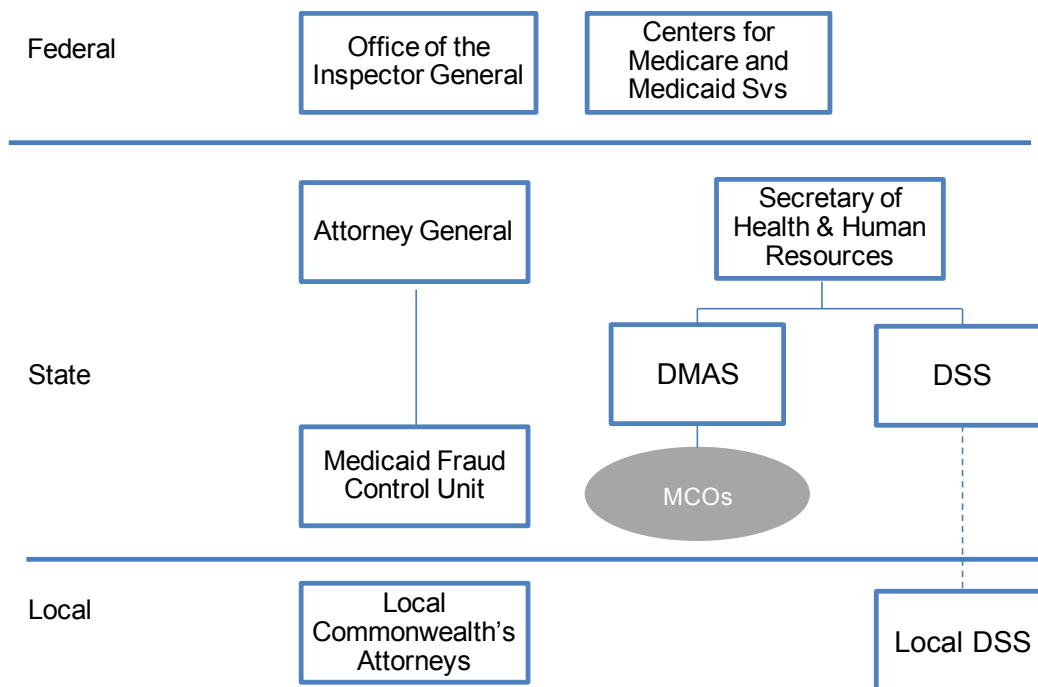
Improved Coordination Is Needed to Address Program Integrity Across the Medicaid System Rather Than Within Single Agencies

In Virginia, Medicaid program integrity activities and responsibilities are dispersed through different units and divisions within DMAS, DSS, local departments of social services, the MFCU, and Commonwealth's Attorneys (Figure 13). Improved coordination between these entities is needed to ensure effectiveness and to fully capitalize upon improvements made in any one area of the program integrity process.

However, coordination between agencies is only loosely directed by language in various interagency agreements, the DSS Medicaid manual, and various State and federal statutes and regulations. This fragmented approach diminishes the ability of these agencies to coordinate their activities, thereby limiting the effectiveness of any systematic effort to reduce fraud and error. This review has identified several opportunities for improved coordination:

- DMAS should improve the coordination of MCO lock-in programs with each other, and with the fee-for-service program.
- Divisions within DMAS should strengthen their coordination to more fully utilize information obtained during the provider enrollment process to reduce improper payment risks.
- DMAS and DSS should address concerns identified by local departments regarding the need for more formal avenues of communication with DMAS, the establishment of standards for the content and review of cases that are referred, and a reevaluation of the recipient fraud responsibilities assigned to each agency.

Figure 13: Responsibility for Medicaid Program Integrity Is Dispersed Among Many Agencies and Levels of Government



Source: JLARC staff analysis of statutory and regulatory responsibilities.

DSS and DMAS Need to Improve Oversight of Local Departments and MCOs to Ensure Compliance With Medicaid Policies

Coordination is necessary to ensure operational effectiveness when organizations engage in similar activities. This is often the case when similar activities are conducted by peer agencies, such as DSS and DMAS. Both DSS and DMAS have respective oversight responsibilities which should be better fulfilled in order to strengthen program integrity. As this report indicates, improper payments often result from a failure of agencies to enforce compliance with Medicaid policies, including eligibility standards and MCO contract provisions.

To some degree, the improper payments resulting from eligibility determination errors result from the lack of direct oversight by DMAS over local departments, and the inability of DMAS to ensure DSS oversees local departments. And though DSS is statutorily required to oversee local departments, in a 2005 report, *Operation and Performance of Virginia's Social Services System*, JLARC observed that statute does not identify specific supervisory responsibilities for DSS over local departments. Despite this lack of specificity, DSS is the only organization that can evaluate and oversee local department activities on an ongoing basis. To ensure that lo-

cal departments fulfill their role in the Medicaid program integrity process, DSS should use its existing authority by

- increasing the frequency and scope of its reviews of local eligibility decisions,
- identifying systemic issues that occur in more than one local department and take appropriate corrective action, such as improved training, to ensure these issues are corrected statewide, and
- ensuring that its reviews of local departments use a statistically significant sample of cases to determine eligibility error rates in order to ensure that variation in error rates between local departments is reliably measured and addressed.

In contrast to DSS, which lacks a clear means of enforcing compliance with its oversight responsibilities, DMAS is the contracting authority with Medicaid MCOs. As a result, DMAS should exercise the degree of oversight needed to ensure compliance with contractual requirements and other Medicaid policies. Specifically, DMAS should enforce all requirements of the managed care contract regarding program integrity planning and reporting, and evaluate this information to assess the effectiveness of their efforts. To this end, DMAS should consistently

- enforce requirements that MCOs adequately process and edit subcontractor data for completeness and accuracy, and
- hold MCOs accountable for the completeness and accuracy of the expenditure data they report for setting rates by comprehensively processing and auditing that data to detect potential errors and over-reporting.

To meaningfully minimize the risk of improper payments, each of these five areas of concern should be addressed in a comprehensive manner. Improvements should be made to the program integrity activities of the Medicaid system as a whole, otherwise gaps could persist that allow improper payments to go undetected.

ADDITIONAL RESOURCES AND INTERAGENCY PLANNING APPEAR NEEDED TO ADDRESS SYSTEMIC ISSUES

Although the State's program integrity activities have successfully identified a reasonable amount of improper payments, the findings presented in this report indicate that weaknesses spanning the Medicaid system should be addressed in order to further reduce the risk of improper payments. The dispersed nature of this risk was noted by the Auditor of Public Accounts (APA) in a 2005 audit of DMAS. The APA concluded that a substantial control risk exists because no single agency has the ability to plan or implement

changes in administration or policy across the entire Medicaid system. The audit added that neither DMAS nor DSS “believe that they have the authority or the ability to hold the local departments of social services financially accountable for not performing.” This lack of authority appears to hinder the successful pursuit of program integrity activities, including efforts to reduce Medicaid eligibility error and recipient-related fraud. Moreover, this control risk may be heightened as a result of the increase in Medicaid enrollment expected to result from health care reform.

Special Interagency Task Force Could Evaluate Comprehensive Solutions

Because of the systemic nature of the concerns, and the apparent need for cross-agency changes, a special interagency task force may be the most appropriate means of evaluating the comprehensive solutions that appear needed and developing an appropriate plan. In particular, the task force should review specific recommendations in this report pertaining to the use of new IT systems and data to track errors made by individual caseworkers and local departments and provide caseworkers with access to more complete and timely information (Recommendations 1 and 2). The task force should also work in concert with the permanent body that is recommended as a means of continuously evaluating ways to reduce the eligibility error rate (Recommendation 3). Consideration should also be given to the nature and scope of responsibilities for the investigation of Medicaid recipient fraud and error, including an identification of potential options for a realignment of responsibilities between DMAS, DSS, and local departments (Recommendation 5). The use of an administrative disqualification hearing process should also be assessed (Recommendation 6). As part of this evaluation, a plan should be developed that addresses both short- and long-term needs.

Investment of Additional Resources Could Prevent Future Improper Payments

In addition, the task force should determine whether the existing program integrity resources within DMAS, DSS, and local departments of social services are adequate to address the recommendations in this report and to fully mitigate the risk of improper payments. Presently, data are not sufficient to determine the precise extent to which additional resources may be needed, but it appears that a modest investment in additional staff or IT resources may allow the State to prevent a much larger amount of improper payments by implementing a more accurate eligibility determination system. If additional resources are given, however, some measure of the return on investment or other performance measures should be used to assess the effectiveness and efficiency of the resources.

Recommendation (26). The General Assembly may wish to consider establishing a special interagency task force to examine some of the recommendations in this report, other relevant issues, and the potential effects of health care reform upon the fiscal integrity of the Medicaid program as it relates to improper payments. The task force should be chaired by the Secretary of Health and Human Resources, and include the Director of the Department of Medical Assistance Services, the Commissioner of the Department of Social Services, two members each of the State Boards of Social Services and Medical Assistance Services, five directors of local departments of social services, and the Auditor of Public Accounts. The General Assembly may wish to consider requiring the task force to develop a comprehensive improvement plan to address the changes needed, with mechanisms to guide and measure its progress over successive administrations. The General Assembly may also wish to require the task force to present a comprehensive improvement plan to the Senate Finance and Rehabilitation and Social Services Committees, and the House Appropriations and Health, Welfare, and Institutions Committees, prior to the 2013 General Assembly session.

JLARC Recommendations:

Minimizing the Risk of Improper Payments in the Virginia Medicaid Program

1. The Departments of Social Services (DSS) and Medical Assistance Services (DMAS) should identify and report the costs, benefits, and feasibility of expanding the Rushmore cases tracking system to the Medicaid program in order to allow local departments of social services to utilize its case management and oversight functions. DSS and DMAS should report to the House Appropriations and Senate Finance Committees before the start of the 2013 General Assembly Session on their conclusion. If the results indicate that Medicaid eligibility errors could be cost-effectively reduced, DSS or DMAS should request funding for the expansion of this system to the Medicaid program. (p. 25)
2. The Department of Social Services (DSS) should develop and implement automated systems that allow caseworkers at local departments of social services to verify the financial and real property assets of Medicaid applicants, including records maintained by Virginia Circuit Courts. DSS should report to the House Appropriations and Senate Finance Committees before the start of the 2013 General Assembly Session on the cost and status of these systems. (p. 26)
3. The Departments of Medical Assistance Services and Social Services should continue to evaluate means to reduce the Medicaid eligibility error rate, and annually report their findings to the Senate Finance and Rehabilitation and Social Services Committees, and the House Appropriations and Health, Welfare, and Institutions Committees. (p. 26)
4. The Department of Medical Assistance Services should develop process and policy changes to increase coordination between the department's Client Medical Management program and the recipient utilization monitoring programs administered by the Medicaid managed care organizations. Policy changes should focus on (1) increasing consistency of standards used to define appropriate levels of service utilization, and (2) ensuring recipients' utilization of medical services is subject to continued oversight when switching from the fee-for-service to managed care program or from one managed care organization to another. (p. 32)
5. The Departments of Medical Assistance Services (DMAS) and Social Services should reconsider the nature and scope of re-

sponsibilities for the investigation of recipient fraud and error in public assistance programs assigned to DMAS and local departments of social services, and determine whether a realignment of responsibilities would more effectively promote the investigation of Medicaid recipient fraud and error. (p. 34)

6. The Departments of Medical Assistance Services (DMAS) and Social Services (DSS) should evaluate whether the implementation of an administrative disqualification hearing process would increase the State's ability to disqualify individuals from Medicaid who have committed fraud but who would otherwise not be prosecuted. This evaluation should include an assessment of the potential financial resources needed to implement this process, and a determination regarding whether this process is permitted by federal and State laws and regulations. If the results indicate that additional individuals could be cost-effectively disqualified, DSS or DMAS should request funding for use of the administrative disqualification hearing process in the Medicaid program. (p. 39)
7. The Department of Medical Assistance Services (DMAS) should revise future contracts with managed care organizations (MCOs) starting in FY 2013 to require MCOs to report data on providers terminated from their networks on at least a quarterly basis. Data should include the provider name, unique identification number, and reason for termination. DMAS should use this information to identify providers that should not be enrolled in the fee-for-service program or that may pose a risk to the program. (p. 48)
8. The Department of Medical Assistance Services (DMAS) should establish policies for ensuring that information collected as part of the fee-for-service provider enrollment and managed care credentialing and termination processes are shared among all DMAS divisions responsible for program integrity activities. Information obtained during the enrollment or termination processes should be used to identify potentially high-risk providers for further scrutiny, which could include intensified claims reviews, audits, site visits, or education. (p. 48)
9. The Department of Medical Assistance Services (DMAS) should evaluate the implementation of a pre-payment audit process for those services, individual providers, and provider types that present a high risk of improper payments. This evaluation should include a determination of the resources necessary to perform these activities and their potential benefits, and whether any statutory changes, such as an exemption from the Virginia Public Procurement Act, are required. DMAS should report the results of its evaluation to the House Appropriation and Senate Finance Committees before the start of the 2013 General Assembly Session. If the results indicate that improper

payments could be cost-effectively reduced, DMAS should request any funding or statutory changes needed to implement pre-payment audits. (p. 50)

