A REPORT
TO THE
MONTANA
LEGISLATURE

LEGISLATIVE AUDIT
DIVISION

17P-02

State Efforts to Mitigate Fraud, Waste, and Abuse in the Montana Medicaid Program

Department of Public Health and Human Services

JUNE 2018

Performance Audits

Performance audits conducted by the Legislative Audit Division are designed to assess state government operations. From the audit work, a determination is made as to whether agencies and programs are accomplishing their purposes, and whether they can do so with greater efficiency and economy.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Members of the performance audit staff hold degrees in disciplines appropriate to the audit process.

Performance audits are conducted at the request of the Legislative Audit Committee which is a bicameral and bipartisan standing committee of the Montana Legislature. The committee consists of six members of the Senate and six members of the House of Representatives.

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June 2018

The Legislative Audit Committee
of the Montana State Legislature:

This is our performance audit of the efforts by the Department of Public Health and Human Services to reduce fraud, waste, and abuse in the Montana Medicaid program.

This report provides the Legislature information about efforts by the department to mitigate the risk of fraud, waste, and abuse in the Montana Medicaid program. This report includes recommendations for improving controls within the department for identifying and pursuing potential Medicaid fraud, waste, and abuse. A written response from the department is included at the end of the report.

We wish to express our appreciation to the director and her staff for their cooperation and assistance during the audit.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

TABLE OF CONTENTS

Figures and Tables

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Performance Audit
State Efforts to Mitigate Fraud, Waste, and Abuse in the Montana Medicaid Program
Department of Public Health and Human Services

June 2018   17P-02   Report Summary

The Department of Public Health and Human Services is responsible for administering the Medicaid program in Montana. Over 20 percent of Montana's population is enrolled in Medicaid, and the state's share of the cost of the program is estimated to be approximately $915 million for the 2019 biennium. The department is responsible for safeguarding the program from fraud, waste, and abuse by both providers and recipients. While the department has controls in place, changes are needed to improve the state's ability to identify and pursue fraud, waste, and abuse. Without these improvements, fraud, waste, and abuse by providers and recipients could go undetected by the department.

Context

Medicaid is a jointly funded federal and state program for health care services for certain low-income and other eligible groups. Medicaid is an important program in Montana as the state's share of the cost of Medicaid services is estimated to be about $915 million for the 2019 biennium, and over 20 percent of the population of Montana is enrolled in the program. When fraud, waste, and abuse occur in Medicaid, it not only increases costs to state and federal governments, but it results in federal and state taxpayer dollars being spent inappropriately. Because of this, increasing attention has been directed to addressing fraud, waste, and abuse in the Medicaid program. While states must safeguard the Medicaid program from fraud, waste, and abuse, these controls take up state resources that could be otherwise used in the program. Therefore, states must strike the right balance between combatting fraud, waste, and abuse in Medicaid with other needs in the program.

In Montana, multiple divisions and functions within the Department of Public Health and Human Services (department) conduct activities to address fraud, waste, and abuse in the Medicaid program. Some of these activities are associated with Medicaid recipients, while others are associated with Medicaid providers. Audit work examined whether the department's efforts to identify and pursue indications of potential fraud or abuse by providers and recipients are conducted in accordance with federal and state requirements and best practices. Audit work also examined the coordination of efforts within the department and between the department, its contractors, and other state entities. While our work was not intended or designed to identify specific instances of fraud or abuse by recipients or providers, we did evaluate the department's efforts and controls in this area.

Results

Our audit found the department has policies and controls in place to identify fraud and abuse in the Montana Medicaid program. However, the audit identified the need for the department to reconsider policy decisions and strengthen its controls in certain areas to reduce vulnerability to fraud and abuse. The audit found several improvements that should be made in identifying and pursuing fraud and abuse by both Medicaid providers and Medicaid recipients. The audit includes six recommendations to the department and one recommendation to the Montana Legislature. Recommendations to the department include:

- Re-evaluating the state's Medicaid recipient eligibility verification policies to reduce vulnerability to recipient fraud and abuse.

- Additional training for Medicaid eligibility workers on how to address potential recipient fraud and abuse.

- Using state tax information to better investigate complaints of Medicaid recipient fraud.

- Ensuring Medicaid providers are revalidated within the federally required time frames.

- Developing a more risk-based and systematic approach in auditing Medicaid providers.

- Developing an overall strategy for addressing Medicaid provider fraud and abuse.

There is also a recommendation to the Legislature to amend current state law to address certain restrictions on audits of Medicaid providers by the department and its contractors.

Recommendation Concurrence	
Concur	5
Partially Concur	1
Do Not Concur	0

Source: Agency audit response included in final report.

Chapter I – Introduction

Introduction

Medicaid is a jointly funded federal and state program for health care services for certain low-income and other eligible groups. The Medicaid program in Montana is administered at the state level by the Department of Public Health and Human Services (department) through a state plan approved by the federal Centers for Medicare & Medicaid Services (CMS). Medicaid is an important program in Montana as the state's share of the cost for Medicaid services is estimated to be about $915 million for the 2019 biennium, and around 230,000 Montanans are enrolled in the program. When fraud, waste, and abuse occur in Medicaid, it not only increases costs to state and federal governments, but it results in federal and state taxpayer dollars being spent inappropriately. Because of this, increasing attention has been directed to addressing fraud, waste, and abuse in Medicaid at both the federal and state levels. Collectively, the reduction of fraud, waste, and abuse in Medicaid is called Medicaid program integrity. The Legislative Audit Committee prioritized a performance audit of the integrity of the Montana Medicaid program. This chapter identifies where the primary Medicaid program integrity efforts currently exist in Montana as well as the scope, objectives, and methodologies of our audit.

Medicaid Program Integrity Terms

Federal regulations require the department to have methods and criteria for identifying, investigating, and referring suspected recipient and provider fraud. To understand this requirement, it is important to recognize the distinction between fraud and waste and abuse in Medicaid and what constitutes a credible allegation of fraud. Below are the definitions of these terms:

> **Fraud:** Federal regulations define fraud as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. An example of provider fraud is billing for Medicaid services that were not performed. Individuals falsifying information pertaining to their eligibility when applying for Medicaid is an example of recipient fraud.

> **Abuse:** Abuse is defined in federal regulations as provider practices that are inconsistent with sound fiscal, business, or medical practices. Abuse results in unnecessary costs to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse involves taking advantage of loopholes or bending the rules. Abuse also includes recipient practices that result in unnecessary cost to the Medicaid program. An example of abuse by providers is billing Medicaid for unnecessary health services. An example

of abuse by recipients is excessive use of emergency services for nonemergent care.

Waste: While not defined in federal regulations, waste includes inappropriate use of services and misuse of resources. Waste is not a criminal or intentional act. An example of waste in the Medicaid program is duplication of tests that can occur when providers do not share information with each other.

Credible Allegation of Fraud: Federal regulations define a credible allegation of fraud as an allegation, which has been verified by the state, from any source, including but not limited to a) fraud hotline complaints; b) claims data mining; and c) patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered credible when they have indications of reliability and the state Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

Montana defines Medicaid fraud in §45-6-313, MCA. Individuals commit Medicaid fraud when they obtain Medicaid payments or benefits by purposely or knowingly submitting false or misleading claims, applications, or other documents to obtain a service or item to which they are not entitled.

Fraud, waste, and abuse in the Medicaid program result in federal and state taxpayer dollars being spent inappropriately. Federal and state entities work to curb fraud, waste, and abuse in the Medicaid program through a variety of program integrity efforts. The following section describes typical Medicaid program integrity efforts and the entities responsible for them.

Medicaid Program Integrity Background and Organization

The Government Accountability Office (GAO) emphasizes reducing the risk of fraud, waste, and abuse in the Medicaid program by focusing on preventing them from happening in the first place. The recommended model includes program integrity controls aimed at prevention, detection, and monitoring, as well as investigation and prosecution that ultimately lead to improved preventive controls. Figure 1 (see page 3) depicts this model.

Figure 1
Recommended Model for Anti-Fraud Controls

Source: Compiled by the Legislative Audit Division from the GAO.
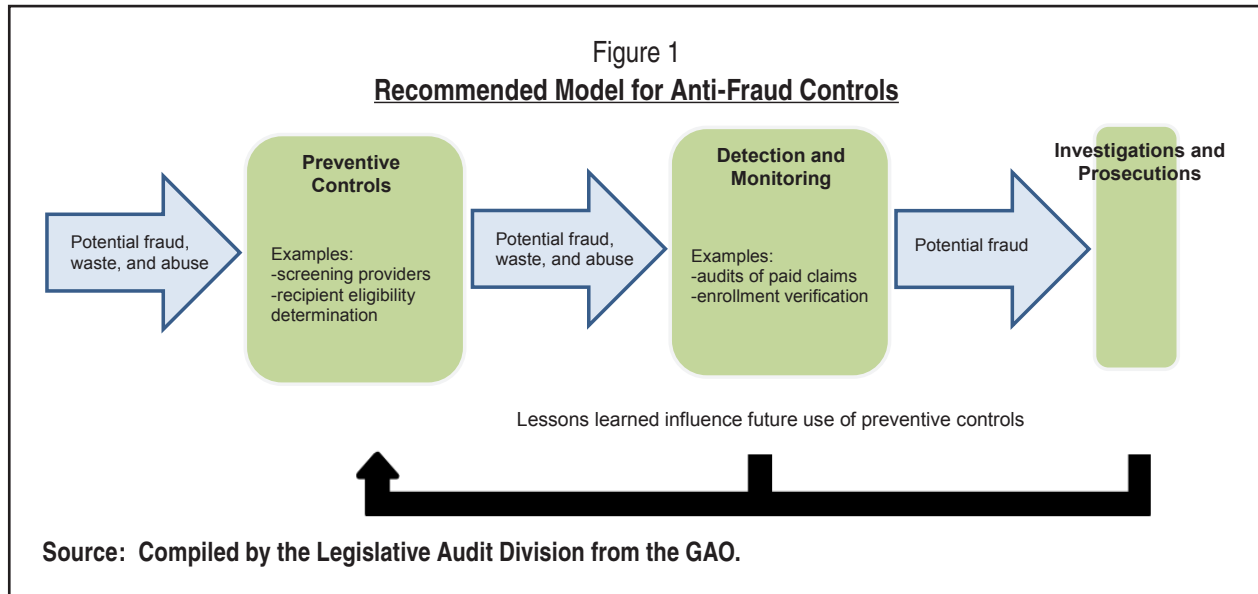
The recommended model emphasizes the importance of preventive controls in reducing fraud, waste, and abuse in the Medicaid program. Examples of preventive controls are screening providers prior to participation in the Medicaid program and making correct determinations of recipient eligibility. If fraud, waste, or abuse bypass these preventive controls, detection and monitoring controls then become essential. Examples of detection controls include auditing claims paid to providers to ensure they were billed according to the rules of the program, and verifying recipient eligibility after enrollment. If potential fraud has been detected, investigation and prosecution are the final steps in addressing it. Rather than relying on investigation and prosecution to curb fraud in the Medicaid program, the recommended model highlights the need to improve preventive controls based on lessons learned throughout the process.

States are allowed considerable flexibility in structuring their Medicaid programs within broad federal parameters, including some aspects of program integrity controls. Typical program integrity controls in state Medicaid programs include a variety of activities to ensure that:

- ◆ Recipient eligibility decisions are made correctly.
- ◆ Prospective and enrolled providers meet federal and state participation requirements.
- ◆ Services provided to recipients are medically necessary and appropriate.
- ◆ Provider payments are made in the correct amounts and for appropriate services.

This report discusses some of the main program integrity controls within the department and includes recommendations for improving them.

Both state and federal entities engage in Medicaid program integrity activities. Oversight and program support for state Medicaid programs are provided at the federal level by CMS within the U.S. Department of Health and Human Services. At the state level, the two divisions within the department with the most active roles in Medicaid program integrity are the Human and Community Services Division (HCSD) and the Quality Assurance Division (QAD). There are Medicaid activities in other branches within the department, but they focus more on the administration of the Medicaid program and play a less direct role in program integrity activities. The HCSD and QAD are highlighted in the department's organizational chart presented in Figure 2, and their roles in ensuring the integrity of the Medicaid program are summarized below.

