

LEGISLATIVE AUDIT DIVISION

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MEMORANDUM

TO: Legislative Audit Committee Members

FROM: Amber Robbins, Senior Performance Auditor

CC: Sheila Hogan, Director, Department of Public Health and Human Services
Laura Smith, Deputy Director, Department of Public Health and Human Services
Marie Matthews, Branch Manager, Department of Public Health and Human Services
Erica Johnston, Branch Manager, Department of Public Health and Human Services

DATE: October 2019

RE: Performance Audit Follow-Up (19SP-21): *State Efforts to Mitigate Fraud, Waste, and Abuse in the Montana Medicaid Program* (orig. 17P-02)

ATTACHMENTS: Original Performance Audit Summary

Introduction

We issued the performance audit titled *State Efforts to Mitigate Fraud, Waste, and Abuse in the Montana Medicaid Program* (17P-02) to the Legislative Audit Committee in June 2018. The audit included seven recommendations. Six recommendations were to the Department of Public Health and Human Services (department) and one was to the Legislature. In August 2019, we conducted follow-up work to assess the department's progress in implementing the recommendations. This memorandum summarizes the results of our follow-up work.

Overview

The audit identified the need for the department to improve its efforts to prevent and identify recipient fraud and abuse. We recommended the department re-evaluate the state's Medicaid recipient eligibility verification policies, provide additional training for Medicaid eligibility workers, and improve its documentation of investigations into suspected recipient fraud. Audit work also found the department should improve its fraud and abuse controls related to providers. We recommended the department ensure Medicaid providers are revalidated according to federally required timelines, develop a risk-based approach in selecting providers to audit, and develop an overall strategy for addressing provider fraud and abuse. While follow-up work indicated the department has taken positive steps to implement the audit's recommendations, not all recommendations have been implemented completely. Our performance audit contained six recommendations to the department. We determined the department implemented three recommendations, partially implemented one recommendation, and is still implementing two recommendations. The one recommendation to the Legislature from the audit was not implemented.

Background

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 program affects many

Montanans and makes up a large portion of state expenditures. The state's share of the cost for Medicaid services was estimated to be about \$915 million for the 2019 biennium. Around 230,000 Montanans were enrolled in the program around the time of the audit. Federal regulations require state Medicaid agencies to have methods for identifying, investigating, and referring suspected recipient and provider fraud. Collectively, the reduction of fraud, waste, and abuse in Medicaid is called Medicaid program integrity. Typical program integrity controls in state Medicaid programs include a variety of activities to ensure:

- 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, and
- Provider payments are made in the correct amounts and for appropriate services.

Audit Follow-up Results

The performance audit contained six recommendations to the department and one recommendation to the Legislature. For follow-up to the audit, we interviewed department staff from the Economic Security Services Branch, the Medicaid and Health Services Branch, and the Operations Services Branch. We reviewed the department's strategic plan and tracking tool, trainings provided to department staff, and documents associated with provider audits. The following sections summarize the department's progress toward implementing the report recommendations.

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**

Implementation Status – Being Implemented

Our review of Medicaid recipient eligibility verification during the performance audit identified vulnerabilities to recipient fraud. These vulnerabilities existed due to eligibility verification policy decisions made by the department that were not always documented. The department re-evaluates policy decisions related to Medicaid recipient eligibility verification as changes occur in the Medicaid program. The department indicated it re-evaluates Medicaid policy decisions:

- Based on the strategic direction of the department,
- When there are changes to federal or state law, or
- In accordance with waiver and plan-required status changes or reviews.

The department has better ways to document the decisions it makes regarding Medicaid eligibility verification. For example, the department established a decision brief process in June 2019. The decision brief process is an internal process for approval of business decisions, which include changes to program

policy. The department can now track timelines, impacts to programs, and effects on department goals and objectives using the new decision brief process. Additionally, the department has a documented process for assessing improvements to its Medicaid eligibility system and other eligibility verification changes. Since the audit, the department has made some changes to Medicaid eligibility processing to prevent potential recipient fraud and abuse. For example, the department added a feature to its Medicaid eligibility system that flags certain entries and prompts the eligibility worker to review before authorizing benefits. The department also started doing more pre-authorization reviews of recipient cases to ensure accuracy.

Our audit report discussed how several of the department's recipient eligibility verification policy decisions increase risk for recipient fraud. The department plans to change some of these policies due to recent statutory changes. One of the policies discussed in our report was post-enrollment verification of income. The Legislature mandated certain changes to recipient eligibility verification during the 2019 Legislative Session with House Bill 658, which extended and made changes to the Medicaid expansion program. The legislation removes post-enrollment verification and requires the department to verify information, such as income and residency, at the time of application. The law also requires the department to request income tax and wage income from the Department of Revenue to verify income provided by Medicaid applicants. The department intends to make changes to its eligibility verification processes to meet these statutory requirements once the waiver related to HB 658 is approved by the Centers for Medicaid and Medicare Services (CMS).

The Legislature intends to reduce risk for Medicaid recipient fraud through the changes to recipient eligibility verification policy now mandated in law. However, the department still needs to evaluate other policies discussed in the report. For example, it is unclear whether the department has reconsidered how it coordinates with the federally facilitated marketplace. The department is one of nine states that opts not to verify income information and to accept the eligibility determination from the federally facilitated marketplace. The department still needs to assess the risk for fraud associated with this policy and determine whether this policy should be changed.

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.