10. The Department of Medical Assistance Services Program Integrity Division should create a central audit plan, based on the current risk-based Provider Review Unit audit plan, which addresses the audit activities of all contracted auditors as well as all units within the Program Integrity Division in order to coordinate all audit activities. This plan should include a discussion of the number of audits to be conducted per provider type and an explanation of how any factors other than the risk score modify the number of planned audits indicated by the risk score alone. (p. 60)
11. The Program Integrity Division of the Department of Medical Assistance Services should include in the annual audit plan a formal assessment of whether actual audits met, fell short of, or exceeded planned audit goals for the previous year. This assessment should document the reasons for deviation from planned audits, evaluate the effect of these deviations, and indicate whether these deviations necessitate a change in audit activities to better meet audit goals or an adjustment of planned audit goals to better reflect the goals of the division. (p. 63)
12. The Program Integrity Division of the Department of Medical Assistance Services should institute a formal mechanism for tracking the disposition of all referrals to ensure that they are evaluated consistently and that appropriate action is taken. (p. 64)
13. The Program Integrity Division of the Department of Medical Assistance Services should create a mechanism for tracking all identified improper payment reductions due to retractions that occur during the reconsideration and appeals stages, including the reasons for those retractions. This information should be utilized to identify any shortcomings in contractor or staff auditing practices, as well as agency policies, and to guide the implementation of any needed corrective action. (p. 67)
14. The Program Integrity Division of the Department of Medical Assistance Services should assess the return on investment for all contract and staff audit resources as part of a centralized audit plan to evaluate whether existing resources are being used efficiently and effectively so as to identify the maximum amount of improper payments. In order to calculate returns effectively, the division should track staff hours spent on each audit and redesign their contracts with outside auditors to enable calculation of the average cost of each type of audit. To ensure accurate representation of identified overpayments, this

return on investment should be based on audit results after all appeals have concluded. (p. 69)

15. The Program Integrity Division of the Department of Medical Assistance Services should institute a formal, documented mechanism of evaluating the outcomes of all staff and contractor audits to determine if potential fraud exists and ensure that all cases of potential fraud are referred to the Medicaid Fraud Control Unit. (p. 71)
16. The Department of Medical Assistance Services (DMAS) and the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General should develop a single unique identifier to be used by both agencies for each individual case. This unique case identifier should be used to track the status of referrals to the MFCU as well as to create invoices at DMAS for completed prosecutions. (p. 80)
17. The Department of Medical Assistance Services (DMAS) should develop and implement a plan to improve and standardize the process of sharing information about improper payments between divisions and agencies, and develop a process to track and review whether invoices are created for each identified improper payment. Representatives from DMAS's Fiscal and Program Integrity Divisions, other divisions within the agency, and the Medicaid Fraud Control Unit should work together to achieve these objectives. (p. 80)
18. The Department of Medical Assistance Services' Fiscal Division should collaborate with the agency's Program Integrity Division to identify information that should be captured in the accounts receivable system to readily calculate collection rates. Information that should be captured includes fields that identify the auditor, type of audit, and type of provider that was audited. Adjustment amounts due to appeals should also be clearly identified. (p. 81)
19. The Department of Medical Assistance Services should establish a unit within the Program Integrity Division to evaluate the program integrity activities of managed care organizations (MCOs). The new unit should, at a minimum, assess whether MCOs are meeting their contractual requirements to have adequate audit plans, sufficient program integrity policies and procedures, and complete reporting on program integrity outcomes. In addition, the unit should examine the outcomes of MCO audits to determine if they are meeting their planned audit goals and if their activities are adequately minimizing improper payments. The results of this review should be documented and provided to the Health Care Services Division. (p. 95)

20. The Department of Medical Assistance Services should take necessary steps to ensure that all requirements of the managed care contract regarding program integrity planning and reporting are fulfilled by each of the managed care organizations. The Health Care Services Division should use information provided by the Program Integrity Division to annually evaluate the adequacy of the managed care organizations' efforts to prevent, detect and recover improper payments within their networks and make all needed adjustments to contractual requirements. (p. 95)
21. The Department of Medical Assistance Services should formally evaluate the benefits of using their External Quality Review Organization to periodically assess the degree to which managed care organizations comply with contractual requirements regarding program integrity planning, executing, and reporting. (p. 95)
22. The Department of Medical Assistance Services should enforce contractual requirements for managed care organizations, including the requirement to apply key edits to subcontractor data to ensure accuracy and completeness. (p. 103)
23. The Department of Medical Assistance Services should develop a plan for using encounter data which has been edited for completeness and accuracy as the basis for setting capitated rates and other reporting purposes. (p. 105)
24. The Department of Medical Assistance Services should evaluate alternatives and select a process for managed care encounter data to be audited against medical records. (p. 106)
25. The Department of Medical Assistance Services should evaluate alternatives and select a process for how all managed care expenditure data used to set rates should be independently audited. (p. 106)
26. The General Assembly may wish to consider establishing a special interagency task force to examine some of the recommendations in this report, other relevant issues, and the potential effects of health care reform upon the fiscal integrity of the Medicaid program as it relates to improper payments. The task force should be chaired by the Secretary of Health and Human Resources, and include the Director of the Department of Medical Assistance Services, the Commissioner of the Department of Social Services, two members each of the State Boards of Social Services and Medical Assistance Services, five directors of local departments of social services, and the Auditor of Public Accounts. The General Assembly may wish to consider requiring the task force to develop a comprehensive improvement plan to address the changes needed, with mechanisms to guide and measure its progress over successive administrations. The

General Assembly may also wish to require the task force to present a comprehensive improvement plan to the Senate Finance and Rehabilitation and Social Services Committees, and the House Appropriations and Health, Welfare, and Institutions Committees, prior to the 2013 General Assembly session. (p. 114)

Study Mandate

HOUSE JOINT RESOLUTION NO. 127

Directing the Joint Legislative Audit and Review Commission to study the Commonwealth's Medical Assistance program to identify opportunities to reduce waste, inefficiency, fraud, and abuse. Report.

Agreed to by the House of Delegates, February 8, 2010

Agreed to by the Senate, March 2, 2010

WHEREAS, public officials have an obligation to the citizens of Virginia to use the Commonwealth's resources wisely and appropriately; and

WHEREAS, medical assistance expenditures through the state Medicaid program represent the second largest category of expenditures by the Commonwealth; and

WHEREAS, Virginia's state Medicaid program is already a narrowly defined program that adheres closely to federal requirements and limits additional spending; and

WHEREAS, in spite of the narrowly defined scope of Virginia's Medicaid program, state medical assistance costs continue to rise in response to growing demand and increasing health care costs; and

WHEREAS, while most health care providers are honest, dedicated individuals and institutions striving to improve health and health care and comply with the complex statutory and regulatory requirements of the state Medicaid program, the very nature of such statutory and regulatory requirements may create a situation in which errors in billing or payments to health care providers result in inefficiencies, inaccuracies, and wasted resources; and

WHEREAS, a few health care providers engage in fraudulent or abusive activities or allow such fraud or abuse to occur, further wasting resources and increasing costs; and

WHEREAS, good government should seek to increase accuracy and efficiency, and reduce regulatory barriers to services that bring about inefficiencies and inaccuracies and allow fraud and abuse, resulting in increased expenditures and waste of state resources; and

WHEREAS, identifying, investigating, and correcting inefficiencies, inaccuracies, fraud, and abuse can result in savings to the Commonwealth; and

WHEREAS, the Commonwealth's Medicaid fraud detection unit, which is located in the Office of the Attorney General, is nationally recognized for its success in identifying and pursuing cases of inaccuracies in, and fraud and abuse of, the state Medicaid program by

health care providers and has recently garnered significant attention for its success in halting fraudulent activities by pharmaceutical companies; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Legislative Audit and Review Commission be directed to study the Commonwealth's Medical Assistance program to identify opportunities to reduce waste, inefficiency, fraud, and abuse.

In conducting its study, the Joint Legislative Audit and Review Commission shall (i) study past or current evidence of waste and inefficiency in the state Medicaid program, and describe the nature and extent of such waste and inefficiency; (ii) study and describe the nature and scope of fraud or abuse of the state Medicaid program by beneficiaries, providers, suppliers, manufacturers, or others who receive benefits from the state Medicaid program, if any; (iii) compare the nature and scope of waste, inefficiency, fraud, or abuse occurring in the Commonwealth with that occurring in other states that are similar to Virginia in terms of geography, demographics, or financial commitment to Medicaid; and (iv) identify programs in the Commonwealth and other states that have proven successful in reducing waste, inefficiency, fraud, or abuse of state Medicaid programs.

Technical assistance shall be provided to the Joint Legislative Audit and Review Commission by the Department of Medical Assistance Services. All agencies of the Commonwealth shall provide assistance to the Joint Legislative Audit and Review Commission for this study, upon request.

The Joint Legislative Audit and Review Commission shall complete its meetings for the first year by November 30, 2010, and for the second year by November 30, 2011, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Legislative Audit and Review Commission intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Research Activities and Methods

This appendix describes the research activities and methods used by JLARC staff to assess the scope and nature of Medicaid program integrity efforts in Virginia, and the methods used by agencies to detect, investigate, and recover funds in cases of Medicaid fraud and error. The principal research methods used to research each major study issue included structured interviews, documentation review, literature review, and data analysis.

STRUCTURED INTERVIEWS

JLARC staff relied on the use of structured interviews as its primary means of collecting information and learning about program integrity activities in the Medicaid program. Interviews were conducted with staff at the key State agencies and selected local departments of social services.

Interviews With Department of Medical Assistance Services Staff

JLARC staff conducted structured interviews with staff in several divisions within the Department of Medical Assistance Services (DMAS) in order to collect information relevant to a variety of topics. Interviews included staff from the divisions of Program Integrity, Program Operations, Fiscal and Purchases, Provider Reimbursement, Long Term Care, and Health Care Services. The interviews served a number of purposes, from gaining a better understanding of agency operations and policies to assessing the feasibility of improvements identified through other research methods.

Interviews With State Department of Social Services Staff

JLARC staff conducted interviews and follow-up discussions with staff from the Division of Benefits Programs and the Fraud Program unit at the Department of Social Services (DSS) in order to collect information related to Medicaid eligibility determination error, delays in eligibility determinations, and recipient fraud. The primary purpose of interviews with DSS in the second phase of the project was to build upon and expand the discussion and findings of the interim report.

Interviews With Local Departments of Social Services

JLARC staff conducted structured interviews with staff in ten local departments of social services in order to discuss the causes of and possible solutions to problems in the recipient eligibility determination process, as well as outcomes of fraud-related activities. The localities in which staff were interviewed are shown in the table.

Local Departments of Social Services Interviewed for This Review

Williamsburg	Richmond City
Harrisonburg/Rockingham	Fairfax County
Montgomery	Portsmouth
Danville	Southampton
Prince Williams	Goochland

Source: JLARC staff analysis of Department of Social Services FY 2009 data on local department of social services fraud activities.