Figure 2
Department of Public Health and Human Services Organizational Chart

Source: Compiled by the Legislative Audit Division from department information.
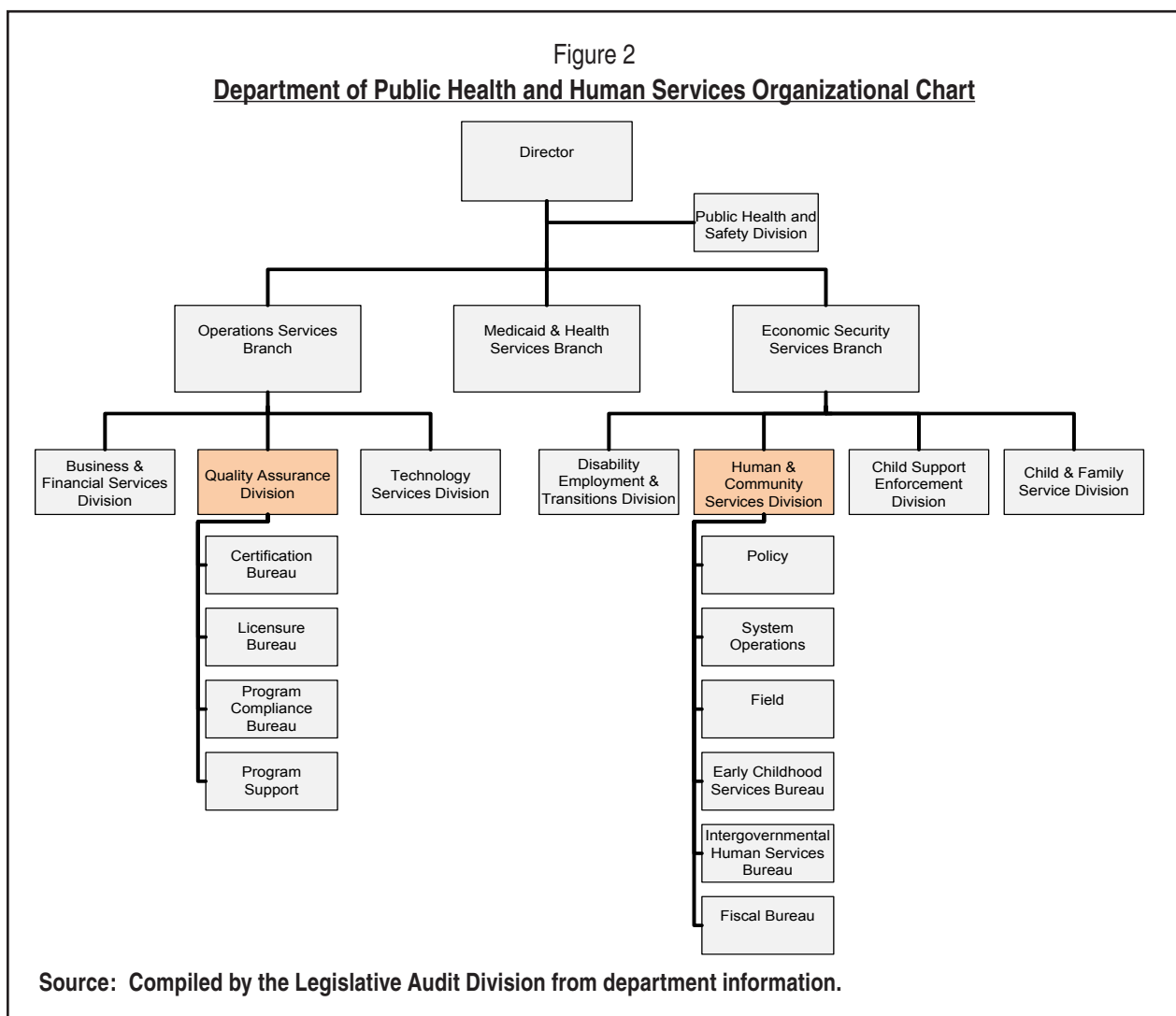
- The **Human and Community Services Division** is responsible for recipient eligibility and enrollment in Medicaid and other public assistance programs. There are 20 Offices of Public Assistance and processing centers throughout

the state that process and determine eligibility for the majority of Medicaid applications in Montana. A contracted information system called the Combined Healthcare Information and Montana Eligibility System – Enterprise Architecture (CHIMES-EA) is used to manage recipient eligibility information. The system also performs certain automated enrollment and eligibility renewal functions, such as electronic checks against various databases.

◆ The **Quality Assurance Division** is responsible for investigating allegations of recipient fraud in public assistance programs, including Medicaid. QAD also conducts retrospective audits of claims paid to Medicaid providers within its Surveillance and Utilization Review Section (SURS) in the Program Compliance Bureau in order to identify potential overpayments due to fraud, waste, and abuse. The SURS unit also oversees the screening and enrollment of Medicaid providers. However, most of the routine provider screening and enrollment activities are conducted by the contractor for the Medicaid claims processing system, the Medicaid Management Information System (MMIS).

Federal regulations require the department to refer cases of suspected provider fraud to the state Medicaid Fraud Control Unit (MFCU). MFCU resides within the Montana Department of Justice and is overseen at the federal level by the U.S. Department of Health and Human Services Office of the Inspector General. MFCU has jurisdiction over cases related to provider fraud and abuse or neglect of patients in health care facilities receiving payment from Montana Medicaid. It does not investigate claims of Medicaid recipient fraud.

Audit Scope

Through audit assessment work, we identified areas of potential risk in the department's efforts to address fraud and abuse in the Medicaid program. The scope of these efforts included the department's prevention, detection, and investigation processes. Audit assessment and planning work identified risks in these processes related to both Medicaid recipients and providers. Since HCSD and QAD conduct the most direct program integrity activities in these areas, audit work largely focused on these two divisions. This work also involved field offices and contractors under these divisions.

Program integrity efforts include multiple divisions within the department as well as contractors and other outside entities, such as MFCU. Because of this, we also identified potential risk in the coordination of program integrity efforts by the department. While we did conduct work involving investigation activities by the department, we did not examine the effectiveness of the investigation and prosecution process conducted by MFCU after it receives referrals from the department.

Audit work included several data analyses and file review methodologies. These generally focused on data and files from fiscal years 2016 and 2017 and involved information on both Medicaid providers and recipients. While data analysis and file review were conducted as part of audit work, our work was not intended or designed to identify specific instances of Medicaid fraud by either providers or recipients, as this would have required detailed investigation into individual cases. Rather, audit work was designed to examine the department's controls in identifying and pursuing fraud and abuse in the Medicaid program and the coordination of those efforts.

Audit Objectives

Based on audit assessment work, we developed the following three objectives for examining program integrity activities in the Montana Medicaid program:

1. Does the department identify and pursue indications of potential fraud and abuse by Medicaid <u>recipients</u> in accordance with federal and state requirements and best practices?

2. Does the department identify and pursue indications of potential fraud and abuse by Medicaid <u>providers</u> in accordance with federal and state requirements and best practices?

3. Does the department ensure the integrity of the Medicaid program through coordination of efforts across state functions and referrals of suspected fraud and abuse in accordance with federal and state requirements and best practices?

Audit Methodologies

To address our three audit objectives, the following work was conducted:

- Reviewed federal and state laws, rules, and regulations that govern activities related to the audit objectives.

- Reviewed other professional guidance and best practices for Medicaid program integrity from sources such as the Medicaid and CHIP Payment and Access Commission (MACPAC) and the U.S. GAO.

- Reviewed the department's mission, goals, policies, and procedures related to the administration of the Montana Medicaid program.

- Interviewed department management and other staff responsible for various program integrity activities, including recipient eligibility and enrollment, provider screening and enrollment, and post-payment claim reviews.

- Surveyed the state's population of 401 Medicaid eligibility workers in order to understand their role in addressing potential Medicaid recipient fraud. We received 255 responses to the survey for a response rate of 64 percent.

- Reviewed data on recipient fraud hotline calls, investigations by the department, and recipient overpayments.

- Based on a comparison of Medicaid eligibility data with 2016 state tax data, we reviewed a random sample of 100 individuals from a subgroup of Medicaid recipients issued Medicaid benefits in May 2017 to review the department's eligibility verification processes.

- Analyzed data and conducted file review on a random sample of 100 Medicaid providers enrolled in Medicaid in January 2018 to examine the provider screening and enrollment processes.

- Interviewed members of two Montana provider associations with members participating in the Medicaid program to determine whether challenges exist in Medicaid program integrity processes that involve providers.

- Analyzed data and conducted file review on a random sample of 110 post-payment claim audits conducted by the SURS unit within the department.

- Interviewed MFCU staff to understand the extent and nature of coordination between the department and the MFCU.

- Obtained and reviewed the MMIS contract and interviewed MMIS contractor staff to review coordination between the contractor and the department related to addressing provider fraud and abuse.

- Interviewed Medicaid staff from six other states comparable to Montana on their Medicaid service delivery model, Medicaid spending and enrollment, and rural-urban distribution. The states interviewed included Alaska, Colorado, Idaho, South Dakota, Vermont, and Wyoming.

Management Memorandum

A management memorandum is a verbal or written notification to the agency of issues that should be considered by management, but do not require formal agency response. During the audit, we discussed an issue with the department related to the collection of overpayments from Medicaid recipients. The department currently directs its eligibility workers in its business processes to recoup money for services rendered while a recipient was ineligible or when benefits have been used fraudulently. Per our discussions and clarifications with CMS, state Medicaid agencies should not be collecting repayment from recipients for Medicaid services that were rendered, even if the recipient was enrolled fraudulently or was ineligible at the time of service. However, if a Medicaid recipient is convicted for fraud in a criminal court, the recipient can be fined up to $25,000 or imprisoned for up to five years. CMS indicated it is currently drafting additional guidance regarding Medicaid recipient overpayments and the circumstances under which states can terminate Medicaid benefits.

Issues for Further Study

Our work with the department and its contractors identified two issues that may warrant future audit work:

- ◆ We identified a system defect during our file review of Medicaid eligibility verification within CHIMES-EA. The system, in specific scenarios, was not correctly flagging mismatched recipient income at eligibility renewal and alerting eligibility workers to follow up on the discrepancy. After notifying the department of this system defect during the audit, the department indicated the issue was fixed in November 2017. Our office conducted an information systems audit of CHIMES-EA in 2015, but the audit focused on other public assistance programs and did not include Medicaid. As such, a review of CHIMES-EA specific to Medicaid from an information system perspective is a matter for further consideration.

- ◆ The department can prevent payment to providers on certain claims that have been billed in error or that are fraudulent using edits within MMIS. Edits in Medicaid are pre-payment processes within MMIS for determining the validity and acceptability of Medicaid claims submitted by providers. For example, an edit in MMIS would prevent payment on maternity care billed for a male recipient. While these edits prevent many billing errors, they cannot prevent all billing errors. Interviews with provider associations in Montana with members participating in Medicaid identified this as a source of frustration. Providers believed there was more opportunity for the department to prevent common billing errors. While our audit work did review how edits are coordinated between the department and its contractor, this audit did not test the completeness or effectiveness of the edits within MMIS.

Report Contents

The remainder of this report discusses our analysis of the objectives and includes chapters detailing our findings, conclusions, and recommendations in the following areas:

- ◆ Chapter II contains additional background on program integrity activities related to Medicaid recipients. The chapter also includes recommendations for improving department controls in addressing potential fraud by Medicaid recipients.

- ◆ Chapter III addresses our work evaluating the department's processes for preventing, detecting, and investigating potential Medicaid provider fraud and the need for improvements in this area.

- ◆ Chapter IV discusses the coordination of Medicaid program integrity efforts both within the department and between the department, its contractors, and MFCU, and the need to develop an overall strategy related to provider fraud and abuse.