Implementation Status – Implemented

The performance audit found eligibility workers were not consistently addressing potential Medicaid recipient fraud and needed more training. The department conducted refresher trainings for eligibility workers over the last year. It also provided training for newly hired staff that covered suspected fraud or abuse in Medicaid. According to interviews with eligibility workers, refresher trainings on different topics related to Medicaid eligibility that used to be required annually are now offered monthly. This provides more training opportunities for eligibility workers. The Quality Assurance Division also provided training to eligibility workers on overpayments and intentional program violations in all programs (the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and Medicaid) in March 2019. These trainings should help address the inconsistencies we found during the audit in addressing 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.**

Implementation Status – Partially Implemented

In the original audit, we found investigations into allegations of recipient fraud by the department were limited and needed better documentation. The department conducted an internal training for staff responsible for investigating allegations of recipient fraud. The purpose of the training was to reinforce the importance of documenting the steps of each investigation. Staff also received training on Medicaid eligibility to improve investigative competency. Additionally, the department sent correspondence to county attorneys to better understand when and how it should refer cases to law enforcement. The department refers cases to the county attorney for overpayment of benefits between \$10,000 and \$50,000 and to the Office of the Inspector General for amounts greater than \$50,000. However, since we completed audit work, there have been no cases regarding Medicaid recipients that met these criteria. As part of follow-up work, we reviewed the documentation associated with the investigations conducted since the audit. The documentation contained more detail on what eligibility information was verified and how each case was resolved. For example, the department found one family moved out of state but was still receiving Medicaid benefits in Montana. Investigative staff verified the out-of-state address of the family and entered a note into the Medicaid eligibility system. This allowed an eligibility worker to remove the family from the Montana Medicaid program.

During the audit, we also determined state tax data would be useful in Medicaid recipient fraud investigations. The department does not use state tax information to examine income and household composition when investigating complaints of recipient fraud. While the department agreed access to a Medicaid recipient's state income tax return would be useful, the department determined it does not have legal access to this information under current law. During follow-up work, we discussed access to tax information with the legal counsel at the Department of Revenue. The Department of Revenue determined current law does not permit the release of tax return information to the Department of Public Health and Human Services without a court order. Under current law, the Department of Public Health and Human Services can only access a recipient's 1099 information, with consent from the recipient. This information provides limited value in an investigation into Medicaid recipient fraud. A court order or changes to statute would be needed to use state tax return information as part of Medicaid recipient fraud investigations.

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.

Implementation Status – Being Implemented

In our performance audit, we found the department did not revalidate Medicaid providers according to the timeline required in federal regulations. During the audit, the department indicated it was in the process of procuring a module within the Medicaid Management Information System (MMIS) that would include provider enrollment and revalidation functionality. At that time, the department expected to be caught up on provider revalidations in 2019. While the department has successfully procured the service module

that will enable this process, the implementation date has been delayed until the spring of 2020. Monthly electronic screenings of all Medicaid providers are being conducted in the meantime. However, these screenings do not include collecting updated provider ownership and control information, as required for provider revalidation.

RECOMMENDATION #5

We recommend the Department of Public Health and Human Services:

- A. Develop a risk-based approach in selecting Medicaid providers for overpayments audits, and**
- B. Conduct follow-up audits of providers found to have significant billing errors in a regular, trackable manner.**

Implementation Status – Implemented

In the original audit, we found the department focused its overpayment audit efforts on newly enrolled Medicaid providers rather than on risk for fraud and abuse. The department considers more risk areas when selecting providers for overpayment audits. As part of the department's overpayment audit process, staff manually run queries and reports from the Medicaid claims system to review high-risk areas. Examples of high-risk areas are high-risk medical procedure codes, providers who billed for large amounts of supplies or services, and the highest paid providers. As part of follow-up work, we reviewed one of the queries used by the department. The report showed the number of units of a high-risk service billed by providers in fiscal year 2019. The department arranged for some of its own staff to be trained in building these types of queries and works with its contractor to build custom queries when necessary. New provider reviews still make up a sizeable portion of overpayment audits, but the department incorporated more manual assessments of risk for fraud and abuse when selecting providers to audit. Additionally, a new system replacing the existing query system is expected to have more analytical capacity related to overpayment audits. The new system will allow the department to begin moving away from manual risk assessment.

During the performance audit, we also found the department was not systematically conducting follow-up audits on providers found to have significant billing errors in initial overpayment audits. During our follow-up work, we reviewed the list of providers eligible for a follow-up audit as well as two follow-up audits conducted in fiscal year 2018. Providers eligible for follow-up audits are now tracked by the department and staff are required to conduct a follow-up audit every other month.

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.

Implementation Status – Not Implemented

During the audit, we found that legislation from the 2017 Legislative Session reduced the state's ability to identify provider overpayments and potential fraud and abuse. Potential legislation to address this recommendation, Senate Bill 235, was introduced during the 2019 Legislative Session. However, the bill did not pass. The bill would have allowed the department to request up to 12 months of records from a provider when conducting an initial overpayment audit. The bill was opposed by a provider association. The provider association indicated the change would increase the burden on providers due to overpayment audits conducted by the department. The provider association believed there was

insufficient evidence to justify a change from requesting six months to one year of records and Montana was leading other states in a larger national trend toward reducing the audit records request timeline. The bill had no other opponents, no proponents, and died in standing committee. We continue to believe the six-month records request restriction reduces the state's ability to identify provider fraud, waste, and abuse.

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.**

Implementation Status – *Implemented*

The department issued a strategic plan for 2019-2024 that included high-level goals, objectives, and measurable outcomes for the department. One of the outputs the department plans to measure is the number of Medicaid provider overpayment audits. The department is developing a dashboard to track this. Per the department's strategic plan, the purpose of this measure is to ensure the department achieves results in an efficient manner that minimizes costs. As discussed under Recommendation #1, the department plans to use its new decision brief process to evaluate the impacts of any policy changes moving forward.