Medicaid Program Integrity Section is Not Cost-Effectively Identifying and Preventing Fraud, Waste, and Abuse

A presentation to the Joint Legislative Program Evaluation Oversight Committee

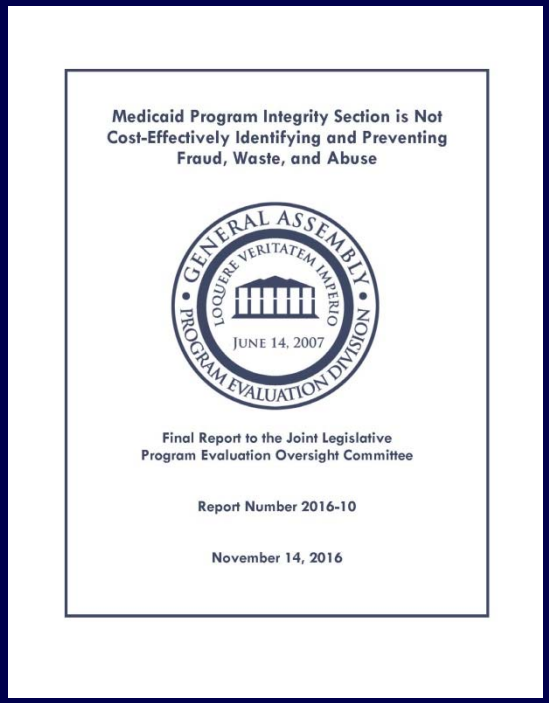
November 15, 2016

Chuck Hefren, Principal Program Evaluator

PROGRAM EVALUATION DIVISION NORTH CAROLINA GENERAL ASSEMBLY

Handouts

The Full Report


Medicaid Program Integrity Section is Not Cost-Effectively Identifying and Preventing Fraud, Waste, and Abuse

GENERAL ASSEMBLY • LOQUERE VERITATEM IMPERIO • PROGRAM EVALUATION DIVISION

JUNE 14, 2007

Final Report to the Joint Legislative Program Evaluation Oversight Committee

Report Number 2016-10

November 14, 2016

Today's Slides


Joint Legislative Program Evaluation Oversight Committee
November 14, 2016

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Program Evaluation Division | North Carolina General Assembly 2

Medicaid Program Integrity 1

Our Charge

Examine the effectiveness and efficiency of the Program Integrity Section of the North Carolina Medicaid program

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Overview: Five Findings

1. Due in part to a lack of access to valid and reliable claim payment data, the number of fraud referrals by the PI Section declined by 84% from FY 2012–13 to FY 2014–15
2. Contract expenditures used to perform reviews of medical service claims exceeded associated savings to state funding requirements by $3.2 million

Overview: Five Findings

3. Lack of policies and procedures limited the effectiveness of the PI Section in deterring fraud and ensuring access to services is not unnecessarily impacted
4. Federal requirements and inadequate performance incentives have limited the effectiveness of the Section's oversight of Medicaid recipient eligibility determinations performed by counties

Overview: Five Findings

5. The PI Section is not effectively using available information from reviews of eligibility determinations and medical service claims to improve the systemic effectiveness of the Medicaid program in reducing fraud, waste, and abuse

Overview: Four Recommendations

1. Develop and implement policies and procedures ensuring available resources are being cost-effectively used to identify and prevent fraud, waste, and abuse
2. In partnership with the Office of Administrative Hearings and the Medicaid Investigations Division, improve the effectiveness of efforts to recoup identified claim overpayments and prosecute fraudulent activity

Overview: Four Recommendations

3. Incorporate a Progressive Corrective Action process for providers selected for enhanced pre-claim and post-claim payment review
4. Require the PI Section to produce an annual performance report documenting results and an annual work plan that provides a roadmap to reduce fraud, waste, and abuse

Background

Background

- Medicaid is predominantly a means-tested entitlement program that provides health care coverage to eligible recipients
- The strategic objective of North Carolina's Medicaid program is to cost-effectively use available resources and leverage partnerships with other program stakeholders to improve health care for all North Carolinians

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Background

- The PI Section contributes to achievement of the strategic objective of the State's Medicaid program by ensuring compliance, efficiency, and accountability within the Medicaid program
  - detecting and preventing fraud, waste, and program abuse
  - pursuing recoupment of improper claim payments and implementing tort recoveries
  - identifying opportunities for cost avoidance