Chapter II – Changes Needed in Addressing Medicaid Fraud by Recipients

Introduction

Ensuring Medicaid recipient eligibility determinations are made correctly is the first line of defense against recipient fraud and abuse in a state's Medicaid program. In Montana, over 20 percent of the state's population is enrolled in Medicaid, making correct eligibility determinations an important part of protecting the state from potential fraud and abuse by recipients. However, the Montana Medicaid program has undergone changes in recent years, some of which include important context for understanding program integrity efforts in regard to Medicaid recipients. This chapter discusses some of these changes and provides recommendations for re-evaluating policy decisions and improving existing controls within the Montana Department of Public Health and Human Services (department) related to identifying and pursuing potential fraud and abuse by Medicaid recipients.

Recent Changes to the Montana Medicaid Program

One of the biggest changes to state Medicaid programs occurred with the enactment of The Patient Protection and Affordable Care Act (ACA) in 2010. The ACA mandated many changes to recipient eligibility policies and processes for Medicaid. For example, the ACA replaced complex income-counting for determining financial eligibility with a more streamlined approach using Modified Adjusted Gross Income, which is a more consistent standard that considers taxable income. Another significant change as a result of the ACA was moving away from in-person and documentation-heavy enrollment processes toward online applications and electronic data checks. Together, these changes moved much of the responsibility for demonstrating eligibility from individuals to the state. The ACA went into effect in Montana in January 2014.

The ACA also allowed states to expand coverage under Medicaid. In 2015, the legislature substantially changed Montana Medicaid with the passage of the Montana Health and Economic Livelihood Partnership (HELP) Act. The HELP Act expanded coverage under Montana Medicaid to low-income, non-disabled, childless adults. Among other provisions, the HELP Act also required enrollees to pay premiums and make co-payments for many services. The HELP Act allowed removal of people from the program, in certain circumstances, if they did not pay these premiums. Coverage under Medicaid expansion became available around January 2016 and the department has since enrolled more than 90,000 individuals into the program. The legislature also included language in the HELP Act recognizing the importance of additional safeguards against fraud, waste, and abuse in the Medicaid program.

The department has also had to consider budget constraints and recent budget cuts in administering Medicaid according to the mission of the program. The mission of the Montana Medicaid program is to "assure necessary medical care is available to all eligible Montanans within available funding resources." One of the department's goals for Medicaid is to assure integrity and accountability of the program. Budget constraints and recent budget reductions have played a role in decision-making by the department in order to balance access to services with program integrity controls. One example of how these budget reductions have impacted the program is in the number of locations and staff available to process and maintain Medicaid applications. While there were roughly 40 Offices of Public Assistance (OPA) with around 507 full-time equivalent (FTE) in January 2015, there were 20 OPAs with approximately 487 FTE in December 2017.

Medicaid Eligibility Verification Decisions by the Department

States are permitted considerable flexibility in structuring their Medicaid programs within broad federal parameters. One area in which states have flexibility is in making decisions on certain eligibility verification policies and processes. This section discusses some of these decisions by the department and provides information on the current Medicaid eligibility verification landscape in Montana.

Individuals can enroll in Medicaid a number of different ways: by applying online through the state, through the federally-facilitated marketplace (FFM), by mail, phone, fax, or in person at a local OPA. There are some common eligibility requirements for all eligibility groups, such as U.S. citizenship. However, some requirements, and the verification of those requirements, may differ by eligibility group. A couple examples of the different eligibility groups under Medicaid are Families with Dependent Children, which is an ACA group, and Aged/Blind/Disabled (ABD), which is a non-ACA group. The eligibility verification processes differ between ACA groups and non-ACA groups. For example, income must be verified at application and individuals are subject to resource limits in non-ACA eligibility groups. Countable resources include certain assets, such as personal checking or savings accounts. However, per CMS, states are required to accept self-attestation of income for enrollment in ACA eligibility groups, and are prohibited from requiring applicants to provide documentation unless self-attested information is not compatible with government and private databases. CMS also prohibits resource limits for ACA eligibility groups. This means low-income individuals may qualify for certain ACA eligibility groups, even if they have high-value assets.

Department Policies Increase Risk of Recipient Fraud

While permitted and approved by the federal government, policy decisions made by the department related to Medicaid eligibility verification make the Montana Medicaid program more susceptible to risk for recipient fraud and abuse relative to other states. As part of audit work, we reviewed national reports on Medicaid eligibility verification policies and processes in other states. We also interviewed Medicaid staff from six other states comparable to Montana on their Medicaid service delivery models, Medicaid spending and enrollment, and their rural-urban distribution. While Medicaid eligibility verification in Montana is similar to other states in many ways, Montana is unique in some areas. Below are three examples of policy decisions by the department that in combination make Montana unique compared to other states in terms of Medicaid eligibility verification:

- **Post-enrollment Verification:** Self-attested information, when permitted for the specific Medicaid program, is verified against various electronic data sources after enrollment. This process is referred to as post-enrollment verification (PEV). During the PEV process, self-attested income is electronically checked within six months of enrollment against quarterly state wage data from the Montana Department of Labor and Industry (DLI). If the self-attested income reported at enrollment in Medicaid is not reasonably compatible with the income reported in DLI's database, the Combined Healthcare Information and Montana Eligibility System – Enterprise Architecture (CHIMES-EA) system generates a case note. Self-attested income is considered reasonably compatible when it is within 10 percent of the income reported in DLI's database. When income is not reasonably compatible, Medicaid eligibility workers must address the discrepancy, which may include requesting hard copy verification of income from recipients. Post-enrollment verification of income for Medicaid is not common and Montana is one of only seven states nationally that does not verify income prior to enrollment. Other states check self-attested income against electronic data prior to enrollment. Alaska and Vermont, for example, are Medicaid expansion states that check self-attested income against electronic data sources at application, prior to enrollment.

- **Determination State:** The department has opted for Montana to be a determination state. This means the federally-facilitated marketplace (FFM) makes final Medicaid eligibility determinations and the state does not verify income information from FFM applications. Montana is one of only nine determination states. Thirty states have instead opted to be assessment states, meaning the state verifies information on FFM applications and makes the final Medicaid eligibility determinations. Interviews with Medicaid staff from non-determination states, such as Idaho and South Dakota, found these states made their decisions to be non-determination states based on concerns with the completeness and accuracy of information on applications from the FFM.

- **Continuous Eligibility for Adults:** The Centers for Medicare & Medicaid Services (CMS) approved a waiver for Montana that, among other

provisions, allows for certain populations of adults to enroll in Medicaid under 12 months of continuous eligibility. Waivers are approvals by CMS to waive certain provisions of federal Medicaid law, which allow states to tailor their Medicaid programs. Individuals enrolled under continuous eligibility are enrolled in Medicaid for 12 months without having to report monthly changes in income or resources. However, the individual may be dis-enrolled from Medicaid if non-compatible income is identified during the PEV process and ineligibility is subsequently confirmed by an eligibility worker. Montana is one of only two states providing continuous eligibility to parents and other adults under waiver authority. This waiver is effective through December 31, 2022.

Review of Medicaid Eligibility Verification Identified Vulnerabilities

In examining the department's eligibility verification processes, we conducted file review on a random sample of 100 individuals from a subgroup of Medicaid recipients enrolled in Medicaid in May 2017. First, we conducted a comparison of Medicaid data from CHIMES-EA with 2016 state tax data from the Montana Department of Revenue. Our review of these data found approximately 218,000 individuals were issued Medicaid benefits in May 2017, including adults and children, and around 53,000 adults from the Medicaid data were identified in the 2016 tax data as the primary tax filer or spouse. Almost 20,000 of these 53,000 adults (approximately 37 percent) had zero monthly income reported in CHIMES-EA. It should be noted that, due to the gap in time between the Medicaid data (May 2017) and the 2016 tax data, it is reasonable to assume some of these individuals may have had a change in circumstances, such as termination of employment.

We then selected a random sample of 100 individuals for further file review from a subgroup of individuals whose income and household information in CHIMES-EA showed "significant differences" with the information from taxes. Individuals with "significant differences" were defined as those having discrepancies between Medicaid data and tax data in both household composition (e.g. marital status or household size) and monthly income. Most of the individuals meeting this definition (93 percent) were enrolled in ACA programs. Additionally, recent federal compliance audit work conducted by our office (#17-14) did not include ACA programs and only included non-ACA programs, as federal requirements for the compliance work prohibited the auditors from doing so. The audit resulted in no audit findings related to non-ACA eligibility. Therefore, we focused our file review for this performance audit on recipients enrolled in ACA programs.

In reviewing the eligibility verification process for the 100 individuals in our sample, we identified certain procedural errors that indicate the state is vulnerable to Medicaid

recipient fraud in certain areas. Some of the procedural errors we identified were caused by CHIMES-EA and others were due to eligibility workers not processing cases according to department policy and procedure. Some examples of the procedural errors we identified during file review are shown in Table 1.

Table 1
Examples of Procedural Errors from a Sample of 100 Medicaid Enrollees

Procedural Errors				
Error 1	Sample Size	Number in the sample with a spouse shown in taxes and Medicaid	Number with incomes not counting together	Percentage out of number possible
	100	44	9	20%
Error 2	Sample Size	Number in the sample not going through PEV	Number with no reason for not going through PEV	Percentage out of number possible
	100	50	3	6%
Error 3	Sample Size	Number in the sample flagged for non-compatible income at PEV	Number lacking timely follow-up on income discrepancy	Percentage out of number possible
	100	34	8	24%

Source: Compiled by the Legislative Audit Division from file review results.

The procedural errors we identified in reviewing our sample of 100 individuals enrolled in ACA programs were:

- There were nine cases where the incomes of spouses were not being counted together. In these cases, the individuals were showing as unmarried in one part of CHIMES-EA, but showing as filing taxes together and claiming children together in another part of the system. Income for enrollment in ACA programs is supposed to be counted based on taxpayer household. Therefore, the incomes for spouses that are living together, filing taxes together, and claiming children together should be counted together.

- There were three cases for which we could not determine the reason for the individual not going through the department's PEV process as outlined in department procedure. It should be noted these individuals still went through electronic data checks at eligibility renewal at least every 12 months.

- We found 34 cases in the sample that were flagged by the department during the PEV process for non-compatible income. Eight of these cases (24 percent) lacked evidence of timely follow-up by eligibility workers to resolve the discrepancy. In three of these eight cases, the discrepancy still remained after renewal of eligibility.

Due to the nature of our sampling methodology, the results from our file review cannot be projected to the entire Medicaid population. However, the discrepancies between Medicaid data and tax data and the procedural errors noted above point to limitations in some of the Medicaid eligibility verification policies and processes used by the department. These limitations increase vulnerability to enrolling ineligible individuals, including individuals who may intend to defraud the program. When ineligible people are enrolled in Medicaid and obtain Medicaid services, federal and state taxpayer dollars cover Medicaid services for people for whom they were not intended. This potentially leaves fewer resources for those actually eligible for benefits. While permitted and approved by CMS, the department has made eligibility verification policy decisions in Medicaid that increase vulnerability to potential recipient fraud.

CONCLUSION

We conclude that, in addition to broad federal requirements, the department has made eligibility verification policy decisions that increase vulnerability to recipient fraud in the Montana Medicaid program.

Eligibility Verification Policy Decisions Not Always Documented

In discussions with the department regarding decisions on Medicaid eligibility verification policies, management indicated some of the policies were incorporated to minimize the administrative burden on the department in order to maintain access to services for recipients. For example, according to the department, it had to implement Medicaid expansion with few additional staff. Consequently, some eligibility verification policy decisions were made to preserve access to coverage for the newly-eligible Medicaid expansion population, though some of the policies discussed in this report pre-date Medicaid expansion. However, the department could not provide documentation as to how the policy decisions, such as opting to be a determination state or verifying self-attested income post-enrollment, were made, or whether risk for fraud and abuse was considered. According to federal standards and guidance, management within state Medicaid programs is responsible for managing fraud risks and implementing practices for mitigating those risks. An important part of any fraud risk framework is documenting analysis of the types of fraud risks.

