



Mitigating the Risk of Improper Payments in the Virginia Medicaid Program

SENATE FINANCE COMMITTEE
Health and Human Resources Subcommittee

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Study Mandate

HJR 127 (2010 Session)

- JLARC studied nature & extent of improper payments (fraud, abuse, waste, and error) in Medicaid
- Interim report briefed in October 2010
- Final report briefed in October 2011

Key Findings

- Agency errors during recipient enrollment present greatest risk of improper payments.
- Greater authority could help exclude more high-risk providers
- Pre-payment analytics and reviews could strengthen prevention efforts
- DMAS provider review activities are effective, but could be better planned and documented to maintain strong performance.
- Most (70%) improper payments are collected, but collection rates vary.

4 Primary Strategies to Mitigate Improper Payments

Enrollment Screening

- Determine whether applicants are eligible to receive Medicaid services (LDSS)
 - Prevent providers from enrolling if fail to meet criteria (DMAS)
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Prevention

- Identify improper claims & services before State funds have been disbursed (DMAS)
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Detection

- Audit providers to determine retrospectively whether paid claims contained improper payments (DMAS)

Prosecution

- Prosecute provider fraud (MFCU)
 - Prosecute recipient fraud (Commonwealth's Attorneys)
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Collection

- Recover money owed by providers and recipients (DMAS)

Recipient Enrollment Errors Present Greatest Risk of Improper Payments

- 2009 federal review found errors in 17% of recipient files examined & estimated potential total cost of \$910 M
 - State share estimated to range between \$18M and \$263M*
- Errors largely driven by lack of documentation to support eligibility & improper calculation of financial resources
 - IT improvements & updates needed to automate data collection, data entry, and calculations
 - Greater oversight of LDSS, caseworker monitoring, and training needed to ensure proper application of complex eligibility rules

* Reflects JLARC staff adjustments that capture subsequent policy changes and differences in interpretation between the State and the federal government. Amounts not recoverable; CMS data constraints limit the precision of estimated statewide improper payments.

Process to Determine Medicaid Eligibility Is Complex and Not Automated



Provider Enrollment Process Not Fully Utilized to Exclude or Identify High-Risk Providers

- DMAS reports lacking sufficient statutory authority to use optional federal criteria to exclude providers who may pose a health or financial risk
 - Few providers excluded; usually due to felony or lack of licensure
- Information collected during enrollment not used to identify potential risks & enhance scrutiny
- Budget amendment submitted (Del. Jones) granting DMAS needed authority and requesting plan for screening out high-risk providers by end of 2012

Pre-Payment Analytics & Reviews Could Strengthen Prevention Efforts

- Current measures prevented \$22M+ (GF) in provider improper payments in FY09
- Pre-payment advanced analytics & reviews could reduce “pay and chase”, but not currently used
 - Successfully used by Virginia MCOs and other states
 - Analytical software detects outliers / suspicious patterns & triggers review of supporting documents before claims are paid
- RFP created by DMAS to enhance data mining
 - Extent of focus on prevention vs. detection unknown
 - Still under review as of 01/12

Federal Review Indicates Almost All Improperly Paid Claims Are Detected

- Post-payment provider audits detected 91% of errors (\$29M of \$32M) found by federal review
- Steps needed to be taken to maintain strong and efficient performance
 - Single audit plan to ensure full risk coverage and efficiency
 - Better controls to ensure proper disposition of referrals
 - Formal analysis of audit results to focus future efforts and ensure resources are used most efficiently

Referrals to MFCU Increased Sharply and Could Continue With Greater Clarity

- DMAS collections from MFCU cases = \$13.0M (FY10)
- Number of referrals to MFCU in 2010 (51) is 8 times higher than in 2006 (6)
 - New bi-monthly interagency meetings
 - Still represents 7% of all audits conducted
- DMAS procedure manuals lack clear criteria for referrals to MFCU
 - Need formal mechanism to evaluate audit outcomes for potential fraud, and ensure referrals consistently made to MFCU

30% of Improper Payments Identified in FY09 Was Not Collected

- Collection rates vary widely
 - Higher for providers (73%) than recipients (27%)
 - Higher for errors (76%) than fraud (61%)
- Collection data could be used to focus detection and collection efforts on cost-effective improper payments
 - Data not readily accessible
 - Systems updates needed to render collection data usable