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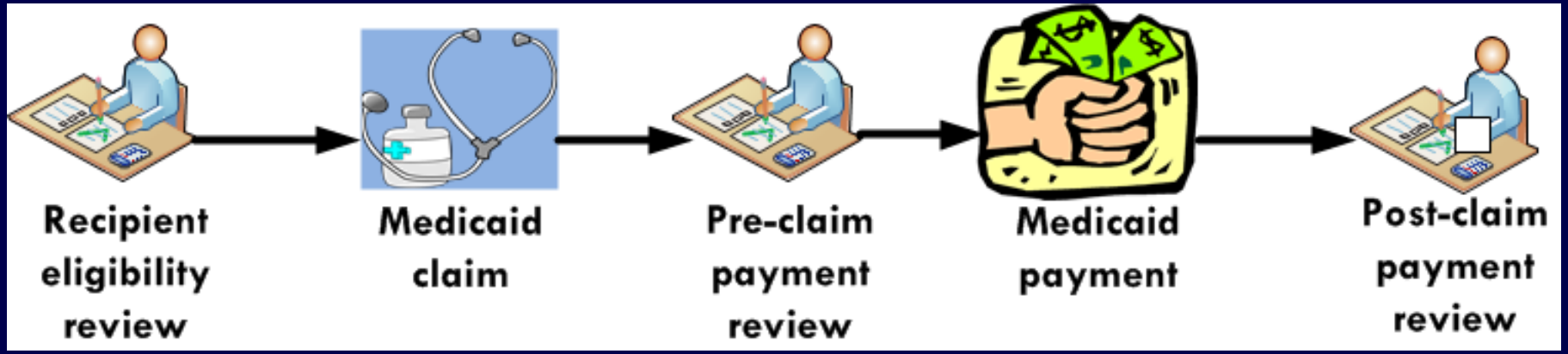
Background

PI Section Oversight Activities

- Recipient Eligibility Determination
- Medical Service Claim Payment Oversight
  - Pre-claim Payment
  - Post-claim Payment

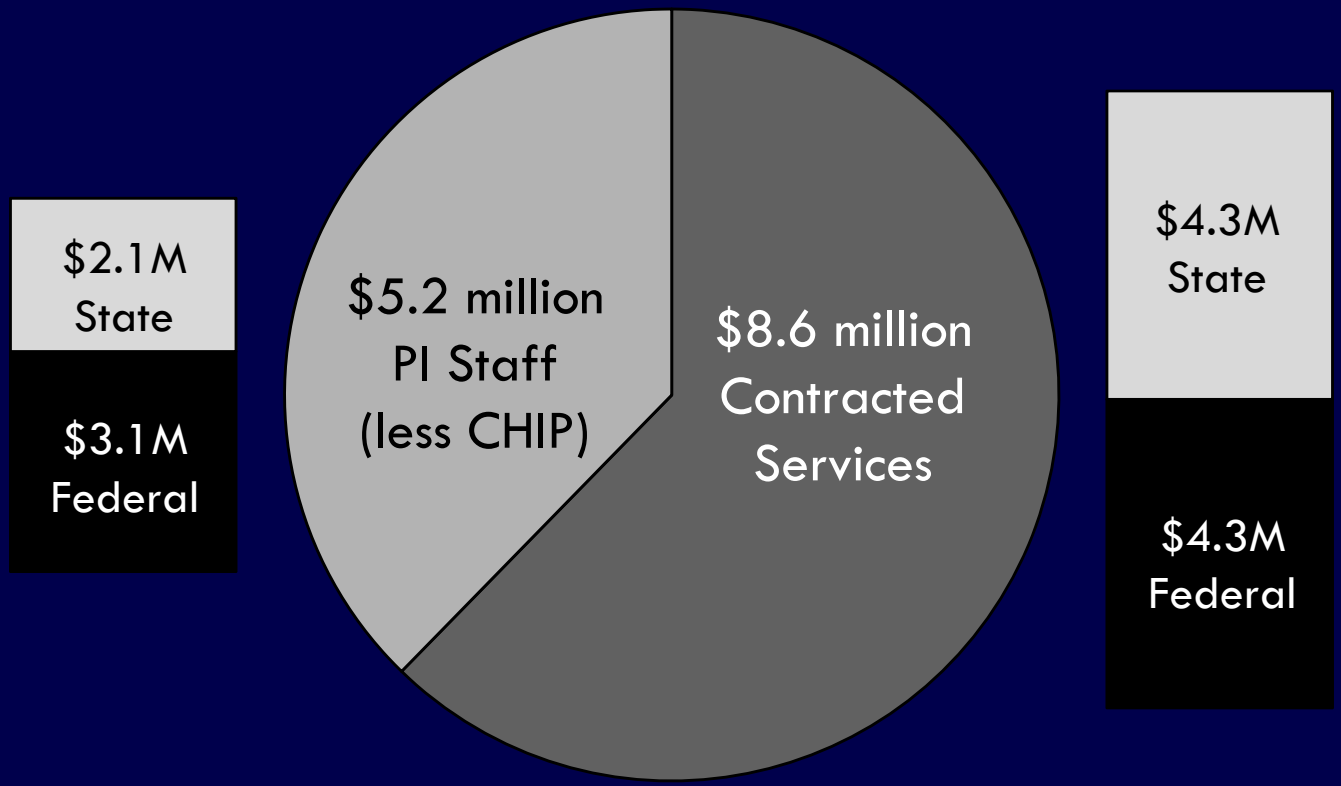


Consider impact on access to quality services

Report pp 5-6

Background

In FY 2014-15 the PI Section Expended $13.8 Million in State and Federal Funds



Total: $13.8M

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Findings

Finding 1

Due in part to a lack of access to valid and reliable claim payment data, the number of fraud allegations referred by the Program Integrity Section to the State's Medicaid Investigations Division (MID) declined by 84% from 122 in FY 2012–13 to 20 in FY 2014–15