Since Medicaid expansion has been fully implemented, the Montana Medicaid program is unlikely to see the large increases in enrollment in the foreseeable future as it did when Medicaid expansion was first introduced. As such, it is an appropriate time for the department to re-evaluate the state's Medicaid eligibility verification

policies, document what factors into these decisions, and identify recipient fraud and abuse risks. Department officials indicated they have a process in place to document decision-making moving forward.

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RECOMMENDATION #1

We recommend the Department of Public Health and Human Services conduct, document, and report on a re-evaluation of its current policy decisions on Medicaid recipient eligibility verification. Re-evaluations should:

  A. *Identify risks for Medicaid recipient fraud and abuse, analyze how policy decisions impact those risks, and determine whether it is feasible to reduce those risks through policy or procedural changes.*

  B. *Include policies such as post-enrollment verification of income, coordination with the federally-facilitated marketplace, and continuous eligibility.*

  C. *Reoccur on a systematic basis after major changes in the requirements of the Medicaid program.*

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Potential Medicaid Recipient Fraud and Abuse Is Addressed Inconsistently

Eligibility workers process and maintain applications for coverage under Medicaid at OPA offices and processing centers throughout the state. Consequently, eligibility workers play an important role in protecting the Medicaid program from potential fraud and abuse by recipients. As part of audit work, we conducted a survey of 401 Medicaid eligibility workers in Montana. We received 255 responses from workers ranging in experience level for an overall response rate of 64 percent. The survey included various questions related to where vulnerabilities in Medicaid recipient fraud or abuse exist and whether eligibility workers thought they were adequately trained on how to address fraud and abuse.

While most of the survey respondents (80 percent) indicated they had been adequately trained on Medicaid eligibility requirements, almost half (48 percent) indicated they had not been adequately trained on how to address suspected Medicaid fraud or abuse. We also asked whether eligibility workers had ever come across a case in which they suspected fraud or abuse by an individual enrolled in Medicaid. Figure 3 (see page 16) shows that a little over half of the survey respondents (51 percent) said they had come across a case at some point in time in which they suspected Medicaid fraud or abuse. Of this 51 percent who indicated having come across suspected Medicaid fraud or

abuse, only 61 percent indicated they referred the case. Cases of potential Medicaid recipient fraud must be referred to the department's Quality Assurance Division (QAD) for investigation.

Figure 3
Results of Survey of Medicaid Eligibility Workers

Have you ever come across a case in which you suspected fraud or abuse by an individual enrolled in Medicaid?

■ Yes ■ No

| 51% | 49% |

Did you refer the case?

39%

61%

■ Yes ■ No

Source: Compiled by the Legislative Audit Division from survey results.
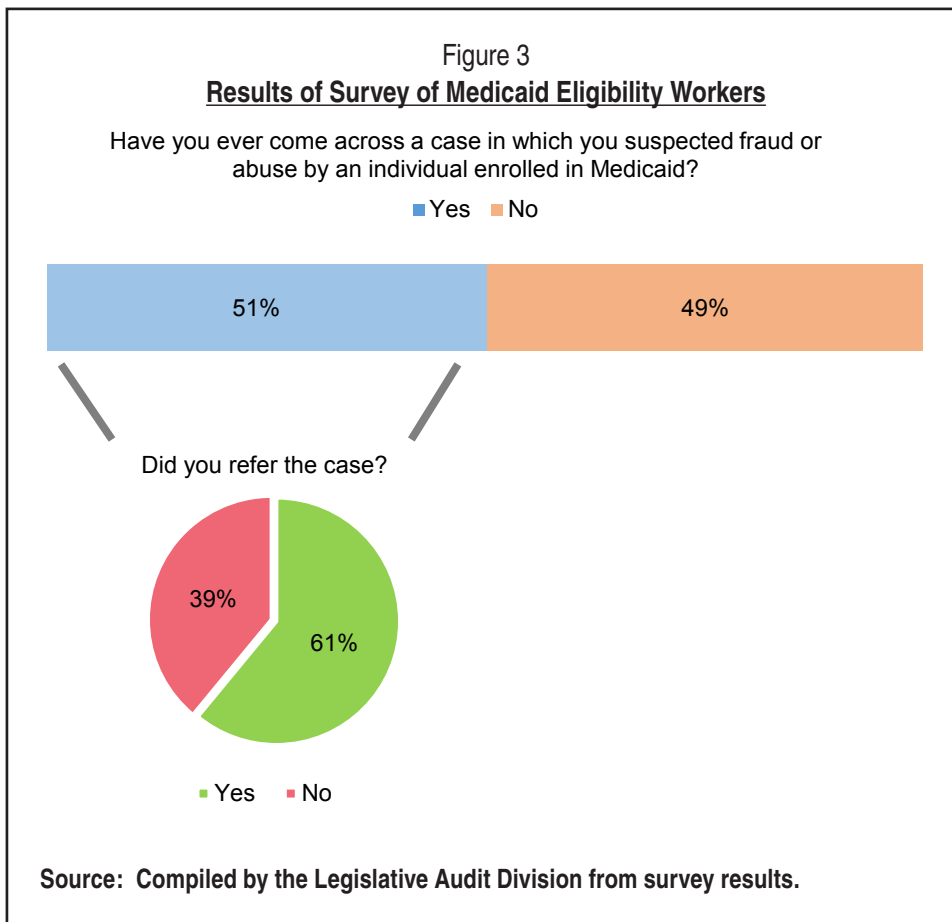
The reasons provided by respondents for not referring a case of suspected Medicaid fraud or abuse ranged from being unauthorized to question self-attested information on Medicaid applications to not knowing where to refer potential fraud cases when they are identified.

Eligibility Workers Need Additional Training on Medicaid Fraud and Abuse

Our survey of eligibility workers revealed the need for additional training on how to address potential Medicaid recipient fraud and abuse. If eligibility workers are not trained in this area, the risk of Medicaid recipient fraud and abuse going undetected by the department increases. While Medicaid providers receive payment for Medicaid services obtained by recipients, there is still risk associated with Medicaid recipient fraud. If recipient fraud goes undetected, taxpayer dollars can cover services for ineligible individuals, leaving fewer resources for those truly eligible.

While the mission of the Montana Medicaid program is to ensure access to medical care, the department is also responsible for integrity and accountability within the program. As discussed in the Montana Operations Manual, an important part of ensuring the integrity of a program is training of staff in internal control areas, such as the proper identification and referral of potential fraud and abuse to QAD. During the audit, department staff acknowledged there were opportunities for additional training for eligibility workers on how to address potential fraud and abuse. According to the department, it has since conducted training for eligibility workers on fraud reporting and has incorporated it into new hire and refresher trainings.

RECOMMENDATION #2

We recommend the Department of Public Health and Human Services incorporate training for Medicaid eligibility workers on identifying and referring suspected Medicaid recipient fraud or abuse into its ongoing training plan.

Important Context in Understanding Medicaid Recipient Fraud

In assessing the department's efforts in addressing Medicaid recipient fraud, it is important to understand that recipient fraud in Medicaid is addressed somewhat differently than recipient fraud in other public assistance programs. For example, federal regulations provide for a clear punitive process for an intentional program violation (IPV) by a recipient in the Supplemental Nutrition Assistance Program (SNAP), including imposing a disqualification period. An IPV occurs when a recipient knowingly makes a false or misleading statement, misrepresents or withholds facts, or violates program regulations to obtain benefits illegally.

The punitive process for IPVs in SNAP can largely be applied by the department, unless the violation exceeds a certain dollar amount. However, punitive measures as a result of fraud by Medicaid recipients, such as dis-enrollment or disqualification from Medicaid, can be applied only after criminal proceedings. That is, while recipients can be dis-enrolled from Medicaid when determined ineligible, they can only be dis-enrolled for fraud after a criminal conviction. Additionally, IPVs in other programs cannot necessarily be applied in Medicaid. That is, if a recipient is enrolled in Medicaid and other public assistance programs simultaneously, an IPV in one program does not necessarily equate to Medicaid fraud.

If a recipient is convicted for Medicaid fraud, the federal Social Security Act allows for dis-enrollment of the individual from Medicaid. States are then permitted discretion as to whether to impose a disqualification period of up to a year following the conviction. However, the department indicated it interprets federal law as prohibiting disqualification of a recipient from Medicaid, even if convicted for Medicaid fraud. Under this interpretation, there is little incentive for the state to pursue Medicaid recipient fraud. We determined this was a misinterpretation by the department based on our review of federal law, discussions with CMS representatives, and interviews with Medicaid staff in other states.

Through our interviews with Medicaid staff from six other comparable states, we found that many states do not impose a disqualification period from Medicaid in practice. Therefore, individuals who are dis-enrolled, whether for ineligibility or fraud, may re-enroll in Medicaid and receive services if determined eligible. Additionally, there is increased risk and liability to states when individuals who are eligible for benefits do not receive needed medical services. Therefore, there is little cost-benefit for states in addressing Medicaid recipient fraud, though states can and should dis-enroll individuals from Medicaid when determined ineligible. Audit work determined the department is dis-enrolling recipients for ineligibility. With that said, federal regulations still require the department to conduct preliminary investigations into complaints of fraud or abuse in order to preserve the integrity of the Medicaid program. If Medicaid recipient fraud is not properly investigated and referred, federal and state taxpayer dollars may continue to cover Medicaid services for ineligible individuals.

Investigations by the Department Into Allegations of Recipient Fraud Are Limited

Federal regulations require the department to conduct a preliminary investigation when it receives complaints of Medicaid fraud or abuse from any source or if it identifies any questionable practices. If the preliminary investigation gives reason to believe a recipient has abused the Medicaid program, the department must conduct a full investigation. The department primarily addresses recipient abuse through its Team Care program, requiring a recipient to see the same provider and go to the same pharmacy. While the Team Care program exists to address recipient abuse, our audit focused on how the department addresses recipient fraud related to eligibility. If there is reason to believe a recipient has defrauded the Medicaid program, the department must refer the case to law enforcement. Preliminary investigations into accusations of Medicaid fraud by recipients are conducted by the Intentional Program Violation (IPV) unit within the department's Quality Assurance Division (QAD). The IPV

unit administers a recipient fraud hotline that receives calls on complaints of public assistance fraud, including potential Medicaid recipient fraud. The hotline number is advertised on the department's website.

As part of audit work, we obtained data on recipient fraud hotline calls between July 2016 and August 2017. Most of the calls to the hotline were for allegations of fraud in other public assistance programs, such as SNAP. There were 643 hotline calls received during this time period, 68 of which (11 percent) referenced Medicaid. Ten of the 68 hotline entries referencing Medicaid indicated the case rose to the level of warranting an investigation by the department. None of the Medicaid hotline calls we reviewed resulted in referral by the department to local law enforcement. Due to the limited documentation supporting what review took place, we could not determine whether or not individual calls merited further investigation or referral to law enforcement. If investigations into Medicaid recipient fraud were more thoroughly documented, including a description of how recipient information is verified and how cases are concluded, resolved, or referred, the department could better support its fulfillment of the requirement to conduct preliminary investigations of complaints of Medicaid recipient fraud.

Access to State Tax Data Will Aid in Medicaid Recipient Fraud Investigations

During the audit, we identified certain limitations in the tools available to the department to verify information when investigating potential Medicaid recipient fraud. As discussed earlier in this report, the primary electronic data source used by the department in verifying self-attested income is quarterly income data from DLI. While DLI's database contains information on both earned and unearned income, such as wages and unemployment insurance benefits, the incomes of certain populations would not be present. For example, income from self-employment is not reported in DLI's database. Additionally, the department does not verify household composition against any electronic data sources at enrollment or in investigating potential recipient fraud. These types of limitations could be partially addressed if the department had access to state tax information when investigating recipient fraud.

Our data analysis and file review work revealed the usefulness of having access to state tax data in identifying potential discrepancies in eligibility information that may be associated with fraud. For example, around 37 percent of the 53,000 adults on Medicaid in May 2017 who filed state taxes in 2016 had zero income reported in CHIMES-EA. Access to state tax data could help identify individuals who reported zero or little income to the department, but may be earning additional income through self-employment. We also found that access to taxes may help identify discrepancies

that are not identifiable in other databases used in investigations, particularly in regard to household composition. In our file review of a sample of 100 recipient cases, we found 16 cases where a spouse was reported in the tax data, but no spouse was present in CHIMES-EA. There were also six cases where a person showed as a spouse in the tax data and was present in CHIMES-EA, but not as the spouse. Our ability to identify these types of discrepancies demonstrated how access to state tax data may help detect potential Medicaid recipient fraud. While the department does not use tax data in recipient fraud investigations and had concerns with doing so, state law currently allows for the department to access state tax data for the purposes of preventing and detecting public assistance fraud and abuse, provided notice to the applicant has been given.