Localities were selected using several factors:

- Local departments that lacked DSS-approved Fraud Reduction and Elimination Efforts plans (13 departments) were eliminated because they appear to lack investigators or defined fraud processes.
- Local departments with a fraud plan (107) were ranked based on the number of FY 2009 recipient fraud investigations conducted for every 1,000 Medicaid recipients in their locality.
- Five localities were selected from the top 20 percent of localities with the highest rate of fraud investigations per 1,000 Medicaid recipients. Specific localities were selected so that no more than two were in the same DMAS Recipient Audit Unit region in order to ensure some geographic variation.
- Three localities were selected from the bottom 20 percent of local departments with the lowest rate of fraud investigations per 1,000 Medicaid recipients. Two of these localities were selected from Recipient Audit Unit regions not already included, while the final locality was selected because it was a low-performing locality in a generally high-performing Recipient Audit Unit region.
- The last two localities were chosen from local departments with an average rate of fraud investigations: Fairfax County was selected because it has the largest Medicaid population in the State but a relatively low number of Medicaid

Recipient Audit Unit Regions

The DMAS Recipient Audit Unit breaks out local departments of social services into seven administrative regions. Each region is assigned a Recipient Audit Unit investigator responsible for coordinating referrals and information requests with local department staff in the region.

investigations, and the City of Richmond because of its central location and large, urban population.

Interviews with Managed Care Organizations

JLARC staff conducted interviews with all of the five Virginia Medicaid managed care organizations (MCO). The primary purpose of these interviews was to collect information regarding activities undertaken by MCOs to prevent, detect, and report improper payments. In addition to these interviews, the study team requested and analyzed data on the number of claims that were processed, examples of post-payment claims audits, and a variety of program integrity policy and planning documents and reports. JLARC staff also attended several meetings between staff from DMAS and the MCOs including rate-setting and general policy workgroups, quarterly meetings with individual MCOs, and the newly-formed MCO program integrity collaborative.

DOCUMENT REVIEWS

JLARC staff reviewed a variety of agency documents, primarily from DMAS and DSS. Documents reviewed included DMAS' program integrity contracts, managed care contracts, fiscal and program integrity policies and procedures, Patient Protection and Affordable Care Act final rules related to provider enrollment, managed care rate-setting databook, and examples of the analyses used by DMAS to monitor performance of their program integrity tasks by contractors. In addition, JLARC staff examined examples of utilization reviews, desk audits, audit plans, and interagency agreements that DMAS has with other State agencies involved in program integrity activities.

Review of Recipient Audit Unit Case Outcomes

In FY 2009, the Recipient Audit Unit completed 1,705 investigations related to suspected Medicaid recipient fraud. JLARC staff randomly selected a sample of 170 case files to review in order to assess the outcomes of the Recipient Audit Unit's process. Specifically, cases were reviewed to assess the adequacy of the process implemented by the unit to identify which investigations should result in a referral for prosecution, the nature of fraud cases, and the process and standards it has adopted to guide its investigations. A sample of size of 170 was selected because it was large enough to allow for general conclusions to be drawn about Recipient Audit Unit investigations, yet small enough to be manageable given time constraints.

DATA ANALYSIS

JLARC staff used data analysis to describe the nature and scope of the Medicaid program, verify statements made by agencies in

structured interviews and documentation, and quantify various agency activities related to Medicaid program integrity. The types of analysis included Medicaid spending, provider and recipient enrollments, error in the claims payment and recipient enrollment processes, fraud and error amounts, collections, and appeals amounts.

Medicaid Provider Enrollment

To quantify the number of enrolled providers, the number enrolling each year, and the number and reasons for the termination of Medicaid providers, JLARC staff analyzed data provided by DMAS. Staff also used this data to identify providers terminated by managed care networks that are still active in the fee-for-service program.

Program Integrity Efforts

JLARC staff analyzed data on the post-payment provider audits conducted by DMAS' Program Integrity Division and their contractors. For audits completed in fiscal years 2006 through 2010, JLARC staff analyzed data from DMAS on the number of audits, types of providers audited, overpayment findings, and appeals results. In addition, JLARC staff examined data on the source of audits, including referrals and data mining. In addition, JLARC staff examined data on DMAS referrals of suspected cases of fraud to the Medicaid Fraud Control Unit.

Provider Fraud Investigations and Prosecutions

JLARC staff examined data on cases prosecuted by the Medicaid Fraud Control Unit including information on the number and type of cases, their outcomes, and the amount of restitution ordered by courts.

Recipient Fraud Investigations and Prosecutions

JLARC staff analyzed DSS and DMAS data on the outcomes of suspected cases of recipient fraud forwarded to Commonwealth's Attorneys, including whether the cases was accepted, the outcome of the trial, and the amount of restitution ordered.

Estimate of the Cost of Overdue Medicaid Eligibility Redeterminations

In order to estimate the cost of overdue Medicaid eligibility redeterminations, JLARC staff analyzed FY 2010 DSS data on eligibility cancellations resulting from redeterminations and the number of overdue redeterminations, and DMAS data on FY 2010 Medicaid enrollment and expenditures.

JLARC staff calculated the rate at which eligibility redeterminations resulted in the cancellation of Medicaid benefits because recipients were no longer eligible for the program, which occurred in approximately 5.7 percent of cases. Due to limitations in DSS data, only the cancellation rate for recipients categorized as Medicaid “Families and Children” could be calculated.

Using DSS data, JLARC staff also calculated the average monthly number of overdue redeterminations in FY 2010 by dividing the total annual number of overdue redeterminations by 12. The average monthly number of overdue redeterminations in FY 2010 was 34,889.

In order to determine how many cases might have been cancelled if eligibility redeterminations had been completed in a timely manner, the average number of overdue redeterminations was multiplied by the Families and Children redetermination cancellation rate attributable to a lapse in Medicaid eligibility. The calculation found that approximately 1,986 cases would have been cancelled each month in FY 2010 due to a loss of eligibility if their redetermination had been processed on time.

To estimate the improper payments associated with ineligible recipients who remained enrolled in Medicaid due to delays in their eligibility redetermination, JLARC staff multiplied the number of overdue redeterminations that would have resulted in benefit-related cancellation (1,986) by the average monthly expenditures incurred on behalf of Families and Children recipients (\$218), and found that overdue redeterminations may have resulted in improper Medicaid expenditures of \$433,856 per month, on average, for an approximate annual total of \$5.2 million in FY 2010.

Federal Payment Error Rate Measurement Review Analysis of Errors in Recipient Eligibility Determinations

As discussed in Chapter 2, the Centers for Medicare and Medicaid Studies (CMS) conducts Payment Error Rate Measurement (PERM) reviews of Medicaid eligibility determinations in each state. The most recent PERM review of Virginia eligibility error was conducted in federal fiscal year (FFY) 2009, which ran from October 1, 2008 to September 30, 2009.

The PERM review randomly sampled 504 eligibility cases in total, 168 from each of three strata, defined as

- new eligibility determinations,
- eligibility redeterminations, and
- ongoing eligibility cases.

The review identified the total Medicaid claims paid for these cases in the month in which the case was reviewed. If the case was found to contain errors, the nature of the error was noted, and any claims paid that month were treated as dollars in error.

CMS estimated that as a result of these 101 errors, approximately \$909,856,202 in improper payments occurred in Virginia in FFY 2009. JLARC staff's revised estimate is based upon the subtraction of the following types of error:

- assignment of eligible recipients to the wrong aid category or program (5 cases),
- technical errors in which the wrong form was used but that did not result in actual eligibility errors (10 cases),
- certain "undetermined" cases where the individuals were eligible under State policy but were ineligible according to the process used by PERM to assess State residency (11 cases) and
- citizenship and identity errors that would no longer be treated as incorrect under federal policy (21 cases).

Because the PERM review was conducted only on a sample of cases, further calculations must be made to estimate the cost of eligibility determination errors for all Medicaid cases. The main concept for estimating dollar amounts for the entire universe of Medicaid cases is:

$$(\text{Size of Universe}) \times (\text{Average cost per case}) = (\text{Total cost})$$

When the number of cases is known, but the average cost per case not, the ideal way to calculate the mean cost per case is to calculate it directly from all cases. In the instance of total Medicaid claims, in 2009 DMAS paid a total of \$5,818,276,041 for a total of 8,733,901 cases, resulting in an average cost per case of \$666.17. This amount is the true population mean, because it is based on all cases. It is calculated as:

$$(\text{Total cost}) / (\text{Number of cases}) = (\text{Average cost per case})$$

When the true average cost per case is not known, it can be approximated by observing the cost of each case in a sample, and calculating the sample mean. The main disadvantage of this approach is that it introduces error due to the sample not being perfectly representative of all cases in the universe. Therefore, sampling error and confidence intervals are often calculated, to provide a range of values that may arise from different random draws of the sample when the true population mean is not known and cannot be compared to the sample mean. The confidence in-

terval is a range of guesses of where the true population parameter would be, based on statistical theory about random draws of the sample.

The PERM sample is shown to be relatively representative of the total population by comparing the sample mean of total claims paid with the true population mean of total claims paid. The PERM (stratified) sample mean is \$618.38, when the true population mean is \$666.17. This amount leads to a projection of total claims paid from the PERM sample of \$5,400,801,621. The difference between the sample and actual expenditures (\$5,818,276,04) indicates that the PERM sample is not perfectly representative of the full population. The sample amounts are 7.8 percent lower than the actual amounts, indicating a slight bias on the low side when estimating using sample data. However, the difference indicates that the sample data do not seem to be substantially atypical of the fuller population, and, therefore, can provide reasonable rough estimates of population amounts.

While the average dollar amount of all claims is known, the average dollar amount of claims *paid in error* is not. Therefore, JLARC staff used PERM sample data to approximate the average amount of claims paid in error.

In order to calculate the stratified sample weight mean dollars in error, JLARC staff first identified the total improper payments due to eligibility errors in each PERM stratum (excluding the cases noted above). Next, the average improper payment due to eligibility errors was calculated for each stratum by dividing the dollars in error by the number of cases in each stratum (168). To estimate total dollars in error, the average improper payment due to eligibility error was multiplied by the sample universe for each stratum, and summed.

In compliance with CMS guidance, JLARC staff calculated its estimate of the fiscal impact of eligible error two different ways: once treating these undetermined cases as errors, and another treating these cases as correct. Treating the remaining undetermined cases as errors, JLARC staff estimate that eligibility error costs Medicaid \$659,483,848 in improper payments annually. When undetermined cases are treated as correct, the estimate of improper payments is reduced to \$44,255,912 per year.

Calculation of Estimated Fiscal Impact of Negative Case Errors

As discussed in Chapter 2, the PERM review also assessed the extent to which recipients had their eligibility for Medicaid cancelled or denied improperly. The PERM review sampled 220 cases in which eligibility was cancelled or denied. Of this sample, the re-

view found that 51 cancellations or denials were made in error: 36 cases in which the eligibility of the recipient was improperly cancelled, and 15 in which an applicant was improperly denied enrollment.

While no claims data were available for the cases, JLARC staff were able to calculate an estimate of the fiscal impact of negative case errors using data provided by DMAS and DSS. First, DSS data were used to identify the number of cancellations (80,944) and denials (39,568) that occurred in FY 2009. These totals were then multiplied by the erroneous cancellation (16 percent) and denial (7 percent) identified by the PERM review. An estimated 13,275 recipients were estimated to have had their enrollment improperly cancelled, and an estimated 2,770 applicants were improperly denied Medicaid benefits. Assuming that enrollment of these individuals would have resulted in annual payments on their behalf equal to the overall program average (\$5,434 in FFY 2009), negative case errors reduce Medicaid expenditures by an estimated \$87,179,808 per year. Improper cancellations of recipient eligibility account for \$72,130,020 of the total, with improper denials representing \$15,049,768 of the estimate.

For several reasons, this estimate should be treated as a hypothetical and second-best method, which would be best used to give a sense of the order of magnitude of the fiscal impact of negative case errors. First, JLARC staff had to use FY 2009 (July 2008 to June 2009) cancellations and denials, instead of totals for the federal FY 2009 (October 2008 to September 2009) period in which the PERM review was conducted. Therefore, the actual numbers of cancellations and denials in federal FY 2009 would differ. Second, the estimate assumes that if they had been enrolled, individuals improperly denied Medicaid enrollment would have incurred health care costs identical to the average Medicaid recipient; the true number could be higher or lower, depending upon the demographic characteristics of negative case errors. Lastly, the estimate assumes that if determined correctly, improperly cancelled and denied individuals would have been enrolled for an entire fiscal year; this may or may not have been the case.