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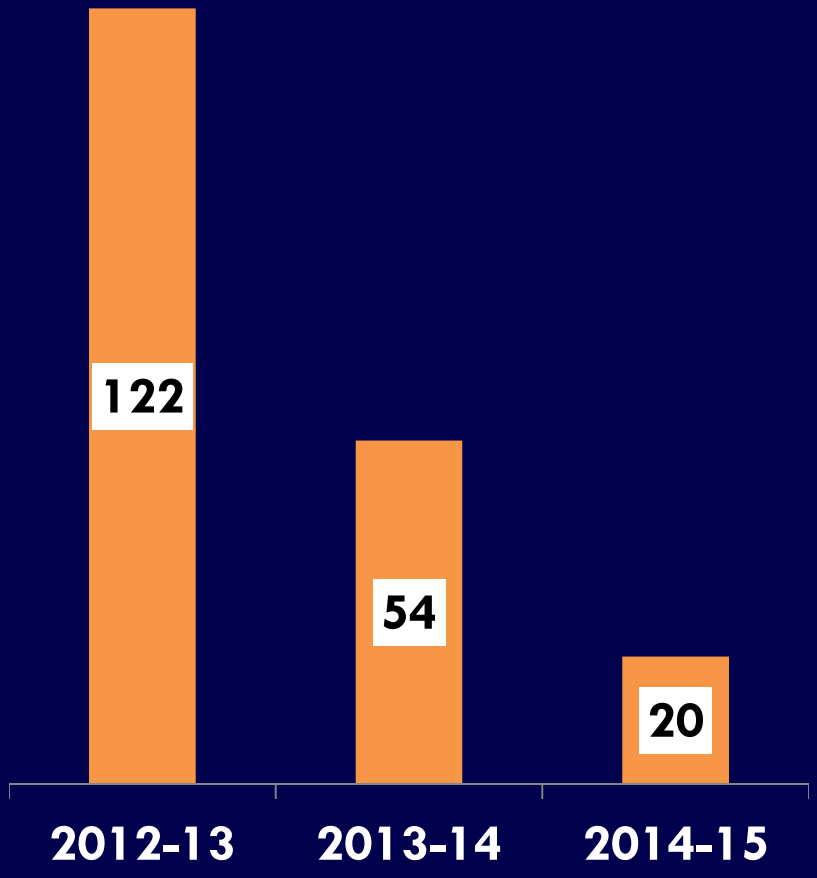
Finding 1: Fraud Referrals

Medicaid fraud referrals by the PI Section declined by 84% from 122 in FY 2012–13 to 20 in FY 2014–15



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Finding 2

Contract expenditures used to perform reviews of medical service claims exceeded the associated savings to state funding requirements by $3.2 million

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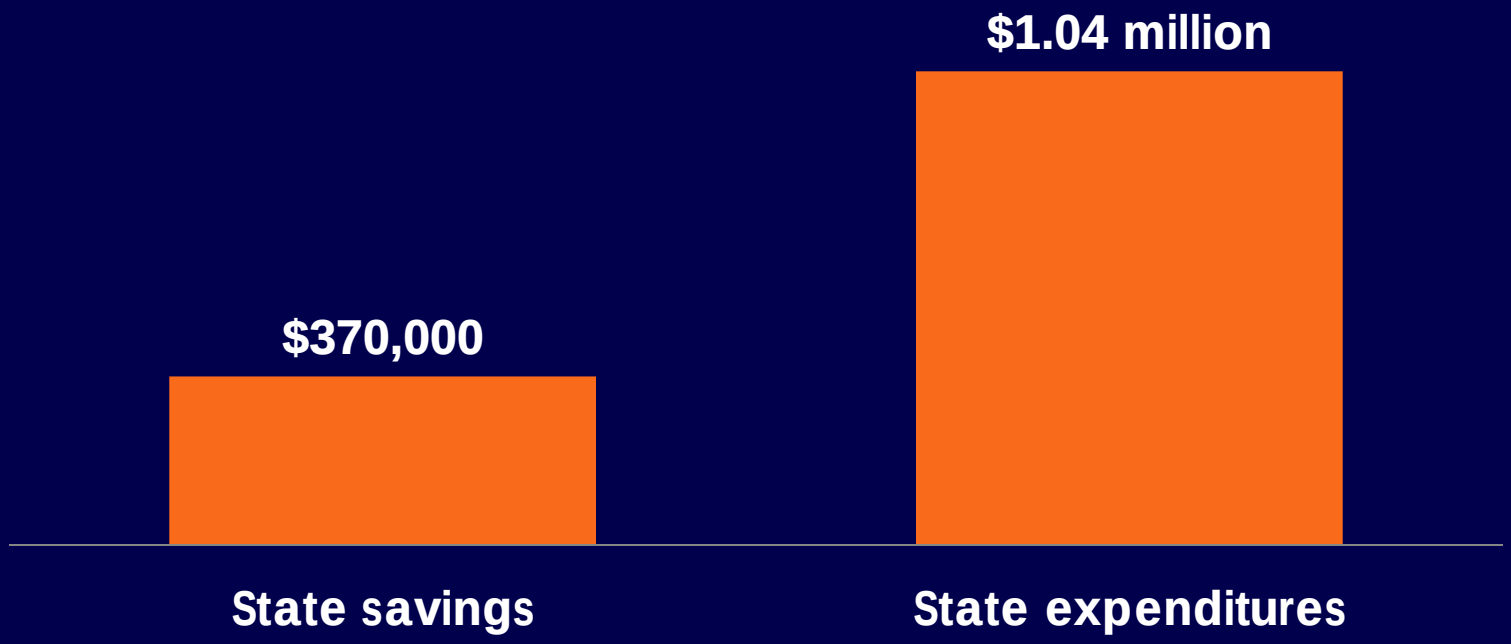
Finding 2: Claim Payment Oversight