While audit work was unable to confirm that any recipients enrolled fraudulently in the Medicaid program, we were able to identify potential discrepancies in eligibility information using state tax data, such as discrepancies in marital status or income, that would be useful in fraud investigations. If not thoroughly investigated, potential recipient fraud in Medicaid could go undetected by the department. When recipient fraud goes undetected, federal and state taxpayer dollars might continue to pay for Medicaid services that are obtained by individuals who may be ineligible for those benefits. Therefore, it is important for the department to use resources that might help identify fraud, such as state tax data, when investigating potential Medicaid recipient fraud.

RECOMMENDATION #3

We recommend the Department of Public Health and Human Services enhance investigations into complaints of Medicaid recipient fraud by:

  A. *Improving the documentation of the nature and resolution of the investigations, including referral to law enforcement when suspected recipient fraud is identified.*

  B. *Using state tax information to examine income and household composition information.*

Chapter III – Improvements Needed to Help Address Medicaid Fraud by Providers

Introduction

A primary focus in ensuring the integrity of the Medicaid program is reducing and eliminating improper payments. An improper payment is any payment that should not have been made or that was made in an incorrect amount under the legally applicable requirements of the Medicaid program. Only a subset of improper payments are the result of fraud and abuse, as some may be the result of waste. The federal Centers for Medicare and Medicaid Services (CMS) estimates the national improper payment rate in Medicaid at approximately 10 percent, which may amount to millions of dollars annually. In fee-for-service (FFS) Medicaid programs, such as Montana Medicaid, participating Medicaid providers are paid for each delivered service for a recipient (e.g. an office visit, test, or procedure). In fiscal year 2017, Montana Medicaid providers were paid over $1.2 billion for benefits and claims, almost $400 million of which are from state funds. Many states largely center their program integrity activities around fraud, waste, and abuse by Medicaid providers, rather than by recipients. This is because providers are paid when participating in the Medicaid program, while recipients receive medical services. Additionally, as discussed earlier in this report, there is little cost-benefit when pursuing recipient fraud as repayment for services cannot be obtained from recipients who have committed fraud, nor are recipients convicted of Medicaid fraud disqualified from the program. This chapter provides information on program integrity efforts by the Montana Department of Public Health and Human Services (department) related to Medicaid providers, and discusses our recommendations for improvements in this area.

Prevention of Medicaid Provider Fraud and Abuse

Nationally, recent Medicaid program integrity initiatives have placed emphasis on implementing preventive controls, rather than attempting to recover overpayments to providers, which is commonly referred to as "pay and chase." The two main preventive controls related to Medicaid providers in state Medicaid programs are: 1) preventing providers with intent to defraud the program from participating in Medicaid through effective provider screening and enrollment practices, and 2) preventing payment on potentially fraudulent claims submitted by providers. The following sections discuss these two controls and how they have been implemented in the Montana Medicaid program by the department.

Provider Screening and Enrollment

Effective provider screening and enrollment is one of the most important preventive program integrity controls in Medicaid. In Montana, the Surveillance and Utilization Review Section (SURS) within the department's Quality Assurance Division (QAD) works with a contractor to ensure the processes for provider screening and enrollment meet state and federal requirements. While the department issues licenses and certifications to providers, the contractor conducts the routine Medicaid provider screening and enrollment activities.

Federal regulations require the department to obtain certain disclosures from providers applying to participate in Medicaid. These disclosures include information on provider ownership and control, business transactions, and persons convicted of crimes. The department must also establish categorical risk levels (limited, moderate, or high) for providers based on their financial risk for fraud, waste, or abuse. The department has opted to assign Montana providers to the risk level they were assigned to by CMS for Medicare, when applicable. Currently, the only provider types designated as high risk in Montana are newly-enrolling durable medical equipment suppliers and newly-enrolling home health agencies. These provider types have been designated high risk in Medicare and Medicaid because they offer services and supplies that are considered most vulnerable to fraud.

States must screen Medicaid providers according to the fraud risk category to which they were assigned. Certain screening activities are required for all providers, regardless of risk level, while other screening activities only apply to those in the moderate or high risk categories. Table 2 summarizes the federally required screening activities by provider risk level.

Table 2
Required Medicaid Provider Screening Activities by Risk Level

Screening Activities	High Risk	Moderate Risk	Limited Risk
Disclosures regarding ownership and control	Yes	Yes	Yes
Verification of licenses	Yes	Yes	Yes

Database checks:
   -List of Excluded Individuals and Entities (LEIE)
   -National Provider Identified Registry
   -National Plan and Provider Enumeration System (NPPES)
   -Excluded Parties List System (EPLS)/System for Award Management (SAM)
   -Social Security Administration records and Death Master File
	Yes	Yes	Yes

Provider/Supplier-specific requirements	Yes	Yes	Yes
Site visits	Yes	Yes	No
Fingerprint-based criminal background check	Yes	No	No

Source: Compiled by the Legislative Audit Division from federal requirements.

The table shows that screening on all providers, regardless of risk level, must include provider disclosures, verification of licenses, database checks, and provider-specific screening. The databases checked during provider screening include various exclusion lists and identity verification databases. Only moderate and high risk providers are subject to on-site visits and only high risk providers are subject to fingerprint-based criminal background checks. It should be noted the department is permitted, in certain circumstances, to rely on screening activities conducted for enrollment in Medicare or for enrollment in other state Medicaid programs. This prevents the department from having to duplicate screening activities that have already been conducted. Audit work related to provider screening and enrollment is further discussed in the next section of this chapter.

Initial Provider Screening and Enrollment Are Conducted According to Federal Requirements

As part of audit work, we examined the department's provider screening and enrollment processes through file review on a sample of Medicaid providers. We obtained our sample by first obtaining data on all active Medicaid providers in January 2018, which included approximately 22,000 Medicaid providers. We then selected a random sample of 100 providers, which consisted of 40 limited risk providers, 40 moderate risk providers, and 20 high risk providers. The sample included a mix of individual providers and organizations as well as a range of initial enrollment dates.

Upon reviewing the enrollment files for the Medicaid providers in our sample, we determined the initial screening activities applicable to all provider types were conducted according to federal regulations. The screening activities we reviewed included obtaining provider ownership information, obtaining provider agreements, checking licensure status, and checking the required databases. We also verified that the additional screening activities for the moderate and high risk providers were conducted. Of the 40 moderate risk and 20 high risk providers in our provider sample, the department was able to rely on screening for Medicare for 34 of the moderate and 19 of the high risk providers. For the remaining moderate and high risk providers, we found documentation of on-site visits conducted by the department and confirmed that a background check took place for the one high risk provider in our sample not enrolled in Medicare. These results indicated the initial provider screening and enrollment processes were conducted according to the requirements of the Medicaid program.

Prevention of Payment on Potentially Fraudulent Claims

The second preventive control related to Medicaid providers is preventing potentially fraudulent claims from being paid. The department contracts for a Medicaid claims processing system known as the Medicaid Management Information System (MMIS). MMIS has hundreds of system controls, called edits, that prevent payment on many types of improperly billed claims. For example, an edit in MMIS would prevent payment on maternity care billed for a male recipient. The department is responsible for ensuring the contractor implements changes to MMIS as the rules surrounding Medicaid change. Department staff indicated it reviews new Medicaid codes quarterly to determine what limits should be included in MMIS, typically following the limits used for Medicare. The department then works with the contractor to design and test any new edits.

CONCLUSION

The department ensures the process for screening providers at initial enrollment is conducted according to the requirements of the Medicaid program, and the Medicaid Management Information System has system controls, called edits, to help prevent potentially fraudulent claims from being paid.

Medicaid Providers Must Be Revalidated at Least Every Five Years

Once a provider is enrolled, federal regulations require states to revalidate the enrollment of the provider, regardless of provider type, at least every five years. Provider revalidation consists of collecting updated ownership and control disclosures from enrolled providers as well as rescreening providers who have not been screened by Medicare or by another state's Medicaid program within the previous 12 months. States were required by CMS to complete revalidation of all providers enrolling before March 2011 by September 2016. Providers enrolling after March 2011 did not have to be revalidated until five years from the date they were initially enrolled.

Department Has Not Conducted Timely Revalidation of Medicaid Providers

While the department has made continued efforts to comply with the five-year revalidation requirement, providers enrolling after March 2011 have yet to be revalidated. Medicaid provider data show there were around 1,500 providers who

enrolled between April 2011 and March 2013. This represents the approximate number of Medicaid providers for which the department has not met the five-year revalidation requirement. The department recently completed the revalidation of Medicaid providers enrolling before March 2011 by contracting for a revalidation project with the MMIS contractor. The project was contracted at an estimated cost of $292,000. However, this revalidation effort did not meet the required September 2016 deadline. When the department requested a waiver from CMS to extend the deadline, it was denied.

The department indicated it did not meet the September 2016 deadline due to a lack of implementation of a sub-system within MMIS. The department is currently procuring a new module within MMIS to include provider enrollment and revalidation functions and intends to complete revalidation of existing providers as part of system implementation. The department expects to be caught up on remaining provider revalidations in 2019. Regular monitoring activities are being conducted in the meantime through monthly electronic screening of all Medicaid providers against various exclusion lists and verification databases. However, an important part of provider revalidation is collecting updated provider ownership and control information so the department can continue to identify providers and provider owners with recent sanctions or exclusions. Therefore, even with the regular monitoring activities, it is important that the department complete revalidation in a timely manner.

RECOMMENDATION #4

We recommend the Department of Public Health and Human Services ensure providers enrolled in the Montana Medicaid program are revalidated at least every five years, as required by federal regulations.

Medicaid Provider Overpayment Audits by the Department

In addition to efforts around provider screening and enrollment, the SURS unit conducts retrospective audits on claims submitted by and paid to Medicaid providers in order to identify and recover erroneous payments. These are referred to as overpayment audits. The overall purpose of the overpayment audit process is to safeguard the Medicaid program from payment on claims due to fraud, waste, and abuse. Provider overpayments can result from a variety of circumstances ranging from lack of documentation related to services to billing for services not actually rendered. As with other Medicaid program integrity functions, the federal government affords states with great flexibility in carrying out provider overpayment audits.

Medicaid providers may be selected for review by SURS based on referrals, data mining, national trends, and whether the provider is new to the Medicaid program. Data mining is the process of identifying anomalies and patterns in data. In data mining overpayment audits, SURS queries claims including certain billing codes or services that are associated with known risk for billing errors. After selecting the provider for an audit, SURS staff query claims paid to the provider during a specified time frame from the MMIS. If necessary, records and other supporting documentation on claims may be requested of the provider. The records supplied by the provider are reviewed by SURS to determine whether the documentation supports the service billed and whether the billing followed the rules of the Medicaid program. Audits may result in no errors being found, provider education to correct billing errors, or in an overpayment with provider education. When an overpayment is identified, the audited provider may initiate an administrative review process to dispute the findings. In the case of suspected fraud, the SURS unit is required to refer the case to the Department of Justice's Medicaid Fraud Control Unit (MFCU). MFCU would then investigate and potentially prosecute the case, depending on the results of its investigation.

Overpayment Audits by the Department Focus on Newly Enrolled Providers

As part of audit work, we reviewed a random sample of 110 overpayment audits conducted by SURS and closed during fiscal years 2016 and 2017. The sample included audits resulting in no overpayment and audits with varying established overpayment amounts. Based on our sample and interviews with department staff, it became evident that new provider reviews make up a large portion of overpayment audit efforts by SURS. Almost three-quarters of our sample were new provider reviews. Twelve were data mining audits and another ten were based on referrals from Medicaid program staff within the department. The remainder were other types of audits, such as referrals from a licensing board, referrals from the department's contractor, or audits based on national trends. Figure 4 (see page 27) illustrates the reasons providers were selected for an overpayment audit and the percentages in which they occurred in our sample.