Federal Payment Error Rate Measurement Review Analysis of Errors in Paid Medicaid Fee-For-Service Claims

In addition to the review of recipient eligibility error, PERM also reviewed paid Medicaid fee-for-service claims to identify claims that were paid in error according to Medicaid policy. The review examined a sample of 556 adjudicated claims processed from October 1, 2008 to September 30, 2009 (FFY 2009). The sample was provided in four quarterly installments, each submitted 15 days after the end of the quarter. The requested sample was created

from the claims universe by dividing the universe into ten strata based on the dollar size of the claims, with each stratum representing ten percent of all paid claims during that period. These strata run from smallest dollars-per-claim to largest dollars-per-claim, so that there are more total claims in the smaller dollars-per-claim stratum than the larger. Each stratum is then given a sampling weight based on the proportion of claims in the universe that were sampled. For example, if the sample looked at one claim for every 500 claims in the universe, the sampling weight would be 500.

The sample of claims is then reviewed and compared to State and federal Medicaid policies, as well as medical record documentation to determine any amounts paid in error. Projected dollars in error for a given stratum are estimated based on the total dollars in error for that stratum times the sampling weight. For example, if there are \$100 dollars in error in the sample for stratum 1 and the sampling weight is 500, then \$50,000 dollars is projected to be in error.

The State error rate is then estimated as the projected dollars in error from all of the strata divided by the projected payments from all of the strata. For Virginia, PERM estimated an payment error rate of 0.72 percent in fee-for-service claims, which was below the national error rate of 1.89 percent. This error rate equates to about \$32 million in payments made in error.

Collection Rates for Program Integrity Activities

JLARC staff analyzed data provided by the DMAS Program Integrity Division, Fiscal Division, and the Medicaid Fraud Control Unit (MFCU) in order to calculate the rates at which actual improper payments identified as a result of program integrity activities are collected. JLARC staff also analyzed the data in order to ensure that collection invoices are created by the DMAS Fiscal Division for all identified improper payments.

In order to calculate collection rates for Medicaid Program Integrity activities described in this report, rather than all DMAS accounts receivables, JLARC staff had to match accounts receivable data with improper payment data provided by the Program Integrity Division and MFCU. In addition, provider enrollment data maintained by the Program Operations Division was used to help identify provider identification numbers for matching purposes. The primary data sources used for this analysis included

- DMAS' data on FY 2009 provider audit outcomes, recipient audit outcomes, and recipient fraud investigation outcomes,
- MFCU's data on FY 2006 to FY 2010 provider fraud investigation outcomes,

- DMAS' accounts receivable data for all provider and recipient invoices since FY 2006, and
- DMAS' file of active and cancelled fee-for-service providers.

JLARC staff had to exclude certain provider error amounts (about \$134,000) from the analysis because they lacked sufficient information to match with invoice data.

Before JLARC staff could attempt to match accounts receivable data to improper payment data, the accounts receivable data had to be unduplicated and summed in order to get a single observation that corresponded with each improper payment. Accounts receivable data often contained numerous invoices and observations corresponding to a single audit or conviction. This occurred for two primary reasons. First, Fiscal staff create multiple invoices for a single audit or conviction if the improper payments initially occurred in different fiscal quarters. Separate invoices are established in order to determine the share of the improper payments owed to the federal government (the federal matching rate can vary by quarter). Second, multiple payments could result in more than one observation for each invoice.

JLARC staff worked with DMAS staff to develop a method of unduplicating various data elements, such as improper payment amounts, adjustment amounts, collection amounts, and MMIS recoupment amounts by invoice number. The unduplicated amounts were then aggregated, or summed, by invoice date and invoice string (the first nine numbers of an invoice number) in order to calculate total improper payment and collection amounts for each audit or conviction.

After establishing a single unduplicated invoice for each audit or conviction, that data could be matched with improper payment data. For provider errors, JLARC staff used provider identification numbers and improper payment amounts to match the data. For recipient errors and fraud convictions, the data were matched using the fiscal year of the improper payment and the improper payment amount (enrollment numbers and names were not provided). Provider fraud convictions had to be matched according to name and other descriptive information, as there was no single identifier used by both the MFCU and DMAS to track these cases.

JLARC and DMAS staff then made additional attempts to identify matching invoices for each audit or fraud conviction. For those audits and convictions that could not be matched to invoices, JLARC staff asked DMAS and MFCU staff for potential explanations and several were provided. First, DMAS staff reported that they did not forward for collection recipient improper payment amounts of

less than \$300 prior to December 2010. For FY 2009, these cases amounted to \$14,000. Second, a number of cases were reportedly not referred to the Fiscal Division for reasons such as the cases were pending action by the courts or MFCU. Together, these cases amounted to \$867,000. If no justification was provided by DMAS, it was assumed that an invoice should have been created but was not. In FY 2009, these cases amounted to about \$841,000 (as discussed in chapter 4). Because of the substantial effort required to research unmatched cases, JLARC staff were only able to calculate an accurate collection rate for FY 2009 improper payments (except for provider fraud convictions).

For those audits and convictions that could be matched to invoices, a collection rate was calculated by dividing total collection amounts by total adjusted invoice amounts (original invoice amounts less any adjustments such as appeals). Collection rates were also calculated for MFCU criminal and civil cases as designated by MFCU data or reports.

Appendix **C**

Agency Responses

As part of an extensive validation process, State agencies and other entities involved in a JLARC assessment are given the opportunity to comment on an exposure draft of the report. JLARC staff provided an exposure draft of this report to the Secretary of Health and Human Resources, the Department of Medical Assistance Services, the Department of Social Services, and the Office of the Attorney General. Appropriate technical corrections resulting from their comments have been made in this version of the report. This appendix includes their written response letters. JLARC staff notes have been appended to the letter from the Department of Medical Assistance Services.



COMMONWEALTH of VIRGINIA

Office of the Governor

William A. Hazel, Jr., MD
Secretary of Health and Human Resources

October 3, 2011

Mr. Glen Tittermary
Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capitol Square
Richmond, Virginia 23219

Dear Mr. Tittermary:

Thank you for the opportunity to review the draft report titled "Mitigating the Risk of Improper Payments in the Medicaid Program." As you know, one of Governor McDonnell's concerns has been the growth of the Medicaid program over the past ten years and he has charged me with ensuring that we implement Medicaid reforms that improve the cost effectiveness and quality of the program, including enhanced program integrity efforts.

While Virginia has been moving forward on these initiatives in a very deliberate fashion, you have certainly given me and the agencies within the Health and Human Services Secretariat I oversee a thought-provoking report. I understand from communications with the Department of Medical Assistance Services (DMAS) and the Department of Social Services (DSS) that this has been a very collaborative experience; while the process has required substantial effort from the staff at these two agencies, I believe the path forward has been better articulated through this process.

I understand that DMAS and DSS are providing more detailed comments on the report, so I will keep my comments at a high level. While I do not concur with the implication that there is an avoidable cost in Virginia's Medicaid program in the range cited by the report based on the PERM eligibility error rate, I agree that the eligibility process is a very serious concern for the Commonwealth. DMAS has expressed significant concerns regarding the methodology utilized to estimate the improper payment levels cited. I would encourage JLARC to consider those concerns. Ninety-three percent of the dollars identified in the report as improper payment due to

eligibility error are for cases in which there is no evidence to support a determination of ineligibility. A serious error has clearly occurred, but the error did not necessarily result in an individual ineligible for Medicaid being determined eligible. Nevertheless, the eligibility system for Medicaid and the other social service programs is in dire need of improvement and modernization.

To that end, last Session I spoke to Legislators about the need for funding to create a modern, enterprise-based customer-friendly eligibility and enrollment system for all of Virginia's social service programs. Advantageous federal funding coupled with the long-standing articulated need for technology infrastructure improvements in these areas, as well as the significant increase in Medicaid enrollment expected under federal healthcare reform, represented the perfect storm. In fact, I utilized the then just-released 2009 PERM eligibility error rate as a symptom of a system in need of repair. In response, the Governor and General Assembly included significant funding to begin the eligibility project, which has been moving forward to address the current antiquated, overstressed system in Virginia.

When completed, Virginia will have a state-of-the-art eligibility system that will serve to mitigate the types of errors cited by PERM, and will allow eligibility workers to focus energy on the more complex cases across the social services spectrum. Because of available enhanced federal funding, Medicaid is the primary driver, and most immediate beneficiary, of this project. In the interim, however, DMAS and DSS are in the process of engaging an independent contractor to examine short-term measures available to reduce Medicaid/CHIP eligibility determination errors and longer-term considerations as the new eligibility system is designed and implemented. I am confident these efforts will drastically reduce the incidence of eligibility error at the local level.

In regards to other aspects of the report, I am excited that on the provider payment side of the PERM equation, it appears DMAS is well-situated for identifying and preventing improper payments. According to the PERM project, less than one percent of provider payments in Virginia Medicaid are improper, and of that amount, your report shows that post-payment review appears to catch the vast majority of those that slip through on the front-end. Virginia's error rate in this regard is much better than the national average, and I am encouraged to continue improving program integrity efforts by building upon that success. I agree with the report that the efforts undertaken by our partners on the Medicaid managed care side of the business could be better articulated and/or improved. All accounts indicate that point has been well-received, and efforts are underway to work on program integrity while maintaining the program flexibility that has proved so successful in Virginia's Medicaid managed care program.

Finally, I would caution that improvements in program integrity for Medicaid will require additional effort in the form of resources, both human and financial; this is not a new issue for DMAS, but it remains a significant one, particularly in the current fiscal environment. As such, the Administration will need to target additional efforts in areas that will best utilize available resources while promoting all aspects of program integrity. While the report was not very specific in regards to prioritizing the recommendations in the reality of limited resources, I look forward to continued discussions with policy-makers on where to best focus efforts.

Again, thank you for the opportunity to review the report, and I look forward to continued discussion.

Sincerely,

A handwritten signature in black ink, appearing to read 'William A. Hazel, Jr.', written in a cursive style.

William A. Hazel, Jr., MD.
Secretary of Health and Human Resources

WAH/sf



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

October 3, 2011

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

Mr. Glen Tittermary
Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capitol Square
Richmond, Virginia 23219

Dear Mr. Tittermary:

Thank you for the opportunity to review the draft report titled "Mitigating the Risk of Improper Payments in the Medicaid Program". Mr. Colvin and the rest of the study team have immersed themselves in the subject matter and produced a thought-provoking, meaningful report. We applaud their effort and bring to your attention the countless hours involved by my staff in responding to the multiple inquiries, data requests, and meetings related to this study. This has been a tremendous collaborative effort to identify ideas for improvement in Medicaid program integrity and while we may not fully agree with all aspects of the report, there is no doubt that the process has been helpful for my staff, and professional throughout.

While the report identifies several areas of potential improvement in Medicaid program integrity at the Department of Medical Assistance Services (DMAS), the Department of Social Services (DSS), local departments of social services (LDSS), and the Medicaid Fraud Control Unit (MFCU) at the Office of the Attorney General, we appreciate the occasional acknowledgement throughout the report of the many successes and improvements in Medicaid program integrity in recent years. While we would have preferred more explicit discussion of the many positive aspects of Virginia's Medicaid program integrity effort, we certainly understand why a report focused on opportunities for continued improvement may not emphasize the many aspects of program integrity in Virginia that serve as a model for Medicaid. As such, while discussing concerns with the report, I will also use this response to the report as an opportunity to provide that positive balance.

I will first focus comments on certain aspects of the report that deserve further consideration, followed by a more general response to the report's recommendations.

The PERM Eligibility Error Rate and Extrapolated Cost

The report leads with a discussion of the 2009 Payment Error Rate Measurement (PERM) eligibility study and presents a range of \$18-\$263 million (General Funds) in improper payments associated with eligibility errors (we have shared many concerns with the study team regarding the PERM methodology for eligibility errors and the appropriateness of its use to identify improper payments; these are articulated as an attachment to this response). While this is certainly an eye-catcher, it is extremely important to understand the data behind the JLARC staff conclusion in order to assess the validity of this misleading finding. Here are the facts behind the JLARC staff estimate:

- The lower bound estimate of \$18 million in improper payment is based on, we believe, 20 errors with an actual claims value of \$5,786.75 – **JLARC has extrapolated less than \$6,000 in actual errors to \$18 million based on 20 cases.**
See JLARC Staff Note #1, p. 155.
- The difference in the upper bound and the lower bound of the range, \$245 million (93% of the total estimated improper payment of \$263 million), is attributable to, we believe, 18 undetermined errors with an actual claims value of \$14,940.27 – **JLARC has extrapolated less than \$15,000 in undetermined “errors” to \$245 million based on 18 cases. It is important to note that for these 18 cases, or more to the point, for the \$245 million representing 93 percent of the range endorsed by JLARC staff, no one can actually say that eligibility was inappropriate, meaning JLARC cannot say with certainty that *any* improper payment actually exists. It is this very reason that CMS has now modified the PERM error rate methodology to exclude undetermined cases from its calculation of an error rate.**
See JLARC Staff Note #2, p. 155.