State funds exceeding $1M used for contracted pre-claim payment reviews to realize less than $0.4M in state savings



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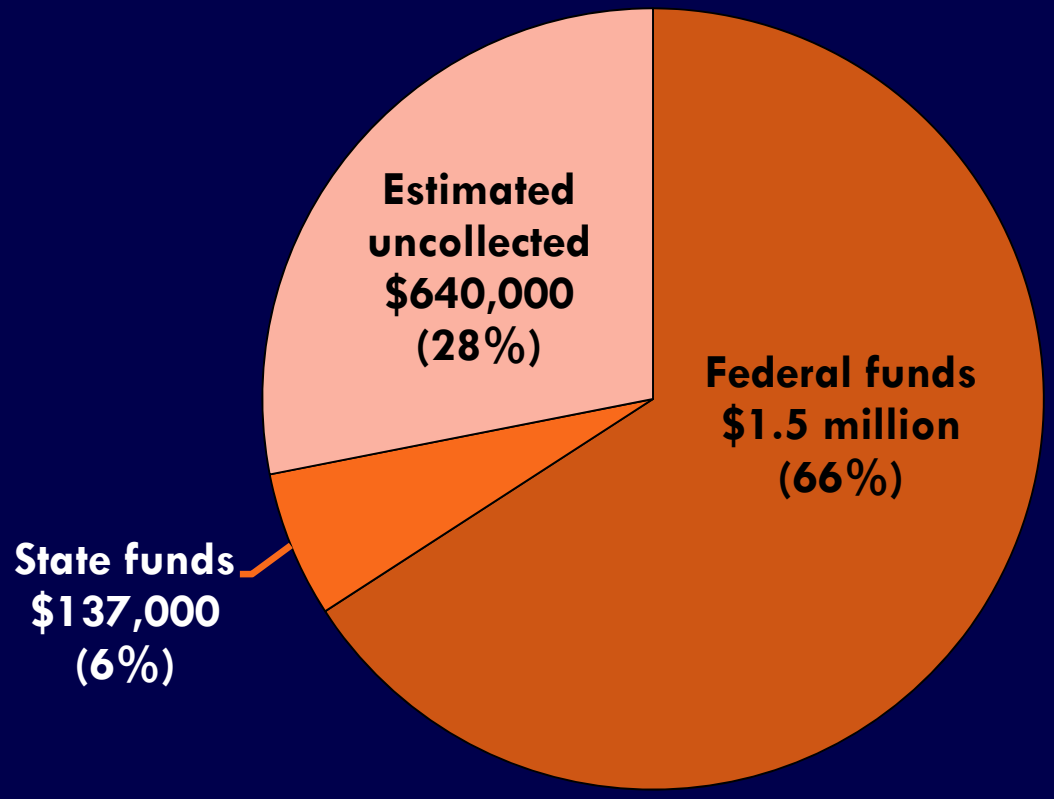
Finding 2: Claim Payment Oversight

State savings from contracted post-claim payment reviews represented only 6% of total identified