Figure 4
Reason for Provide Being Selected for Overpayment Audit by SURS

Data mining audit
11%

Referral from department program staff
9%

New provider review
72%

*Other
8%

*Other
Referral from MMIS contractor (<1%)
Referral from a licensing board (<1%)
Referral from MFCU (<1%)
Provider self-referral (<1%)
Provider self-audit (<2%)
National trends (<1%)
No documentation on reason (<2%)

Source: Compiled by the Legislative Audit Divisions from file review results.

As Figure 4 shows, most of our sample was new provider reviews, demonstrating that SURS focuses on new providers when selecting providers to audit. The overpayments in our sample were due to errors made by the provider in billing, such as the incorrect usage of billing codes. Some overpayments occurred due to documentation from medical records that did not support the claims billed. However, because the sample consisted primarily of new provider reviews, patterns of potentially fraudulent billing behavior by established Medicaid providers were not apparent in the review.

While there is some benefit to auditing new providers in regard to education and early identification of billing errors, focusing too much on new providers is not the most effective practice in identifying potential fraud and abuse. Focusing on new provider reviews limits the state's ability to identify potentially fraudulent or abusive billing practices by more established providers who make up a larger percentage of overall Medicaid claims and payments. Interviews with CMS and Medicaid staff in other states indicated it is more common to take a risk-based approach in selecting providers to audit. For example, the majority of audits conducted in Wyoming are the result of data mining. Alaska uses software to consider several risk factors when selecting a provider for review, such as payments to the provider relative to other providers and average payment amount per claim. Vermont considers factors such as how likely it is to recover potential overpayments. While SURS is not currently using a risk-based

approach in selecting most of the providers it audits, the department indicated it is in the process of procuring a new sub-system within MMIS. This new sub-system is expected to have more analytical capacity related to overpayment audits. The department intends to have this sub-system in place in 2019.

Department Does Not Systematically Conduct Follow-up Audits

Following an initial overpayment audit, providers may be subject to a follow-up audit. According to SURS policy, the follow-up program will "review and prioritize previously audited providers of Medicaid services for re-audit of billing practices based on the number of errors found in initial audit and compliance with education based on audit findings." This process is supposed to take place biannually. During our file review on a sample of overpayment audits, which raised questions about follow-up audits, SURS was unable to provide a list of providers eligible for a follow-up audit. We learned that follow-up audits are conducted infrequently by SURS when compared to new provider reviews and are not currently conducted in a trackable manner. When follow-up audits are not conducted in a systematic way, the state is not revisiting providers who have already shown signs of billing errors that could amount to potential fraud or abuse.

Department's Audit Processes Are Not Effective in Identifying Potential Medicaid Provider Fraud

In fiscal year 2017, Montana Medicaid providers were paid over $1.2 billion in benefits and claims, almost $400 million of which came from state funding sources. Even if fraud, waste, and abuse account for only a small percentage of this, it amounts to millions of dollars in improper payments. With so much state and federal funding for Medicaid services, it is vital to safeguard the program from improper payments, including those due to fraud and abuse by providers. Nationally, the Government Accountability Office (GAO) estimated more than $29 billion in improper payments in Medicaid in 2015. If improper payments go undetected, including those associated with fraud or abuse, state and federal governments could be paying providers for services that were not provided or for unneeded services. When this happens, Medicaid funds are diverted from their intended purpose, beneficiaries who need services may not receive them, or beneficiaries may be harmed by unnecessary care. SURS currently focuses its efforts to identify improper payments on new provider reviews and does not systematically conduct follow-up audits on providers found to have significant billing errors. As discussed, these are not effective practices in identifying potential provider fraud or abuse in Medicaid billing. Therefore, the department should develop more effective overpayment audit processes to better identify potential provider fraud and abuse.

We recommend the Department of Public Health and Human Services:

  A. *Develop a risk-based approach in selecting Medicaid providers for overpayment audits, and*

  B. *Conduct follow-up audits of providers found to have significant billing errors in a regular, trackable manner.*

Recent Legislation Reduced the State's Ability to Identify Overpayments and Potential Fraud and Abuse

In Montana, recent legislation related to overpayment audits by the department and its contractors was passed. In the 2015 Legislative Session, House Bill 237 was passed by the legislature, but was vetoed by the governor. A similar bill was passed and enacted into state law in Chapter 82 in the 2017 Legislative Session. These two bills were put forward based on concerns by the Medicaid provider community in Montana related to large Medicaid overpayment amounts, large documentation requests, and lengthy audit time frames. Additionally, there was a perception that Montana Medicaid had relatively little provider fraud, waste, and abuse, due to a low state-level improper payment rate, called the Payment Error Rate Measurement (PERM). While CMS estimated Montana's PERM rate to be 5.8 percent in fiscal year 2014 and the overall rate for the states in the same PERM cycle was 11 percent, states should take caution when comparing states' PERM rates. Comparisons based solely on PERM rates are not encouraged due to variations in the sizes of states, program variations, and the different ways each state's rate impacts the national PERM rate.

The legislation put certain sideboards on overpayment audits by the department and its contractors, such as:

  ◆ Restricting records requests from providers to six months of claims within the previous three years for initial audits.

  ◆ Restricting follow-up audits of providers found to have a significant billing error rate in an initial audit to the same codes associated with errors from the initial audit. However, the department may request additional records from a lookback period longer than three years for a follow-up audit.

  ◆ Requiring audits to be completed within 90 days of receiving records from providers, unless fraud is suspected.

  ◆ Prohibiting the projection of overpayment results from a sample to a larger set of claims (extrapolation) in an initial audit.

◆ Requiring the department to obtain and consider a peer review, upon request by a provider, of overpayment audit findings.

◆ Requiring annual publication of various statistics regarding all overpayment audits.

◆ Requiring the department to annually evaluate auditor performance to include input from providers.

Many of the provisions in the new law promote a more reasonable balance in the overpayment audit process. For example, prohibiting extrapolation in an initial audit prevents large overpayment amounts from being established based solely on unintentional clerical errors. However, the six-month restriction on records requests has resulted in, and is expected to further result in, negative impacts to the state's ability to identify provider fraud, waste, and abuse.
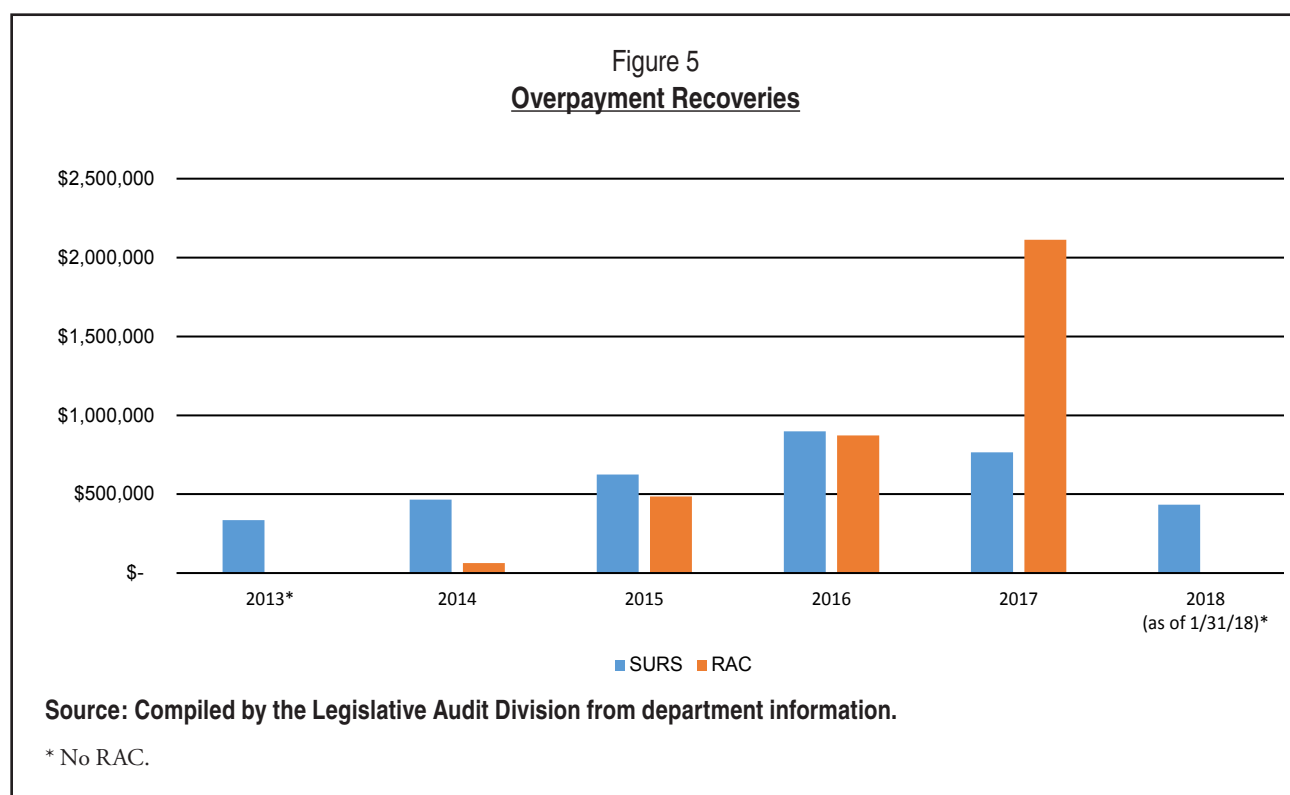
Other States Have Less Strict Records Request Restrictions

Industry standards allow for longer time frames for records requests from providers. In our review of six other comparable state Medicaid programs, none of them had limitations on records requests for overpayment audits as strict as those of Montana. The states we reviewed included Alaska, Colorado, Idaho, South Dakota, Vermont, and Wyoming. The most limited records request restriction identified by another state was 12 months. Two of the states we interviewed permit records requests from providers on Medicaid claims from up to six years. Most of these states indicated a six-month restriction on records requests would greatly reduce their ability to identify legitimate overpayments.

Additionally, states indicated a six-month records request restriction would reduce their ability to identify potential provider fraud, as six months of records is not typically enough to identify a potentially fraudulent billing pattern. This same concern was expressed by staff from the Montana MFCU. CMS representatives indicated that, while states have varying look-back periods and records request restrictions, they were not aware of other states with a records request restriction as strict as six months. CMS representatives also recognized that this level of restriction would impact the amount in overpayment a state can recover, particularly in smaller states. The true extent of the reduction in overpayment amounts in Montana is not yet known, as the department may receive the actual payment on overpayments that were established months or even years beforehand. However, department staff indicated future collection on overpayments will likely decrease.

Department Could Not Procure a Recovery Audit Contractor

The six-month records request restriction also affects other program integrity measures in Montana. Federal regulations require states to contract for a Recovery Audit Contractor (RAC). The RAC program has been identified by CMS as a key anti-fraud and abuse activity that was expanded to Medicaid from Medicare. Medicaid RACs perform additional reviews of claims submitted by providers to identify improper payments and are paid based on a percentage of the overpayment they recover. This percentage was 10 percent in Montana. Figure 5 shows the amounts recovered in Medicaid overpayments by both SURS and the RAC between fiscal years 2013 and 2017.

Figure 5
Overpayment Recoveries

Source: Compiled by the Legislative Audit Division from department information.

* No RAC.

The figure shows the overpayment recoveries by the RAC became comparable to recoveries identified by SURS, even exceeding SURS recoveries during the most recent year in which the department contracted for a RAC. However, the department was unable to procure a new RAC after the most recent contract expired because of the six-month records request restriction in the new law. The department recently received a waiver for the RAC program from CMS, but this waiver expires August 7, 2019. Therefore, Montana is currently without the additional safeguard of the Medicaid program by a RAC.