The methodology utilized by JLARC staff to estimate the “cost” of the errors is inappropriate for the purpose implied in the report. While JLARC staff appear to be simply adapting a CMS methodology, it is important to note that CMS utilizes the PERM program as an educational tool for states to identify and correct deficiencies in their eligibility systems; the methodology produces a “cost”, but CMS does not use the methodology to recoup those costs because it is not rigorous enough to support identification of a defensible claim of financial liability. To present this magnitude of “improper payments” based on the PERM review (even at the JLARC lower bound) as being an unambiguous avoidable cost in Virginia Medicaid is to report a conclusion that is not supported by fact.

See JLARC Staff Note #3, p. 155.

The truth of the matter is that the PERM eligibility study was an eye-opener for DMAS, DSS, and LDSS. All of the entities involved in Medicaid eligibility determination knew the system has been stressed for many years in terms of human resources and technical infrastructure, but the magnitude of the PERM error was still a surprise to many individuals involved in the eligibility determination process on a day-to-day basis. Needless to say, correcting these errors is a very high priority of the agencies involved.

To that end, DMAS and our DSS/LDSS partners are working toward rectifying the issues with a new eligibility system to serve as a backbone for all social services offered in the

Commonwealth, including Medicaid. This system will modernize, and to the extent practical, automate eligibility determination to allow eligibility workers time to focus on complex cases and to deal with the added workload Virginia faces under federal health reform. In the interim, DMAS and DSS are in the process of engaging an independent contractor to examine short-term measures available to reduce Medicaid/CHIP eligibility determination errors at the local departments of social services, as well as longer-term considerations as we design and implement the new eligibility system. We are confident these efforts will drastically reduce the incidence of eligibility error at the local level.

Program Integrity Generally

While the report provides some ideas that will allow continued evolution of program integrity, the report fails to sufficiently highlight the success of program integrity efforts at DMAS over the past 5-6 years. This successful effort was substantiated in the 2009 PERM review of payment accuracy (which, unlike the eligibility review, actually follows a methodology that allows for dollar extrapolation). The 2009 payment accuracy study found a **0.7% payment error rate** for Virginia Medicaid. In other words, **DMAS limits improper payments to less than one percent of total expenditures** utilizing various pre-payment tools as measured by PERM. Then, as the report points out, through audits and other post-payment efforts, it appears that we identify nearly all (91 percent) of the improper payments missed by pre-payment review. We appreciate that JLARC has reported these successes in the draft report, and to the extent they were not highlighted sufficiently, I bring them to your attention now.

Additionally, CMS has found that certain Virginia Medicaid program integrity efforts serve as models for other states. In the March 2011 final report "Medicaid Integrity Program: Virginia Comprehensive Program Integrity Review", CMS highlighted the following Noteworthy/Effective Practices:

- Checking for excluded personal care attendants (PCAs) in Virginia's consumer-directed PCS program
- Enhanced auditing through contractors
- Effectively communicating program integrity concerns and providing training on an agency-wide basis
- Automated Medicare Exclusion Database (MED) interface with Virginia's MMIS
- Expanded provider outreach and education on exclusion checking

We continue to work with our partners to evolve program integrity, as evidenced by Virginia being asked to be one of three states working closely with CMS and HHS to assist with implementation of new screening regulations (referenced by JLARC) on a Provider Screening and Enrollment Workgroup. DMAS' voice in the discussion has added valuable information about the challenges and limitations of the currently envisioned process of the new screening regulations. For example, DMAS has provided important feedback about the needed data elements that can be extracted from Medicare's provider database and the process workflow needed to successfully piggyback Medicare's enrollment and screening process. Participation on

this workgroup will better position DMAS to implement the screening regulations and further mitigate the risk of fraud, waste and abuse in Virginia.

Managed Care Organization (MCO) Integrity Issues

Both DMAS and the health plans agree that more work is needed in documenting MCO post-payment activities, and to that end, we are actively involved in a new program integrity collaborative. However, by focusing solely on documented integrity efforts, the draft report fails to recognize the full value added to the Virginia Medicaid program by our managed care partners. By design, the Commonwealth provides some level of flexibility to MCOs in return for the assumption of financial risk (among other items) associated with service delivery to a population in dire need of healthcare services.

In addition to Virginia's contracted health plans being listed in the top 50 NCQA Medicaid plans in the country, the Department, like most States, contract with health plans because its delivery system benefits the Commonwealth in a multitude of ways:

1. Financial stability – The plans are at full risk and are paid a capitation rate which covers all administrative and medical services for the patient and program. It allows for ease in forecasting and utilization since, during the year, it does not vary.
2. Member benefits – The Medicaid enrollees receive many benefits through health plans that are not duplicated in fee-for-service: health education, provider access, 24/7 call center, chronic care management, enhanced maternity and child program, enhanced provider network, and ultimately, improved health outcomes.
3. Provider networks – The plans have divisions that manage, recruit, contract, monitor, credential, and develop variable payment mechanisms, including incentives for high quality outcomes.
4. Program flexibility – The plans can add new programs, pay provider variable payments, and can establish new processes without regulatory limitations. CMS routinely excludes the MCOs from new burdensome policies and procedures which allows them flexibility to design and implement their own programs and arrangements.
5. Utilization review management – The plans have strong clinical teams who develop clinical protocols, review variances, and develop programs to control utilization (from special programs for aged, blind and disabled, to robust prepayment controls).
6. Quality outcomes – The plans, through the work of their clinical staff and relationships with their providers, improved the health outcome of Medicaid membership.
7. Collaboratives - The plans are very willing to work with the state entities in management of Medicaid members in both quality and program integrity initiatives.
8. Standardization – Virginia Medicaid Plans are required to obtain and maintain NCQA accreditation, which is a very rigorous national standard.

The draft report fails to recognize these benefits and the flexibility needed to achieve them, thereby presenting an incomplete, or one-sided discussion of the issues related to the MCO program administration.

The Need for Additional Resources

In the litany of suggestions for improvement in the Department's integrity efforts, the draft report pays little credence to the notion that resources (staffing, technology, and financing) are required to implement the changes articulated. JLARC staff seems to ignore the question of cost-effectiveness by ignoring the resource needs associated with the recommendations, and by avoiding the calculation of a potential financial benefit to the suggested changes. Other than the PERM eligibility error (and despite our significant reservations about the ramifications of the JLARC findings related to this issue), the report says very little about the potential dollar impact, in terms of increased identification of improper payments, associated with the 25 recommendations.

If the JLARC team is assuming resources to implement the recommendations could be provided from a reduction in improper payments, it should be reiterated that a further reduction of improper payments, if achieved, would serve to offset cost on the medical side of the ledger (much of which would be reflected in some level of a reduced rate of growth in program costs, not additional resources on hand at DMAS); the functions and enhancements envisioned by JLARC, however, would require significant investment on the administrative side. We can only assume the JLARC team believes the 25 recommendations will have a positive ROI, and for many of them, we tend to agree. As we have stated during this entire two-year review, we agree in principal that additional efforts will further reduce improper payments, but that resources need to be provided to make that additional effort.

Comments on Specific Recommendations

Recommendation 1: The Department of Social Services (DSS) should identify and report the costs, benefits, and feasibility of expanding the Rushmore cases tracking system to the Medicaid program in order to allow local departments of social services to utilize its case management and oversight functions. DSS should report to the House Appropriation and Senate Finance Committees before the start of the 2013 General Assembly Session on their conclusion. If the results indicate that Medicaid eligibility errors could be cost-effectively reduced, DSS should request funding for the expansion of this system to the Medicaid program.

Response to Recommendation 1: DMAS and DSS should assess this recommendation in light of the technology project currently underway – it is expected that the new eligibility system will have case management functionality. It is also expected that the independent review of eligibility issues (mentioned above) would consider this recommendation.

Recommendation 2: The Department of Social Services (DSS) should develop and implement automated systems that allow caseworkers at local departments of social services to verify the financial and real property assets of Medicaid applicants, including records maintained by Virginia Circuit Courts. DSS should report to the House Appropriation and Senate Finance Committees before the start of the 2013 General Assembly Session on the cost and status of this recommendation.

Response to Recommendation 2: DMAS and DSS should assess this recommendation in light of the technology project currently underway – it is expected that the new eligibility system will have asset verification functionality, per the federal mandate. It is also expected that the independent review of eligibility issues (mentioned above) would consider this recommendation.

Recommendation 3: The Departments of Medical Assistance Services and Social Services should create an interagency committee to continuously evaluate means to reduce the eligibility error rate, and annually report its findings to the Senate Finance and Rehabilitation and Social Services committees, and the House Appropriations and Health, Welfare, and Institutions committees. A primary goal of this group should be to find cost-effective ways to reduce the eligibility error rate in the Virginia Medicaid program, including further automation of the Medicaid eligibility determination process.

Response to Recommendation 3: DMAS and DSS are already actively involved in collaboration on improvement in the eligibility determination function. The relationship is formalized in the *Code of Virginia* and operationalized in an existing interagency agreement. In addition to the existing collaboration, the two Departments are in the process of engaging an independent contractor to evaluate short-term improvements and recommend longer-term enhancements under the technology project (as mentioned previously).

Recommendation 4: The Department of Medical Assistance Services should develop process and policy changes to increase coordination between the department's Client Medical Management program and the recipient utilization monitoring programs administered by the Medicaid managed care organizations. Policy changes should focus on (1) increasing consistency of standards used to define appropriate levels of service utilization, and (2) ensuring recipients' utilization of medical services is subject to continued oversight when switching from the fee-for-service to managed care program or from one managed care organization to another.

Response to Recommendation 4: Workgroup meetings have already begun to review the ability of DMAS to share CMM information with health plans; however, staff and system changes are required to be able to do this effectively. Lock-in information will be required from each plan monthly, compared to enrollment changes, and transition of CMM and claims information will need to be shared with new plans as an individual moves.

Recommendation 5: The Departments of Medical Assistance Services (DMAS) and Social Services should reconsider the nature and scope of responsibilities for the investigation of recipient fraud and error in public assistance programs assigned to DMAS and local departments of social services, and determine whether a realignment of responsibilities would more effectively promote the investigation of Medicaid recipient fraud and error.

Response to Recommendation 5: DMAS does not agree that a realignment of Medicaid fraud investigative efforts is appropriate. A realignment of fraud responsibilities to the

local departments of social services whom are also the administrators of the program appears to be a conflict of interest under APA audit criteria.

Recommendation 6: The Departments of Medical Assistance Services and Social Services should consider the implementation of an Administrative Disqualification Hearing process for the Medicaid program.

Response to Recommendation 6: It is possible that the implementation of Administrative Disqualification Hearings could reduce barriers to prosecution of recipient fraud. Any implementation of a Medicaid ADH process would require an exemption from current statutes governing restrictions of Medicaid eligibility, and statutory and/or regulatory change would be needed. Current Medicaid restrictions place limits only on recipients convicted of Medicaid fraud. Further, this process would generate a whole new category of appeals to DMAS that would require significant resources.

Recommendation 7: The Department of Medical Assistance Services (DMAS) should revise future contracts with managed care organizations (MCOs) starting with FY 2013 to require MCOs to report data on all providers terminated from their networks on at least a quarterly basis. Data should include the provider name, unique identification number, and reason for termination. DMAS should use this information to identify providers that should not be enrolled in the fee-for-service program or that may pose a risk to the program.

Response to Recommendation 7: MCOs have consistently notified DMAS of any network providers whose participation is ended due to program integrity reasons as well as providers who fail to meet re-credentialing criteria to participate in the MCOs provider network for program integrity reasons. As a result, the July 1, 2011 MCO contracts were revised to capture the full scope of the above mentioned, on a quarterly basis. In terms of the process for reporting these provider network participation denials, the reports will be sent to the DMAS PI Division and they, in turn, will report the information to HHS-OIG.