Total = $2.3 million

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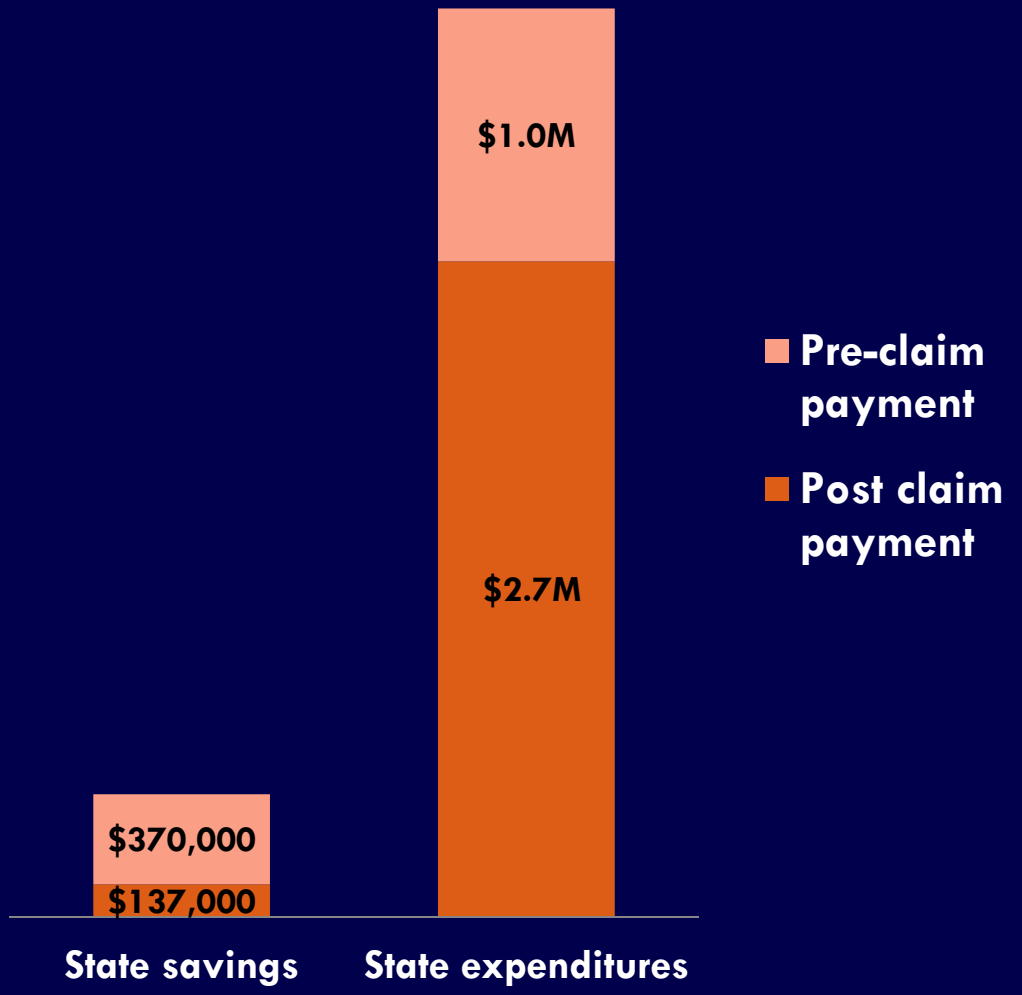
Finding 2: Claim Payment Oversight

State funds for contracted pre- and post-claim payment reviews exceeded associated savings by $3.2M



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Finding 2: Claim Payment Oversight

- Risk assessment of Medicaid service categories can help ensure effective allocation of resources
- Risk factors should include
  1. Annual number and average value of Medicaid eligibility determination/claim payments
  2. Estimated percentage of valid Medicaid eligibility determination/claim payment errors
  3. Cost to identify payment errors and realize savings to state funding requirements
  4. Number of fraud referrals accepted by MID

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Finding 3

Lack of policies and procedures has limited the effectiveness of the Program Integrity Section in deterring fraud and ensuring access to services is not unnecessarily impacted

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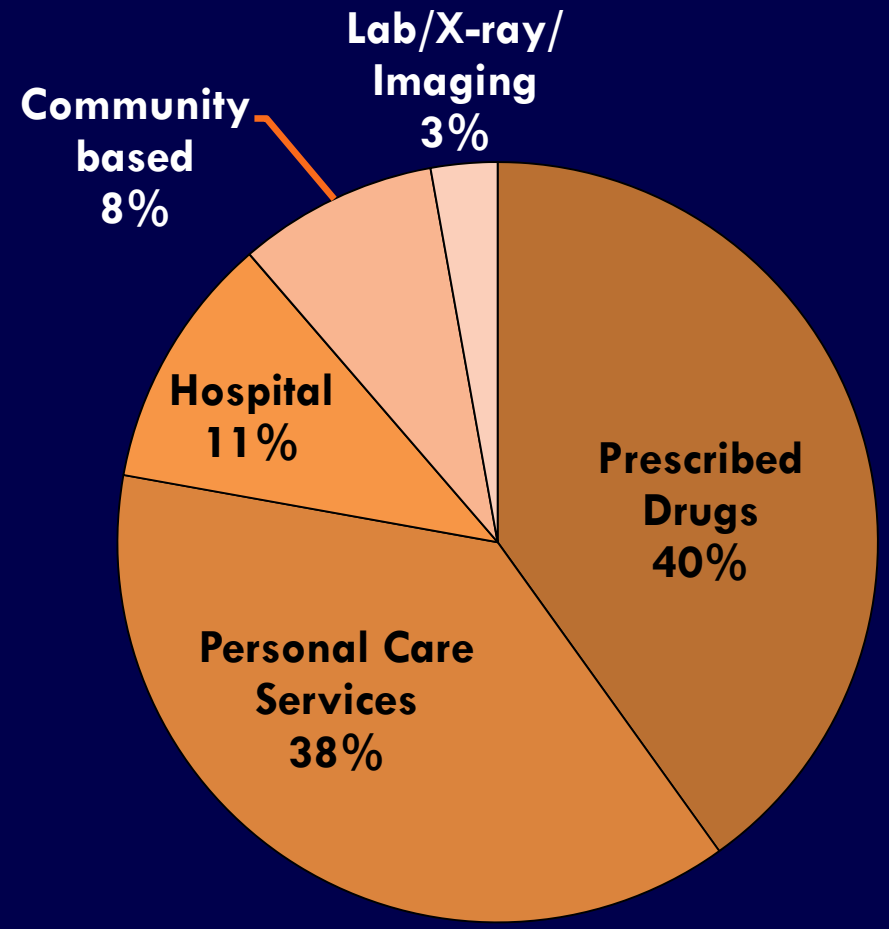
Finding 3: Deterrence—Claim Reviews