Changes to the Law on Overpayment Audits Are Needed

Nationally, state Medicaid programs face challenges in balancing program integrity control activities with preventing these controls from discouraging honest providers from participating in Medicaid. When fewer providers are willing to participate in Medicaid, program recipients may not have sufficient access to needed medical services. It is important, however, to ensure the reduction of provider burden is done in a manner that preserves the state's ability to safeguard the Medicaid program from fraud, waste, and abuse. Therefore, while many provisions in the recent state law on overpayment audits reduce the administrative burden on Medicaid providers, audit work determined the six-month records restriction provision unnecessarily reduces the state's ability to identify provider fraud, waste, and abuse. Audit work determined the department needs access to at least one year of provider records to sufficiently identify patterns of fraudulent billing. On the other hand, we recognize there may be certain types of audits for which the department may want to request less than a year's worth of records, such as for new provider reviews. Therefore, if the department did have the option to request more than six months of records from providers, it still has the option to request fewer records for certain types of audits.

RECOMMENDATION #6

We recommend the Montana Legislature amend state law to allow the Department of Public Health and Human Services and its contractors to request at least one year of records from Medicaid providers for overpayment audits.

Chapter IV – Coordination in Program Integrity Efforts

Introduction

The laws, rules, policies, and best practices surrounding Medicaid exist at the federal and state levels. Because of this, the Medicaid program is complex and the roles in program integrity efforts have blurred over time. Coordinated efforts both within the Department of Public Health and Human Services (department) and between the department, its contractors, and other state functions are vital to ensuring the integrity of the Medicaid program. One of our audit objectives was to determine whether reasonable coordination of efforts exists in Montana in safeguarding the Medicaid program from fraud and abuse.

The majority of states' strategies to combat fraud and abuse in Medicaid largely focus on providers, rather than recipients. This may be due to the nature of the Medicaid program in the sense that Medicaid providers receive payments for providing services, and therefore may have more incentive to defraud or abuse the program. Additionally, the cost-benefit to the state in pursuing potential Medicaid recipient fraud may be lower than in pursuing Medicaid provider fraud and abuse. Because of this, we largely focused our review on the coordination of efforts in identifying and pursuing Medicaid fraud and abuse by providers. While our previous chapter focused on improvements the department could make to better identify potential fraud and abuse by providers, this chapter provides our recommendation for improving coordination in state efforts to mitigate the risk of provider fraud and abuse in the Medicaid program. Our work found that, while the department has controls in place to ensure reasonable coordination of Medicaid program integrity efforts, the department needs to develop an overall strategy for combatting provider fraud and abuse in the Medicaid program.

Coordination Between the Department and the Contractor

Since Medicaid in Montana is administered through many contracted services, coordination between the department and its contractors is important in safeguarding Medicaid from provider fraud and abuse. Some coordination in this area exists in the Medicaid provider screening and enrollment processes. The department contracts for a Medicaid claims processing and payment system called the Medicaid Management Information System (MMIS). The MMIS contains a sub-system for the screening and enrollment of Medicaid providers. The contractor performs the routine provider screening and enrollment activities within the sub-system, such as the intake, screening,

approval, and final review of applications. However, some provider types require approval from the department to enroll in Medicaid. For example, newly-enrolling home health agencies, considered high risk for fraud, require approval by the program officer within the department before their applications can be approved within the provider sub-system.

As part of the enrollment process, Medicaid providers are electronically screened by the contractor at initial enrollment and monthly thereafter against various exclusion lists and verification databases. If inconsistencies or sanctions against the provider are identified, an alert is generated. The contractor addresses most of the alerts, though an alert is sent to the Surveillance and Utilization Review Section (SURS) within the department if it is for a sanction on the provider within the last three years. While our file review work on a random sample of 100 Medicaid providers did not include any providers with alerts that warranted being worked by SURS, we obtained documentation that alerts are being sent to and addressed by the department when necessary.

In addition, contract oversight activities by the department include monthly reporting by the contractor on certain performance criteria. Some of these performance criteria, jointly developed by the department and the contractor, pertain to provider screening and enrollment. For example, one criterion is that alerts generated during the monthly screening of providers are either worked by the contractor or referred to SURS within ten days. The contractor's report from September 2017 indicated it met this performance criterion. Based on our review, we determined that reasonable coordination between the department and the contractor exists regarding program integrity efforts.

Coordination Within the Department

Medicaid program integrity efforts span multiple divisions and functions within the department. As such, coordination within the department is key to ensuring provider fraud and abuse is properly identified and pursued. This section describes some of the other coordinated efforts we identified within the department.

SURS conducts audits of paid claims in order to identify provider overpayments due to fraud, waste, or abuse. However, other divisions within the department are responsible for administering the various Medicaid programs within Montana Medicaid, including the Senior and Long Term Care Division, the Developmental Services Division, the Addictive and Mental Disorders Division, and the Health Resources Division. These divisions review claim reports from the MMIS and may refer audit topics or individual providers to SURS based on spikes in these reports or other observations in the field. We reviewed 110 overpayment audits by SURS and found that 10 of them were based on referrals from these divisions, indicating these types of referrals are being made.

The SURS overpayment audit process also includes a review by the Medicaid Review Committee (MRC) for provider overpayments of more than $5,000. The MRC reviews overpayment findings and votes on the resolution of cases, including consideration as to whether fraud may have occurred. The voting process is currently conducted via e-mail in order to complete overpayment audits within the required 90 days specified in state law. The MRC is made up of staff from QAD, other department divisions, and the Medicaid Fraud Control Unit (MFCU) within the Department of Justice. The voting and nonvoting members are listed below.

Voting members:

- QAD Administrator
- QAD Program Compliance Bureau Chief
- Human Resources Division Administrator (or designee)
- Addictive and Mental Disorders Division Administrator (or designee)
- Senior and Long Term Care Division Administrator (or designee)
- Developmental Services Division Administrator (or designee)
- The Bureau Chief from the affected Medicaid program
- Senior Medicaid Policy Officer

Nonvoting members:

- MRC meeting coordinator (designated SURS staff)
- SURS Supervisor
- SURS auditor responsible for the case being presented
- Program Officer or Program Manager associated with case
- MFCU Supervisor
- Chief of the Office of Legal Affairs (or designee)

The MRC provides a coordinated approach in the overpayment audit process and allows the department to consider how large overpayments may impact providers and access to Medicaid services by recipients. That is, a provider may be the only Medicaid provider in a rural community. A large overpayment may affect such a provider's willingness and ability to accept Medicaid patients and therefore would affect access to Medicaid services for recipients in the area. However, access to services does not affect consideration as to whether suspected fraud has occurred and is referred to MFCU. Additionally, the MRC allows an opportunity to identify needed clarifications or changes in the department's administrative rules for Medicaid billing. Medicaid staff from the six other states we interviewed during the audit indicated program divisions are informed and included to various extents on overpayment audit issues.

Coordination Between the Department and the Medicaid Fraud Control Unit

Federal regulations require the department to refer all cases of suspected provider fraud to the state MFCU within the Montana Department of Justice. If an allegation of fraud is then established as credible, the department must suspend Medicaid payment to the provider, though there are certain exceptions. The department has established an agreement with MFCU detailing each party's responsibilities in regard to pursuing potential Medicaid provider fraud. For example, the agreement states the department will provide MFCU with access to the records and information needed for investigations by MFCU. The agreement also establishes a MFCU representative as a nonvoting member of the MRC process. Additionally, MFCU and SURS conduct cross-trainings about every other month on various topics, such as training on querying claims from MMIS. The SURS unit and MFCU share information on cases that are open and being worked in order to prevent duplication of effort.

Decline in Referrals to MFCU

There have been recent concerns about the decline in referrals to MFCU from the department. For example, a 2013 review of Montana's SURS unit by the Centers for Medicare and Medicaid Services (CMS) identified several risks to Medicaid program integrity, including a low number of referrals to MFCU. Figure 6 shows the history of the number of referrals to MFCU by SURS and from other areas within the department.

Figure 6
Referrals to the Medicaid Fraud Control Unit by the Department

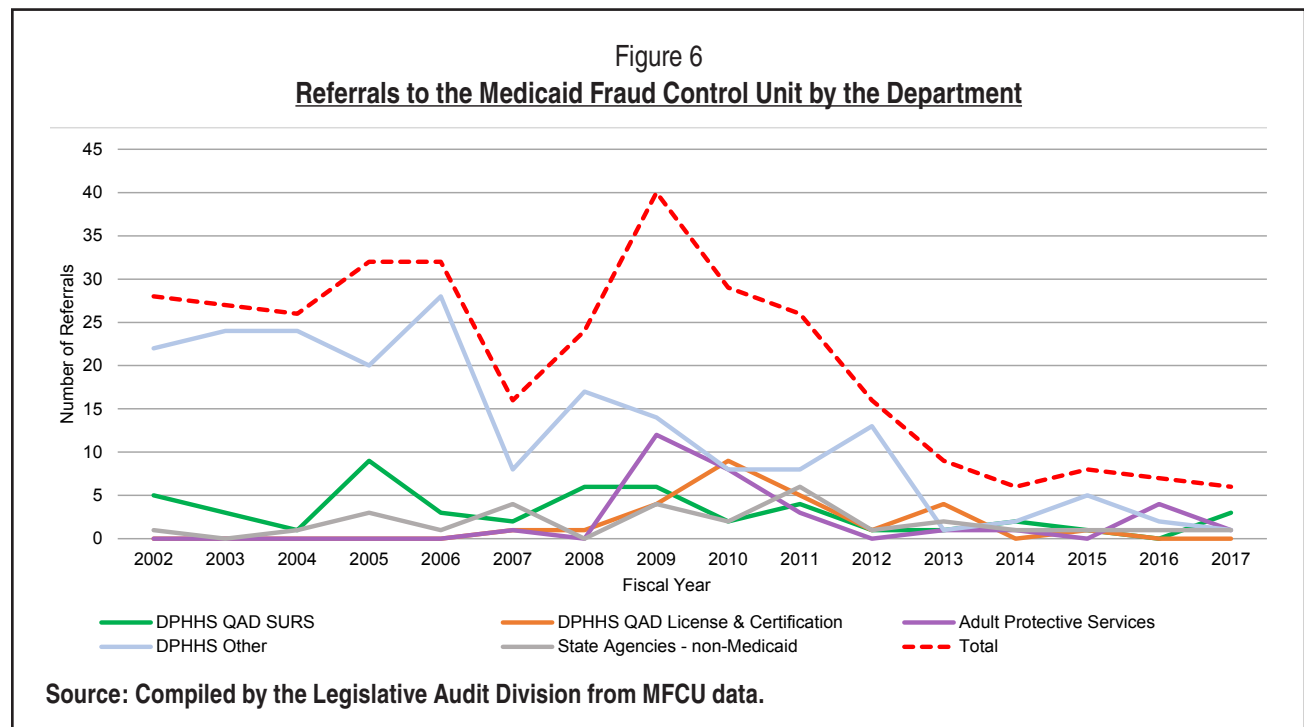**Source: Compiled by the Legislative Audit Division from MFCU data.**

Figure 6 shows the number of referrals to MFCU from the department began to decline around 2009. Referrals from the department went from around 20 to 30 referrals per year in the early 2000s to around six referrals per year in recent years.

Per department staff, there may be several factors that have contributed to this decline in referrals. For example, department management indicated there was some initial concern from staff related to the impact of restricting records requests from providers to six months in terms of demonstrating enough evidence to refer a case to MFCU. However, the six-month restriction in overpayment audits in the law and in practice by SURS occurred after the decline in referrals. Improvements to MMIS during this time frame may have also included preventive controls that contribute to fewer instances of provider fraud, though this would not entirely explain why decline in referrals occurred.

A recent Legislative Audit Division financial-compliance audit (#17-14) identified that SURS had been misinterpreting the distinction between the level of proof necessary to constitute "suspected fraud" versus a "credible allegation of fraud." Cross-training documents between SURS and MFCU indicated this is a potential topic for further training, and the department has moved toward more informal communication with MFCU prior to a formal written referral. Department staff also indicated they were in the process of reviewing the department's policies, processes, and the agreement with MFCU to address this recommendation from the financial-compliance audit (#17-14). This indicated the department is making a concerted effort to address the areas under its control that may factor into this decline in referrals to MFCU. In addition, the implementation of earlier recommendations in this report may also lead to an increased number of referrals to MFCU by the department. Therefore, we determined reasonable coordination exists between the department and MFCU.