Recommendation 8: The Department of Medical Assistance Services (DMAS) should establish policies for ensuring that information collected as part of the fee-for-service provider enrollment and managed care credentialing and termination processes are shared among all DMAS divisions responsible for program integrity activities. Information obtained during the enrollment or termination processes should be used to identify potentially high-risk providers for further scrutiny, which could include intensified claims reviews, audits, site visits, or education.

Response to Recommendation 8: Information is shared between divisions (PO, PI, HCS) regarding providers that have been disenrolled due to licensure, legal convictions, and/or fraudulent activities.

Recommendation 9: The Department of Medical Assistance Services Program Integrity Division should create a central audit plan, based on the current risk-based Provider Review Unit audit plan, which addresses the audit activities of all contracted auditors as well as all units within the

Program Integrity Division in order to coordinate all audit activities. This plan should include a discussion of the number of audits to be conducted per provider type and an explanation of how any factors other than the risk score modify the number of planned audits indicated by the risk score alone.

Response to Recommendation 9: DMAS does have an audit plan and the number of providers audited is based on risk scores.

Recommendation 10: The Program Integrity Division of the Department of Medical Assistance Services should include in the annual audit plan a formal assessment of whether actual audits met, fell short of, or exceeded planned audit goals for the previous year. This assessment should document the reasons for deviation from planned audits, evaluate the effect of these deviations and indicate whether these deviations necessitate a change in audit activities to better meet audit goals, or an adjustment of planned audit goals to better reflect the goals of the division.

Response to Recommendation 10: While we understand the concern with formal documentation in order to evaluate decisions, an agency often needs to react in a multitude of ways, at varying levels of internal and external formality. The desired outcomes of the documentation envisioned by JLARC already occur through the existing agency interaction, both formal and informal.

Recommendation 11: The Program Integrity Division of the Department of Medical Assistance Services should institute a formal mechanism for tracking the disposition of all referrals to ensure that they are consistently evaluated and that appropriate action is taken.

Response to Recommendation 11: DMAS does have a tracking system in place (a database) to capture all information regarding referrals including what unit, entity, or individual submitted the referral. The database tracks if the referral was considered a case and the overpayment amount post audit. The database also tracks if the referral was sent to the MFCU and if it was accepted by that agency. Also, DMAS formally analyzes data and as a result of identifying improper payments, the PID adjust reviews and request additional funds, if need be, to conduct reviews in areas of concern or providers who are considered high risk.

Recommendation 12: The Program Integrity Division of the Department of Medical Assistance Services should create a mechanism for tracking all identified improper payment reductions due to retractions that occur during the reconsideration and appeals stages, including the reasons for those retractions. This information should be utilized to identify any shortcomings in contractor or staff auditing practices, as well as agency policies, and to guide the implementation of any needed corrective action.

Response to Recommendation 12: DMAS is establishing a new unit that will focus on tracking data regarding reductions in retractions due to reconsiderations during and after the appeals process.

Recommendation 13: The Program Integrity Division of the Department of Medical Assistance Services should assess the return on investment for all contract and staff audit resources as a part of a centralized audit plan to evaluate whether existing resources are being used to identify the maximum amount of improper payments given existing resources. In order to calculate returns effectively, the division should track staff hours spent on each audit and redesign their contracts with outside auditors to enable calculation of the average cost of each type of audit. To ensure accurate representation of identified overpayments, this return on investment should be based on audit results after all appeals have concluded.

Response to Recommendation 13: While we agree that ROI is an important factor in targeting audit resources, we disagree that Program Integrity activities should solely be measured by the number of audits conducted and the amount of dollars retracted from providers. Instead, consistent with the term, we define program integrity with assuring that provider networks adhere to the regulations and policies as agreed to in the terms and conditions of the provider agreement. As such, the Department uses a combination of many factors, including ROI, in the creation of the audit plan.

Recommendation 14: The Program Integrity Division of the Department of Medical Assistance Services should institute a formal, documented mechanism of evaluating the outcomes of all staff and contractor audits to determine if potential fraud exists and ensure that all cases of potential fraud are referred to the Medicaid Fraud Control Unit.

Response to Recommendation 14: Every audit conducted at DMAS is reviewed by multiple layers of DMAS staff which include contract monitors, supervisors and program managers. MFCU and PID meet on a monthly basis to discuss case status and referrals. All referrals are tracked in a database with current disposition noted on a case level. Communication and cooperation between these two agencies is extraordinary and is often found to be a best practice.

Recommendation 15: The Department of Medical Assistance Services (DMAS) and the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General should develop a single unique identifier to be used by both agencies for each individual case. This unique case identifier should be used to track the status of referrals to the MFCU, as well as to create invoices at DMAS for completed prosecutions.

Response to Recommendation 15: The Department is open to discussing this recommendation with the MFCU.

Recommendation 16: The Department of Medical Assistance Services (DMAS) should develop and implement a plan to improve and standardize the process of sharing information about improper payments between divisions and agencies, and develop a process to track and review whether invoices are created for each identified improper payment. Representatives from DMAS' Fiscal and Program Integrity Divisions, other divisions within the agency, and the Medicaid Fraud Control Unit should work together to achieve these objectives.

Recommendation 17: The Department of Medical Assistance Services' Fiscal Division should collaborate with the agency's Program Integrity Division to identify information that should be captured in the accounts receivable system to readily calculate collection rates. Information that should be captured includes fields that identify the auditor, type of audit, and type of provider that was audited. Adjustment amounts due to appeals should also be clearly identified.

Response to Recommendation 16 & 17: While we do not believe a problem has been identified in these areas, we are always open to improvement in internal and external communication.

Recommendation 18: The Department of Medical Assistance Services should establish a unit within the Program Integrity Division to evaluate the program integrity activities of managed care organizations (MCOs). The new unit should, at a minimum, assess whether MCOs are meeting their contractual requirements to have adequate audit plans, sufficient program integrity policies and procedures, and complete reporting on program integrity outcomes. In addition, the unit should examine the outcomes of MCO audits to determine if they are meeting their planned audit goals and if their activities are adequately minimizing improper payments. The results of this review should be documented and provided to the Health Care Services Division.

Recommendation 19: The Department of Medical Assistance Services should take necessary steps to ensure that all requirements of the managed care contract regarding program integrity planning and reporting are fulfilled by each of the managed care organizations. The Health Care Services Division should use information provided by the Program Integrity Division to annually evaluate the adequacy of the managed care organizations' efforts to prevent, detect and recover improper payments within their networks and make all needed adjustments to contractual requirements.

Recommendation 21: The Department of Medical Assistance Services should enforce contractual requirements for managed care organizations, including the requirement to apply key edits to subcontractor data to ensure accuracy and completeness.

Response to Recommendation 18, 19, & 21: The establishment of the Program Integrity Collaborative with membership of the MCOs, Health Care Services, and Program Integrity Divisions, is making progress in addressing the substance of the findings in the draft report related to the sharing of program integrity information within DMAS, including agreement on terminology (e.g. fraud, waste, payment errors, etc.) and the development of templates for use by the MCOs in sharing program integrity data with DMAS. In addition, it is serving as a forum for the discussion of case studies, technologies, and corporate policies that will facilitate program integrity efforts. It is clear that MCO corporate program integrity efforts take place in different business units within highly complex organizations which will require a focused effort to reflect the total program integrity effort. This Collaborative will be a very effective tool for addressing many of the JLARC findings and recommendations that require joint efforts by the MCOs and DMAS.

Recommendation 20: The Department of Medical Assistance Services should formally evaluate the benefits of using their External Quality Review Organization to periodically assess the degree to which managed care organizations comply with contractual requirements regarding program integrity planning, executing, and reporting.

Response to Recommendation 20: DMAS will evaluate the cost and potential benefit associated with this recommendation.

Recommendation 22: The Department of Medical Assistance Services should develop a plan for using encounter data as the basis for setting capitated rates and other reporting purposes.

Recommendation 23: The Department of Medical Assistance Services should evaluate alternatives and select a process for managed care encounter data to be audited against medical records.

Recommendation 24: The Department of Medical Assistance Services should evaluate alternatives and select a process for how all managed care expenditure data used to set rates should be independently audited.

Response to Recommendation 22, 23, & 24: Medstat (now Thomson Reuters) over a two year period conducted a study of the encounter data system (MMIS) at DMAS as well as the MCOs. Deliverables included the evaluation of discrepancies between the MCO and DMAS encounter data, development of a User Guide and Data Element dictionary, and detailed reports for each MCO and DMAS summarizing the issues identified in the data and suggesting potential action items for both DMAS and MCOs. Subsequently, these findings have been used to make continual improvements in the encounter data for use in utilization studies and quality improvement activities. Improvements in the encounter data have been instrumental in our current development of invoicing for MCO drug rebates. As a result of the previous consulting work, DMAS will be using pharmacy encounter data for the invoicing of MCO drug rebates (3rd Quarter) scheduled for mid-November 2011. In summary, however, DMAS already uses “encounter data” for rate setting, albeit not the same dataset as submitted through the MMIS. While we believe this data is reliable and **meets the standards established by CMS for rate setting**, we will review the recommendations and adopt any recommendations that will improve the data in a cost-effective manner. We appreciate support for funding to evaluate and improve the data; a budget decision is being developed to fund a consulting study and staffing to determine an optimal approach for the use of encounter data for MCO rate-setting.

Recommendation 25: The General Assembly may wish to consider establishing a special inter-agency task force to examine some of the recommendations in this report, other relevant issues, and the potential effects of healthcare reform upon the fiscal integrity of the Medicaid program. The task force should be chaired by the Secretary of Health and Human Resources, and include the Director of the Department of Medical Assistance Services, the Commissioner of the Department of Social Services, two members each of the State Boards of Social Services and

Mr. Glen Tittermary
October 3, 2011
Page 12 of 12

Medical Assistance Services, five directors of local departments of social services, and the Auditor of Public Accounts. The General Assembly may wish to consider requiring the task force to develop a comprehensive improvement plan to address the changes needed, with mechanisms to guide and measure its progress over successive administrations. The General Assembly may also wish to require the task force to present a comprehensive improvement plan to the Senate Finance and Rehabilitation and Social Services committees, and the House Appropriations and Health, Welfare, and Institutions committees, prior to the 2013 General Assembly session.

Response: The major concern articulated in the draft report is regarding eligibility determination errors at the local departments of social services. While this is a serious concern, especially in light of federal healthcare reform, it is being addressed through the development of a modern eligibility system that will mitigate errors that occur currently in varying levels of manual intervention in the process. DMAS and DSS are already pursuing short-term improvements through an independent review as we design and implement the new system. Further, the Commonwealth, including DSS and DMAS, participates in the Maximum Enrollment Grant through the Robert Wood Johnson Foundation which continues to focus collaborative efforts on improvements in eligibility policy and procedure.

Regarding payment error, the report references the PERM review resulting in an error rate of 0.7 percent, which is simply extraordinary. While the report believes there are improvements to be made, and DMAS concurs, it hardly necessitates the form and structure articulated in this recommendation. This recommendation would divert already stretched resources away from core functions and would not be the best use of resources.

Again, thank you for the opportunity to review this report. We look forward to working with interested parties to continue to improve the program integrity program in Virginia Medicaid.

Sincerely,

A handwritten signature in black ink that reads "Cynthia B. Jones". The signature is fluid and cursive, with the first name "Cynthia" being the most prominent part.

Cynthia B. Jones
Director

Attachment

CBJ/sf

Attachment:
DMAS Technical Concerns with the PERM Eligibility Error Calculation

Throughout the discussions with JLARC staff for two years now regarding the PERM methodology and process, we have attempted to point out the statistical limitations related to extrapolation of cost, particularly in relation to the eligibility side of PERM. In defense of the JLARC study team, we are not questioning the fact that they are utilizing, as a base methodology in their dollar estimates, the methodology articulated by the Centers for Medicare and Medicaid Services (CMS) to extrapolate the PERM error rate to a full program impact. What is not clear in the report is that CMS does not utilize their own methodology to determine a pay-back amount associated with PERM. The PERM process is, by design, an educational tool to identify program errors for corrective action to improve program integrity. As such, the calculation CMS prescribes is not one that is designed to be rigorous enough to support identification of a defensible claim of financial liability. Moreover, states have varied their resource commitment to the PERM project under the assumption of its use as an educational tool, as opposed to a financial audit.