Most recent federal review estimated prescribed drug services accounted for 40% of claim errors in North Carolina



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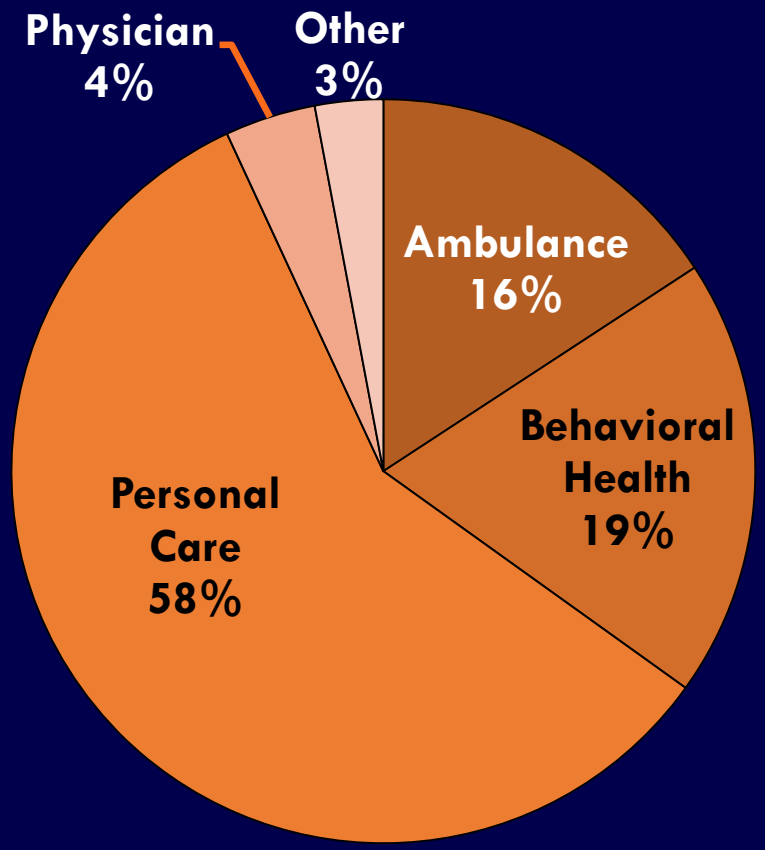
Finding 3: Deterrence—Data Analytics

Over 90% of the identified provider allegations of aberrant billing practices were associated with only three types of Medicaid services



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Finding 3: Access to Services

- Enhanced pre-claim payment reviews may create unintended consequence of limiting access to services
  - 12 of 23 providers subjected to pre-claim reviews in May 2016 had stopped participating in the Medicaid program
  - For the remaining providers, claim volume decreased by 76%, from an average of $159,904 to $38,542
  - Most of these providers had no allegations of fraud

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Finding 3: Access to Services

- The PI Section has not developed policies and procedures to ensure the cost-effectiveness of enhanced oversight of claims for Medicaid services
- Areas that should be addressed include
  1. Provider Selection
  2. Claim Error Determination
  3. Level of Oversight

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Finding 4

Federal requirements and inadequate performance incentives have limited the effectiveness of Program Integrity Section oversight of Medicaid recipient eligibility determinations performed by counties

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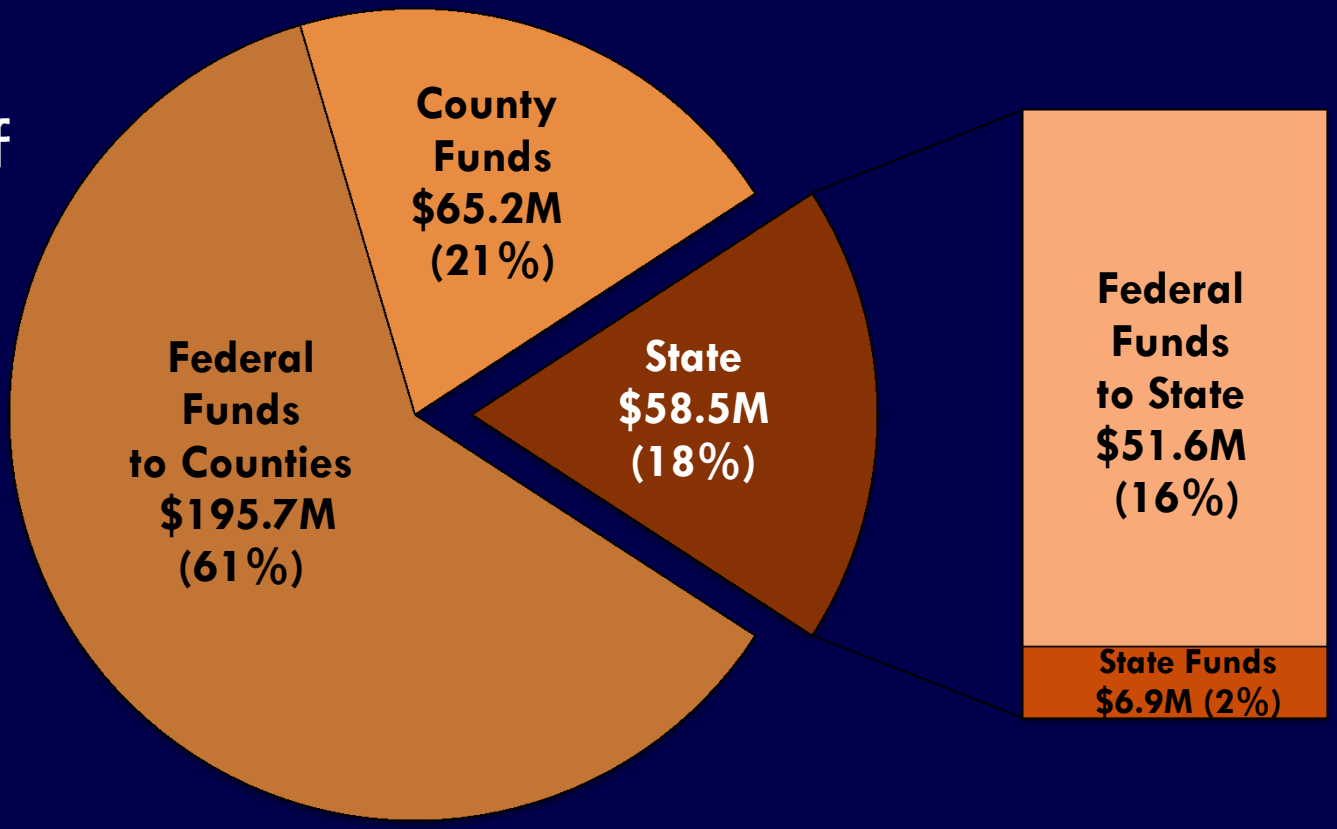
Finding 4: Recipient Eligibility