CONCLUSION

We conclude the department has controls in place to ensure reasonable coordination of Medicaid program integrity efforts across state functions in accordance with federal and state requirements and best practices.

Department Has No Overall Program Integrity Strategy

While coordination of efforts across state functions exists, the department does not have an overall strategy for addressing fraud and abuse in the Medicaid program. Multiple factors contribute to the lack of an overall strategy by the department. For example, audit work determined there has been a general shift in department policy

and processes that makes the department's program integrity activities less onerous for Medicaid providers. Interviews with department staff indicated the department has made an effort to be less burdensome on providers across Medicaid divisions, primarily due to a large provider overpayment that had been identified. Interviews with provider groups and the department also indicated the large overpayment precipitated many of the provisions in the new law on overpayments. Additionally, program divisions were instructed by management to cease conducting informal reviews of providers from a clinical perspective due to the large overpayment. SURS staff were also directed to find alternatives in its overpayment processes to be less punitive on providers. This was, at least in part, due to the passage of the legislation that put sideboards on overpayment audits.

Another reason an overall strategy related to Medicaid fraud and abuse did not exist was that it may not have been at the forefront of the department's objectives. That is, the department may not have prioritized a comprehensive anti-fraud strategy. For example, the department had to implement the expansion of Medicaid, which involved enrolling over 90,000 people into the program. In order to provide access to services for the newly-eligible population, in addition to maintaining the traditional Medicaid programs, the department may not have prioritized or had the resources to develop an overall anti-fraud strategy. Over half of the eligibility workers who responded to our survey disagreed that identifying Medicaid recipient fraud and abuse was a high priority in the department.

MFCU staff also indicated the department emphasizes protecting providers and preserving access to services for Medicaid recipients, which may have contributed to a decline in referrals from the department to the MFCU. The department could not provide a complete explanation as to why referrals to MFCU have declined over time. This speaks to how the department does not have a complete understanding of the potential cumulative effects of policy and other changes on risk for fraud and abuse in the Medicaid program.

Increased Risk for Fraud and Abuse Makes an Overall Strategy Necessary

Several factors in Montana contribute to an increased risk for fraud and abuse in Medicaid, which warrants an overall strategy by the department for combatting provider fraud and abuse. In Montana, Medicaid services are provided on a fee-for-service basis in which providers are paid for each service rendered (e.g. an office visit, test, or procedure). With the expansion of Medicaid covering an additional 90,000 recipients, more services are being delivered by providers, meaning more Medicaid dollars are

being spent and there is an increased risk for fraud and abuse in the program. At the same time, the department has made an effort to be less burdensome on Medicaid providers based on concern from the provider community, leading to the passage of legislation on overpayment audits. This legislation not only reduced the ability of SURS to identify overpayments and potential provider fraud, but it led to an unsuccessful procurement of a Recovery Audit Contractor (RAC). The RAC had recovered more than $2 million in fiscal year 2017 and is an important mechanism for identifying and recovering improper Medicaid payments to providers. Therefore, fewer safeguards against provider fraud and abuse exist, leading to increased risk.

Medicaid program integrity requires a balance between reducing improper payments and discouraging honest and qualified providers from accepting Medicaid-insured patients. Concern over placing undue burden on providers, the majority of whom are presumed to be honest, is a counterforce to program integrity activities. Part of ensuring the appropriate balance includes effective fraud risk management.

The Government Accountability Office (GAO) issued a Fraud Risk Framework, which includes a fraud risk assessment and a risk-based anti-fraud strategy. The GAO identifies the components of an effective fraud risk framework as:

- Committing to combatting fraud by creating an organizational culture and structure conducive to fraud risk management.

- Planning regular fraud risk assessments and assessing risks to determine a fraud risk profile.

- Designing and implementing a strategy with specific control activities to mitigate assessed fraud risks and collaborate to help ensure effective implementation.

- Evaluating outcomes using a risk-based approach and adapting activities to improve fraud risk management.

Based on our review of department information and discussions with department officials, we determined the department has not fully developed an overall strategy in regard to detecting and deterring provider fraud and abuse in Medicaid. The department does not have a formal risk assessment process and has not assessed the cumulative effects of policy and other changes to risk for Medicaid provider fraud and abuse in Montana. Therefore, the department needs to develop a comprehensive fraud risk framework for Medicaid. This requires an assessment of existing risks and an evaluation of how policy changes affect the risk for Medicaid provider fraud and abuse in Montana in order to promote processes that are conducive to identifying and pursuing fraud and abuse. When the department does not have a fraud risk framework or an overall strategy for addressing provider fraud and abuse, the department may not

be placing its program integrity controls where the highest risks exist. This could result in provider fraud and abuse in Medicaid going undetected by the department at cost to state and federal taxpayers.

RECOMMENDATION #7

We recommend the Department of Public Health and Human Services develop a fraud risk framework for Montana Medicaid to design an overall strategy related to Medicaid provider fraud and abuse. This is to include:

A. *A strategic plan for promoting processes to identify and pursue Medicaid provider fraud and abuse.*

B. *An ongoing means for assessing existing risks through an evaluation of how policy changes affect Medicaid fraud and abuse.*

Department Response

Department of Public Health and Human Services

Department of Public Health and Human Services

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MONTANA
DPHHS
Healthy People Healthy Communities.
Department of Public Health & Human Services

Steve Bullock, Governor

Sheila Hogan, Director

June 1, 2018

Angus Maciver
Legislative Auditor
Office of the Legislative Auditor
State Capitol, Room 160
Helena, Montana 59620-1705

Re: Performance Medicaid Audit

Dear Mr. Maciver:

The Department of Public Health and Human Services has reviewed the *Performance Medicaid Audit* (17P-02) completed by the Legislative Audit Division. Our responses and corrective action plans for each recommendation are provided below.

Recommendation #1:

We recommend the Department of Public Health and Human Services conduct, document, and report on a re-evaluation of its current policy decisions on Medicaid recipient eligibility verification. Re-evaluations should:

A. Identify risks for Medicaid recipient fraud and abuse, analyze how policy decisions impact those risks, and determine whether it is feasible to reduce those risks through policy or procedural changes.

B. Include policies such as post-enrollment verification of income, coordination with the federally-facilitated marketplace, and continuous eligibility.

C. Reoccur on a systematic basis when the requirements of the Medicaid program change.

Response: Concur

Corrective Action: The Department will conduct a re-evaluation of its policy decisions and document considerations, analysis and conclusions. Policy change evaluation and documentation will be incorporated into change management processes going forward.

Planned Completion Date: December 31, 2018

Recommendation #2:
We recommend the Department of Health and Human Services incorporate training for Medicaid eligibility workers on identifying and referring suspected Medicaid recipient fraud or abuse into its ongoing training plan.

Response: Concur

Corrective Action:
This was implemented with refresher training in November 2017 for all staff. The refresher training is available to all staff at all times via our eLearn platform. A fraud waste and abuse module is included in new hire training for eligibility staff.

Planned Completion Date: Completed

Recommendation #3:
We recommend the Department of Public Health and Human Services enhance investigations into complaints of Medicaid recipient fraud by:
   A. Improving the documentation on the nature and resolution of the investigations, including referral to law enforcement when suspected recipient fraud is identified.

   B. Using state tax information to examine income and household composition information.

Response: Partially concur

Corrective Action:
Quality Assurance Division, Program Investigation Unit will work with Human Community Services Division (HCSD) to receive Medicaid eligibility training for the Program Integrity Investigators (PII). Training will include modules through the eLearn training environment. The additional training will enhance the PII's ability to identify and investigate Medicaid recipient fraud. A separate, internal training will be held to reinforce the importance of complete and accurate case documentation.

The Program Investigation Supervisor will reach out to law enforcement and county attorney associations to discuss the necessary components required for potential criminal prosecution. Following these discussions, updated internal procedures will be implemented.

The Department agrees access to a recipient's state tax returns would be a useful tool in the investigation process. However, DPHHS Office of Legal Affairs and the Department of Revenue Legal Department have determined that under the current laws, DPHHS is not legally permitted to receive tax information from the Department of Revenue without a

court order or a comprehensive restructuring of statutes, rules, and internal policies. The Department will continue to look for avenues for verifying application information.

Planned Completion Date: December 31, 2018

Recommendation #4:

We recommend the Department of Health and Human Services ensure providers enrolled in the Montana Medicaid program are revalidated at least every five years, as required by federal regulations.

Response: Concur

Corrective Action:

DPHHS has processes in place to assure providers are adequately screened and monitored while working toward full compliance of revalidating all providers at least every five years. The Department will also require all providers to revalidate their information within the required timeframe through the provider enrollment and maintenance services currently under procurement. The Department anticipates implementation of the service module – which will require providers to revalidate – to be complete by August 2019.

Planned Completion Date: August 1, 2019

Recommendation #5:

We recommend the Department of Public Health and Human Services:
   A. Develop a risk-based approach in selecting Medicaid providers for overpayment audits and

   B. Conduct follow-up audits of providers found to have significant billing errors in a regular, trackable manner.

Response: Concur

Corrective Action:

The Surveillance, and Utilization Review Section (SURS), Quality Assurance Division, will create and identify a manual risk based analysis using the systems currently in place. Utilizing the fiscal agents Query Path program, SURS will run aggregate queries that will yield basic information. In addition, SURS will work with the Strategic Planning, Research, and Analysis team within the department to identify anomalies in payments to providers.

More sophisticated data analytics will be a feature of the MPATH modularity sub-system designed to perform complex algorithms on Medicaid payment data.

To identify providers for follow-up audits, a list of provider reviews that concluded with a 5% or more error rate will be compiled. Program Integrity Compliance Specialists will be given the expectation to open a minimum of two follow up reviews per month, as the list supports.

Planned Completion Date: September 30, 2018

Recommendation #6:

We recommend the Montana Legislature amend state law to allow the Department of Health and Human Services and its contractors to request at least one year of records from Medicaid providers for overpayment audits.

Response: N/A

Corrective Action: N/A

Planned Completion Date: N/A

Recommendation #7:

We recommend the Department of Health and Human Services develop a fraud risk framework for Montana Medicaid to design an overall strategy related to Medicaid provider fraud and abuse. This is to include:

A. A strategic plan for promoting processes to identify and pursue Medicaid provider fraud and abuse.

B. An ongoing means for assessing existing risks through an evaluation of how policy changes affect Medicaid fraud and abuse.
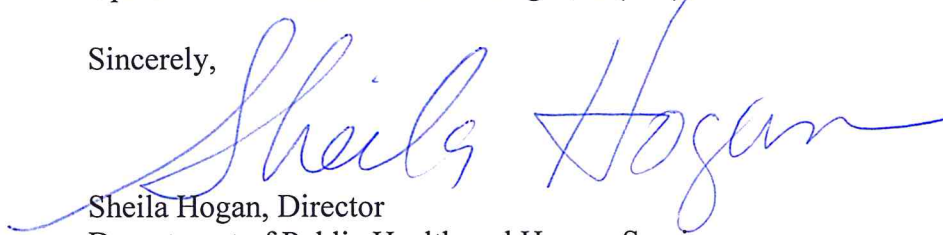
Response: Concur

Corrective Action:
The Department will include a fraud risk framework in the Department's strategic planning process.

Planned Completion Date: December 31, 2018

If you have any questions regarding our response, please contact Erica Johnston, Operations Services Branch Manager, at (406) 444-9773.

Sincerely,

Sheila Hogan, Director
Department of Public Health and Human Services

cc:
Laura Smith, Economic Security Services Branch Manager
Marie Matthews, Medicaid & Health Services Branch Manager
Erica Johnston, Operation Services Branch Manager
Jamie Palagi, Human and Community Services Division Administrator
Michelle Truax, Program Compliance Bureau Chief, Quality Assurance Division
Gene Hermanson, Medicaid Systems Operations Manager, Medicaid Systems Support
Chad Hultin, Audit Liaison, Operations Services Division