The study team attributes accuracy to their extrapolation based on a mathematical calculation where they demonstrate that their projection of total expenditures in the PERM sample is within 8 percent of actual expenditures (Appendix B). That is, the draft report makes the point that the PERM sample is shown to be representative because the PERM sample mean cost per case is roughly equal to the known population mean. This conclusion is not disputed. However, as has been discussed multiple times, the fact that the sample supports a somewhat acceptable estimate of the error rate in the population of cases does not mean that the error rate in cases can be assumed to equal the error rate in the dollars associated with the cases. There is a logical and statistical disconnect here that JLARC staff does not appear to appreciate. It is a fundamental principle of sampling statistics that one cannot infer from a population that was sampled (cases) to a population that was not (dollars). If one wants to infer to dollars, dollars should be the sampling unit.

We have stressed that there is extensive literature on how to properly sample if one wants to estimate a dollar error rate, but the draft shows no evidence that there is any acknowledgement of the related principles. This is not a mere theoretical concern. In the present case, the sample can have the same average cost per case as the population, and there can still be a systematic relationship between cost of each case and likelihood of the case being in error. If there is such a relationship, then the error rate for cases will necessarily be a poor (biased) estimate of the error rate for dollars. The PERM sampling method on the eligibility side was not designed by CMS to support valid extrapolation to dollars, so the estimates in the tables presented are not valid. They may by chance be correct, or they may be too high or too low. The only thing that is certain is that their accuracy is unknown. We have said before, and we continue to recommend that JLARC staff research the sampling methods that are required if one wants to make inferences about dollar error rates.

Further, the study team apparently has no concern with the representativeness of the PERM sample and therefore the ability to extrapolate the results against the full program population. Appendix B of the draft report provides detail regarding the PERM methodology and the sample

size. The PERM sample was divided into three “strata” with 168 cases randomly sampled from each stratum. It is important to understand that each stratum represented a different type of case, or more accurately, a different type of eligibility determination. In other words, each stratum represented an independent sample of a particular type of eligibility determination. Because eligibility is conducted in over 120 localities, it is likely that some localities were unrepresented in the sample for each stratum, while larger localities, in terms of Medicaid recipients/applicants, were dominant.

While JLARC has apparently dismissed our concerns regarding the representativeness of the sample for statewide extrapolation based on sample size, JLARC acknowledges in this report as well as the interim report last year that eligibility practices, and by implication, error rates, vary significantly by locality. In fact, JLARC recommended, in the interim report, that DMAS and DSS pursue a pilot to identify locality-specific error rates to prove this concern. Further, in this draft report, the study team acknowledges, in discussion of the Medicaid Eligibility Quality Control (MEQC) reviews, that “any given review typically includes only one or two cases per locality...As a result, the determination of a statewide error rate is of only limited use because it cannot be used to distinguish between those errors that occur statewide and those that occur only in particular localities (emphasis added).” It is unclear to DMAS how the study team’s concern can be true of MEQC reviews, but not of PERM. In fact, by extrapolating the PERM error rate, the study team is contradicting its own determination of the usefulness or statewide error rates based on unrepresentative samples.

Aside from the issue of statistical validity, there are concerns about the confusing and possibly misleading way that some conclusions are presented. We would call your attention to the discussion on page iv. In the second paragraph it says “... \$[263] million was improperly paid on behalf of individuals who, based on the best information available, were not eligible ...” In the third paragraph, it says that \$245 million (93%, or nearly all) of the above amount is related to “undetermined” cases, where “... the recipient’s file lacked the necessary documentation (or in some instances, the entire file) to establish whether they were eligible ...” These two statements can not both be true (at least not with respect to 93% of the cases in question). Either they were not eligible, or it’s unknown if they were eligible. It can’t be both.

While we believe all these estimates of dollar error are statistically invalid, even if that were not the case, it is misleading to state that “eligibility errors resulted in \$263 million of improper payments” when 93 percent of that cost, or \$245 million is attributable to cases in which JLARC staff, DMAS, DSS, or anyone else cannot state with any level of certainty that the individuals identified were not eligible for coverage. By definition, documentation did not exist that would allow such a determination. While that constitutes a process error that is extremely troublesome, to unequivocally attribute the JLARC-associated \$245 million in costs as “improper” is simply incorrect.

JLARC Staff Note #1:

This statement is potentially misleading. The PERM extrapolation was designed by CMS following a formal regulatory process. The extrapolated value was used to calculate a national improper payment amount, which CMS reported to Congress as required by the federal Improper Payments Information Act (IPIA). The cases (and associated claims values) upon which the extrapolation was based were reviewed by DMAS and any identified errors were reported to CMS. In accordance with the PERM methodology, a statistically significant number of cases were reviewed by DMAS such that the results would be representative of all cases statewide, within a 95 percent level of confidence. After consulting with DMAS, JLARC staff revised this estimate by treating certain errors and their associated values as correct to account for changes in eligibility policy since DMAS reported the errors to CMS. This revision did not reduce the number of sampled cases and thus did not disturb the level of statistical significance.

JLARC Staff Note #2:

These statements are potentially misleading. As stated in Note #1 above, the PERM methodology was designed by CMS and executed by DMAS. Although JLARC staff agree that the “undetermined” recipients could have been eligible, CMS treats these cases as errors in accordance with guidance from the federal Office of Management and Budget (OMB) on implementation of the IPIA. As noted by CMS, “‘Undetermined’ cases must not be excluded as payment errors as they are cases in which there is insufficient documentation to verify whether, or not, payments made on behalf of the sampled case were appropriately paid. Under OMB’s IPIA guidance, such cases must be included as errors.” Source: https://www.cms.gov/PERM/downloads/Fin_Rule_Aug_2.pdf

In addition, although CMS has modified the PERM error rate methodology, it has instead “allow[ed] States to have their State specific error rates calculated with undetermined cases included as errors, and with undetermined cases excluded as errors.” This is similar to the approach adopted by JLARC staff, who used a range to illustrate the impact resulting from the inclusion and exclusion of the undetermined cases.

JLARC Staff Note #3:

JLARC staff agree that CMS did not design PERM to recoup costs, and instead intend it to be used as an educational tool. For that reason, JLARC staff have characterized the extrapolated amounts resulting from eligibility errors as an estimated fiscal impact that cannot be collected, only prevented.



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

Office of the Commissioner

Martin D. Brown
COMMISSIONER

October 3, 2011

Mr. Glen S. Tittermary, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capitol Square
Richmond, Virginia 23119


Dear Mr. Tittermary:

Thank you for sharing JLARC's exposure draft report: *Mitigating the Risk of Improper Payments in the Medicaid Program*. I appreciate the opportunity to comment on the report and to provide you with my assurances that the Virginia Department of Social Services remains committed to working in partnership with the Department of Medical Assistance Services and our local departments of social services to address errors and inefficiencies in the Medicaid eligibility determination process.

After carefully reviewing the draft report, I have enclosed some comments and recommendations that the Department hopes that JLARC would consider before finalizing the report and making its recommendations to the Joint Commission.

Should you have any questions regarding our comments, please do not hesitate to contact me.

Sincerely,


Martin D. Brown

MDB:ts

VDSS RESPONSE TO EXPOSURE DRAFT REPORT: MITIGATING THE RISK OF IMPROPER PAYMENTS IN THE MEDICAID PROGRAM

JLARC RECOMMENDATIONS FOR THE DEPARTMENT OF SOCIAL SERVICES

NEW INFORMATION TECHNOLOGY AND DATA ARE NEEDED TO IMPROVE INTERNAL CONTROLS AND INCREASE PERFORMANCE MEASUREMENT

1. VDSS agrees with JLARC's recommendation that it examine the costs, benefits and feasibility of expanding the Rushmore case tracking system to the Medicaid program that will allow both local departments of social services and VDSS to better monitor case errors. An examination of the costs have begun and VDSS will contact Rushmore and VITA about expansion of the program to Medicaid before the end of this year. Through the use of Rushmore, local agencies and VDSS would have an additional process to identify and monitor systemic eligibility errors on an agency, regional and state basis.

VDSS also supports the administrative redetermination process and has promoted the implementation of administrative renewals in connection with the Maximizing Enrollment for Children grant. This technological change would allow renewal forms pre-printed with enrollee data to be downloaded by local agencies and sent to the client for verification of the information on the forms. VDSS sees this as a method both to reduce barriers to enrollees as well as a labor-saving process for local agencies. However, while streamlining local workloads and removing client barriers, we question JLARC's conclusion that there are minimal risks to this approach.

VDSS also supports efforts, included as part of the Maximizing Enrollment grant, to simplify the Medicaid Eligibility Determination Manual and to make the online manual easier for workers to navigate. Local agency staff have worked with VDSS staff in making recommendations to simplify the Medicaid Eligibility Determination Manual, the main reference manual LDSS follow in processing eligibility determinations. We encourage the use of Maximizing Enrollment grant funds to take the recommended revised Eligibility Manual revisions and to use software to make the Manual more user-friendly for the eligibility staff as a way to reduce worker errors when applying Medicaid policy. However, as long as the Medicaid policy remains so complex a new manual format will do little to reduce errors.

Other IT enhancements such as the VDSS customer portal and a worker portal, as well as the Commonwealth Gateway which will allow for data verification from data sources such as the Department of Motor Vehicles and other Virginia agencies, should also assist in the reduction in errors. Moving the eligibility determination of applicants for the category of the Aged, Blind and Disabled from a manual eligibility determination to one that is automated should also greatly assist workers in reducing errors. VDSS also recommends that in any redesigns of a state Medicaid eligibility system and MMIS that edits be built into the system that reduce the likelihood of eligibility determination errors.

AUTOMATED ASSET VERIFICATION SYSTEMS SHOULD BE EXPLORED

2. VDSS is willing to examine the feasibility of local departments of social services verifying the financial and real property assets of Medicaid applicants through records maintained by Virginia's Circuit Courts. Prior to the development of a separate automated system, however, VDSS recognizes that there is a federal requirement that Virginia must meet before the end of 2013 to have an Asset Verification System: this proposed system has been under discussion with DMAS. Also, as part of the federal government's preparation for the 2014 implementation of Medicaid eligibility provisions of the Affordable Care Act (ACA), the federal government plans to create a data hub where state eligibility staff can verify a variety of applicant data necessary to determine eligibility from sources such as the Internal Revenue Service, Homeland Security and the Social Security Administration. VDSS is interested in learning more about the planned federal data hub and the extent to which asset and financial information will be a part of the hub. Also under ACA, states, including Virginia, are examining their Medicaid eligibility determination systems and making preparations for these systems interconnectivity to health insurance exchanges. VDSS, working with DMAS, is interested in exploring the integration of an asset verification capability with the necessary revisions to the system designed to determine eligibility for Medicaid and the health insurance exchange.

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND SOCIAL SERVICES SHOULD CREATE AN INTER-AGENCY COMMITTEE TO CONTINUOUSLY EVALUATE THE ELIGIBILITY ERROR RATE

3. VDSS supports meeting with DMAS staff, local agency and local government staff in a concerted effort to address the eligibility error rate. The committee's purpose could include the examination of training needs, automation, program integrity resources, data analysis, corrective action remedies, and potential legislation necessary to reduce the eligibility error rate with a report to the pertinent General Assembly committees recommended by JLARC. This committee could also examine the feasibility of increasing the number of local agency monitoring reviews, agency-specific error rates, as recommended by JLARC, and the resources that would be needed to commit to those processes. The committee should also study how health care reform will impact program integrity efforts since PERM, the MEQC process, and Medicaid eligibility will be changing in 2014 under ACA.

To avoid a duplication of effort, it would appear that this committee will need to understand how its charge would be distinct from JLARC's recommendation for a General Assembly mandated committee (See Recommendation Number 25) led by the Secretary of Health and Human Resources.

DMAS AND THE DEPARTMENT SHOULD RECONSIDER THE NATURE AND SCOPE OF THE RESPONSIBILITIES FOR THE INVESTIGATION OF RECIPIENT FRAUD AND ERROR IN PUBLIC ASSISTANCE PROGRAMS.

5. VDSS supports this recommendation.

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND SOCIAL SERVICES SHOULD CONSIDER THE IMPLEMENTATION OF AN ADMINISTRATIVE DISQUALIFICATION HEARING PROCESS OF THE MEDICAID PROGRAM.