Counties spent $261 Million of the $319 Million used to perform Medicaid Eligibility determinations in Fiscal Year 2014–15



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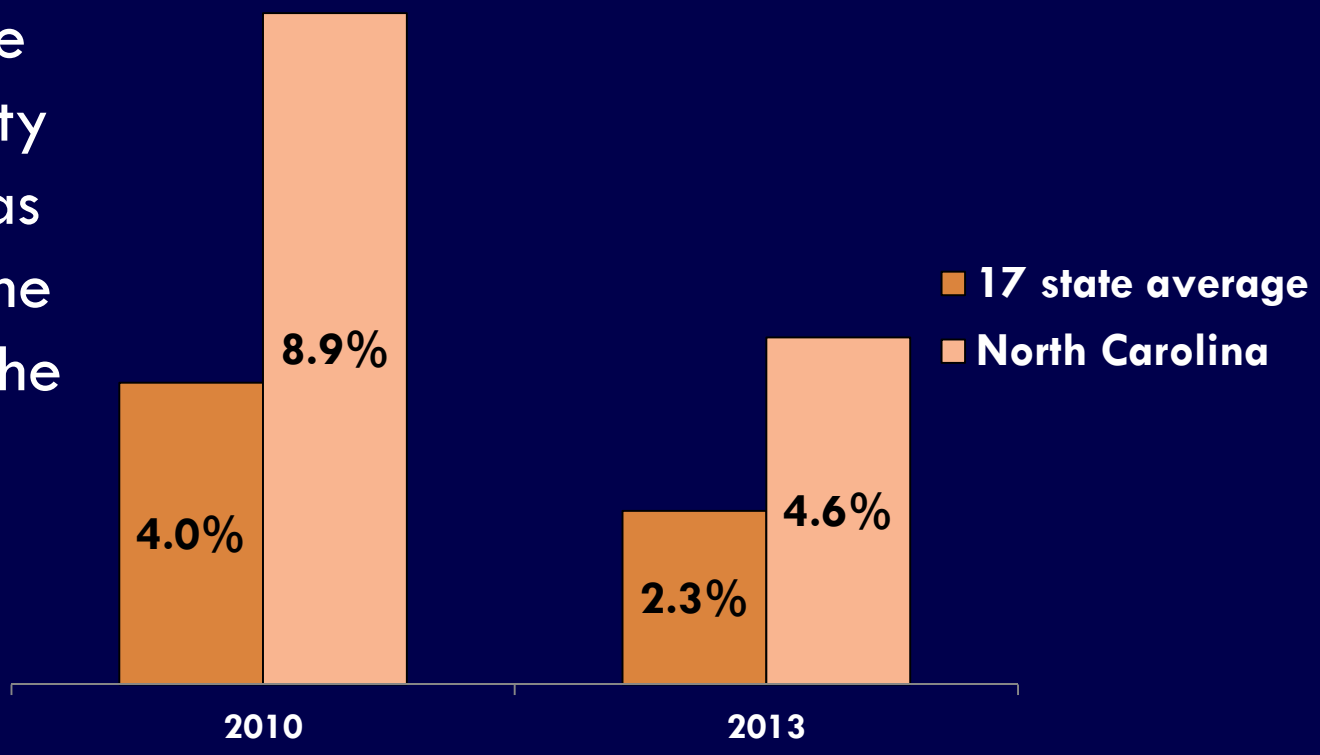
Finding 4: Recipient Eligibility

North Carolina's claim payment error rate for inaccurate Medicaid eligibility determinations was more than twice the average rate of the 17 states in its review cycle



Finding 4: Recipient Eligibility

- The PI Section did not conduct comprehensive reviews of recipient eligibility determinations in FY 2014–15
  - Required to participate in federal pilot review from June 2014 through September 2017
- Establishment of performance incentives can help improve accuracy of recipient eligibility determinations and reduce associated payment errors

Finding 5

The PI Section is not effectively utilizing information from oversight activities to improve Medicaid program business processes in reducing fraud, waste, and abuse

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Finding 5: Business Process Improvement

- Lack of established policies and procedures
  - Root-cause analysis of identified deficiencies
  - Notification of identified systemic deficiencies to Medicaid program
  - Determination of appropriate corrective action
  - Effectiveness of business process improvement

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Finding 5: Business Process Improvement

- Federal Payment Error Rate Measurement (PERM) requires plan to identify and address identified eligibility and payment errors
  - NC Medicaid Program identified 4 system deficiencies associated with nearly $188 million in identified claim payment errors
  - Corrective action plan included
    - Software modifications
    - Provider education
    - Medicaid policy and procedure revisions
  - However, no requirement to determine effectiveness

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Finding 5: Business Process Improvement

PI Section is not effectively using the results of the oversight activities performed by other federal and state entities to include:

- Federal CMS
  - Payment Error Rate Measurement (PERM) Program
  - Medicaid Integrity Contractors
- North Carolina Office of the State Auditor

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Finding 5: Business Process Improvement

- Ability to utilize results of oversight from other entities is limited due to lack of a uniform method to compile information
  - Compilation of eligibility determination and claim payment errors allows for more targeted analysis and better estimates of impact on state funding
  - Different methodologies to identify errors and determine impact
    - Medicaid program disagreed with State Auditor on 19 of 50 identified payment errors
    - PERM and PI Section eligibility error impact methods vary

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Recommendations

Recommendation 1

The General Assembly should require the North Carolina Medicaid program to develop and implement policies and procedures ensuring available resources are being cost-effectively used to identify and prevent fraud, waste, and abuse

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Recommendation 1 (cont'd.)

- Ensure payment errors can be categorized by provider type, medical procedure, and associated oversight activity
- Provide incentives for counties to ensure the accuracy of Medicaid eligibility determinations
- Ensure effective consideration of the results of periodic root-cause analysis of claim payment errors

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Recommendation 2

The General Assembly should direct the North Carolina Medicaid program, in partnership with the Office of Administrative Hearings and the Medicaid Investigations Division, to identify alternatives to improve the effectiveness of efforts to recoup identified claim overpayments and prosecute fraudulent activity

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Recommendation 2 (cont'd.)

- Limit the value of identified overpayments reduced during OAH appeal process
- Improve the collection rate of identified overpayments
- Increase the percentage of fraud referrals accepted by MID for further investigation and prosecution

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Recommendation 3

The General Assembly should require the North Carolina Medicaid program to develop policies and procedures to ensure any additional oversight cost-effectively addresses identified noncompliance

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Recommendation 3 (cont'd)

Amend statute to require the Medicaid program to develop and incorporate a Progressive Corrective Action process to ensure

- credible allegations of fraud are established and referred to MID, as appropriate
- increased oversight is limited to addressing identified billing errors with insufficient evidence to establish a credible allegation of fraud

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Recommendation 4

The General Assembly should require the Program Integrity Section to produce an annual performance report that documents results and an annual work plan that provides a roadmap to reduce fraud, waste, and abuse

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Recommendation 4 (cont'd)

Require Medicaid program to produce annual report to include

- Cost to perform each oversight activity
- Number and value of identified valid claim payment errors associated with waste and abuse
- Number of reviews of Medicaid service providers and of recipient eligibility determinations
- Reductions in Medicaid state funding requirements associated with business process improvements
- Number of fraud referrals accepted by MID

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Recommendation 4 (cont'd)

Require Medicaid program to provide results of an annual risk assessment, which considers

- annual number and average value of Medicaid eligibility determination/claim payments
- estimated percentage of eligibility determination and claim payment errors from all sources
- cost to identify payment errors and realize savings to state funding requirements
- number of fraud referrals accepted by MID

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Summary: Findings

1. Number of fraud referrals declined by 84%
2. Contracted claim oversight expenditures exceeded savings by $3.2 million
3. Claim oversight is not providing effective deterrence and may adversely impact access to services
4. Program Integrity Section oversight of recipient eligibility determinations is not effective
5. Results of oversight activities not being used to improve Medicaid program operations

Summary: Recommendations

1. Develop procedures to cost-effectively identify and prevent fraud, waste, and abuse
2. Improve the effectiveness of efforts to recoup identified claim overpayments and prosecute fraudulent activity
3. Use a Progressive Corrective Action process for providers selected for enhanced oversight
4. Require the PI Section to produce an annual performance report and work plan

Legislative Options

- Refer report to any appropriate committees
- Instruct staff to draft legislation based on the report

Report available online at www.ncleg.net/PED/Reports/reports.html