6. VDSS supports studying the feasibility of implementing administrative disqualification hearings for Medicaid; however, there is no specific federal authority from the Centers for Medicare and Medicaid Services. Without federal approval, this will not be possible.

THE GENERAL ASSEMBLY MAY WISH TO CONSIDER ESTABLISHING A SPECIAL INTER-AGENCY TASK FORCE TO EXAMINE RECOMMENDATIONS IN JLARC'S REPORT. THE TASK FORCE WOULD BE HEADED BY THE SECRETARY OF HEALTH AND HUMAN RESOURCES AND INCLUDE AMONG ITS MEMBERSHIP THE COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES AND MEMBERS OF THE STATE BOARD OF SOCIAL SERVICES AS WELL AS LOCAL DIRECTORS OF DEPARTMENTS OF SOCIAL SERVICES.

25. VDSS, while fully supportive of a comprehensive examination of the fiscal integrity of the Medicaid program, believes that it may be helpful to have a better understanding of the impact of proposed health care reform rules on the Medicaid program in Virginia before the establishment of this task force. It may also be helpful to have the recommendations from the interagency committee (Recommendation 3) before convening this high level task force to avoid duplication of effort.

ADDITIONAL VDSS RECOMMENDATIONS

EXPAND THE CAPABILITIES OF THE VDSS QUALITY ASSURANCE UNIT TO EXAMINE MEDICAID ERRORS

Currently, the Quality Assurance Unit's role in monitoring Medicaid error rates is limited primarily to MEQC pilots and an occasional special project since most of the Quality Assurance Units' resources are directed to the SNAP error rate. VDSS recommends expanding the personnel resources of the Quality Assurance Unit so that it can have a more active, consistent role in case reviews and error rate measurement of Medicaid eligibility determinations. Even with an increase in technology for Medicaid eligibility determinations, there will still be a need for an internal, back-end review of eligibility determinations and case decisions that should be conducted periodically. Under ACA, more flexibility is given to accepting data verifications as well as client statements. There needs to be back-end quality assurance reviews to confirm that the data used and

client statements accepted support the eligibility determination made to assure program integrity. Previously Benefit Programs within VDSS had supported case reviewers placed in each regional office to review Medicaid eligibility determinations but state budget restraints did not allow the addition of case readers. Additional Quality Assurance staff could assist in reviewing systems reports, such as Rushmore reports, as well as Medicaid cases and pinpointing systemic errors.

EXAMINATION OF DMAS ADMINISTRATIVE FUNDING TO VDSS TO SUPPORT PROGRAM INTEGRITY FUNCTIONS

VDSS supports the examination of the need for possible increased DMAS funding to VDSS to support program integrity and quality assurance activities. The Department recommends that the sufficiency of funding from DMAS to support program integrity functions be studied either as part of the interagency task force or as a separate study.

VDSS RESPONSE TO EXPOSURE DRAFT REPORT: MITIGATING THE RISK OF IMPROPER PAYMENTS IN THE MEDICAID PROGRAM

AREAS OF DISAGREEMENT

PAYMENT ERROR RATE METHODOLOGY

1. We disagree with the methodology JLARC has utilized in determining the payment error rate resulting from incorrect local social service agency Medicaid eligibility determinations because of its considerable deviation from the methodology utilized by the federal PERM process. We believe that JLARC's methodology that assumes that all of the undetermined cases (those files that were missing or lacked documentation of the eligibility determination) would be ineligible for Medicaid benefits inflates the payment error rate. While we can understand that JLARC may be reluctant to accept the PERM alternative approach of assuming that all undetermined cases were in fact eligible, which yields an error rate of an estimated \$44 million, a more realistic approach would have been to do a pro-rating of the undetermined errors that allowed for a percentage of the errors to be determined eligible with another percentage ineligible. This would have resulted in a more realistic payment error estimate.

SUFFICIENCY OF VDSS TRAINING

2. While VDSS hardly supports additional training opportunities for its local agencies as a way to address changes in policy, to provide refresher training for complex policies, and to address systemic issues identified in internal and external audits, we do not agree with JLARC's assertion that both formal and informal training provided by VDSS was insufficient during the period of the study and that insufficient training led to worker errors.

JLARC was presented with an extensive list of Medicaid training courses that were available to local agency staff that included VISSTA face-to-face training, online training tutorials, WEBEX training sessions, and training offered by both DMAS and VDSS regional consultants. The majority of the errors identified by PERM were not related to the failure of local agency staff to understand Medicaid policy (for example, there were more errors in the less complex category of Families and Children Medicaid eligibility determination that is completed by the workers through ADAPT than there were in the far more complex, Aged, Blind and Disabled category of Medicaid which is completed manually outside of ADAPT.) Local agency staff's ability to attend VDSS training sessions provided during the study period was compromised because of the State's economic situation and its impact on local agencies described in more detail in #3 below. Neither did local agency staff have sufficient time, due to the economic impact in their communities, to devote a substantial amount of time to internal training of staff. We value training, however, we realize that outside contractors can be resource intensive,

therefore, we have brought the formal training process in-house to gain more control and direction over the formal training process.

IMPACT OF ECONOMIC DOWNTURN

3. We are disappointed that JLARC did not take into account the impact of Virginia's economic situation before and during the Study period and the PERM audit. Starting in July 2007, local departments of social services began to see a marked increase in the number of applications for all of its benefit programs because of the economic downfall. Since July 2007, the Supplemental Nutrition Assistance Caseload has increased by 82%. In 2009-2010, Medicaid enrollment increased 10% and nearly 20% overall since the beginning of the recession. An unprecedented number of individuals whose families had been impacted by unemployment reached out to local departments for medical coverage and nutritional benefits. During this same period, local agencies were faced with a workforce suffering high attrition rates, including many in agency leadership positions, due to "aging out" of veteran staff. In addition, cash-strapped local governments were and some remain reluctant to replace local agency staff or provide additional staff to handle the major increases in caseloads.

We believe that the environment these last few years of local agencies doing far more with less contributed significantly to worker errors, including the failure to adequately document eligibility determinations in case files and to process timely Medicaid redeterminations. Although VDSS has supported budget amendments to increase the number of eligibility workers statewide following two consultant studies, there has not been an increase in eligibility staff to support the increase in caseloads. We are disappointed that the study did not acknowledge the workload increases that local agencies have had to absorb without any additional resources. The failure of lost files or undocumented files leading to undetermined errors could also been in part to the collapse of the EZ Filer System utilized by some local agencies in their attempts to have an electronic case management system. Approximately 21 local agencies statewide used this private system before ownership issues required local agencies to abandon EZ Filer causing agencies to have to recreate case files.

The report also notes that many local agencies use "generalists" that can determine eligibility for a variety of public assistance programs. While having staff that can specialize in complex Medicaid eligibility determinations is optimal, it is unrealistic given the unprecedented caseload growth without additional resources.

VDSS MONITORING OF SYSTEMIC ERRORS

4. We differ with JLARC on its conclusion that there has not been an effort to identify and address systemic errors made by local agencies in Medicaid eligibility determinations. While we believe that there can be enhancements to the current risk monitoring process that would use technology, such as Rushmore, we believe that statewide and within regions, as evidenced by MEQC pilots, review of appeals, case readings by regional consultants, and previous audits such as Eligibility Review Projects

conducted by an outsider contractor, VDSS has identified systemic errors made by local agencies and have introduced both systems modifications and additional training of local staff to address those errors. We remain committed to doing more.

VDSS DEFINED AUTHORITY

5. We believe that the JLARC report does not sufficiently address the lack of statutory authority provided VDSS in its supervisory role over local departments of social services in Virginia's state-supervised locally administered social services system. The 2005 JLARC report, *Operation and Performance of Virginia's Social Services System*, outlined in its recommendations, the specific supervisory responsibilities that the General Assembly might want to define for VDSS in its role with local agencies. We believe that these recommendations should be revisited in this report. That same report addressed some of the challenges faced by local agencies under the current delivery system.



SEP 27 2011

COMMONWEALTH of VIRGINIA

Office of the Attorney General

Kenneth T. Cuccinelli, II
Attorney General

900 East Main Street
Richmond, Virginia 23219
804-786-2071
FAX 804-786-1991
Virginia Relay Services
800-828-1120
7-1-1

September 27, 2011

Mr. Glen S. Tittermary
Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capitol Square
Richmond, VA 23219

Dear Director Tittermary:

Thank you for allowing us to comment on your draft report titled *Mitigating the Risk of Improper Payments in the Medicaid Program*. As stated on page 68 in the first sentence of the second paragraph: "Additional analysis of provider fraud collections by JLARC staff indicated that the funds returned to DMAS from cases prosecuted by the MFCU are substantially lower than the recoveries reported by the MFCU in its annual reports." As we discussed, the Code of Federal Regulations requires state MFCU's to report ALL court ordered restitution, fines and penalties as "recoveries" in their required Annual Report. This is a grant requirement which must be fulfilled to receive the 75% federal funds match for state MFCU's.

We respectfully request that you consider changing that sentence to read: "Additional analysis of provider fraud collections by JLARC staff indicated that the funds returned to DMAS from cases prosecuted by the MFCU are substantially lower than the "recoveries" reported by the MFCU in its annual reports, as the term "recoveries" is defined by applicable federal regulations to include all court ordered monetary penalties whether actually collected or not." This change would indicate proper compliance with federal law, and not make it appear that the MFCU is being misleading in its annual reports.

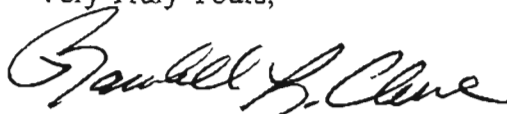
As you know, the Virginia Attorney General's Office sponsored House Bill #2454 (patron Delegate M. Loupassi) in the 2010 General Assembly session. That bill, which was sent to the Crime Commission for further study, would have authorized full law enforcement authority to qualified MFCU investigators. MFCU investigators are required by the Code of Virginia to investigate allegations of fraud being committed by providers against the Virginia Medicaid program, as well as those abusing or neglecting the elderly and incapacitated adults. Many of our cases involve the arrest and conviction of individuals who fraudulently bill the Virginia Medicaid program millions of dollars annually. Since the MFCU investigators have to rely on sworn federal, state and local law enforcement officers to serve legal documents, search

warrants and arrest warrants, as well as to safeguard our unarmed personnel during operations in high crime areas, the completion of our cases with the resulting restitution back to the Commonwealth is significantly delayed. In some cases where immediate action is necessary to seize evidence and assets before they can be destroyed, hidden, or shipped overseas, waiting until other law enforcement agencies are available to assist can literally cause us to lose such evidence and assets entirely.

Therefore, we would request your consideration of recommending in your report to the General Assembly that the investigators assigned to Virginia Attorney General's Office's Medicaid Fraud Control Unit be given law enforcement authority in an effort to streamline investigations and return stolen Medicaid funds to the Commonwealth in a more timely and efficient manner. Your consideration on this request is greatly appreciated. If there is anything we can do to assist you and your staff, please do not hesitate to call.

With kindest regards,

Very Truly Yours,

A handwritten signature in black ink, appearing to read "Randall L. Clouse". The signature is fluid and cursive, with the first name "Randall" being more prominent.

Randall L. Clouse
Director and Chief
Health Care Fraud and Elder Abuse Section
Medicaid Fraud Control Unit

JLARC Staff

Lauren W. Axselle
Janice G. Baab
Jamie S. Bitz
Justin C. Brown
Andrew B. Dickinson
Martha L. Erwin
Kathryn A. Francis
Harold E. Greer III
Mark R. Gribbin
Anna B. Haley
Nia N. Harrison
Joan M. Irby
Betsy M. Jackson
Paula C. Lambert
Bradley B. Marsh
Joseph M. McMahon
Ellen J. Miller
Nathalie Molliet-Ribet
Gregory J. Rest
David A. Reynolds
Kimberly A. Sarte
Walter L. Smiley
Tracey R. Smith
Glen S. Tittermary
Massey S. J. Whorley
Christine D. Wolfe

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Joint Legislative Audit and Review Commission

Suite 1100 • General Assembly Building • Capitol Square • Richmond, Virginia 23219
804-786-1258 • Fax 804-371-0101 • <http://jlarc.virginia.gov>