Identifying Improper Payments in High-Risk Programs: A Look at Medicaid

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Presenters:
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Kathy Davis, Staff Auditor, Division of Audits (OR)
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Identifying Improper Payments in High-Risk Programs: A Look at Medicaid

Wednesday, June 20, 2018

Presentation by:

Daryl G. Purpera, CPA, CFE

Louisiana Legislative Auditor
1. Testimony to Joint Meeting of the Subcommittee on Government Operations & the Subcommittee on Intergovernmental Affairs - April 12, 2018

a. Inadequate Audit Requirements

b. State Auditors Do Not Have Access to Federal Tax Information

c. Costly Effect of Reasonable Compatibility Standard

d. Why These Issues are Important
2. Inadequate Audit Requirements
   a. MAGI key determinate
   b. State Medicaid administrators not required to use tax information
      i. 28 states use FTI at application
      ii. 27 state use FTI at renewal
   c. State Auditors told to not audit MAGI determinations
   d. Pilot projects
   e. CMS evaluating and changing
3. State Auditors Do Not Have Access To FTI

   a. 26 USCA 6103(d)(2)(A)
   b. Wage data is incomplete
   c. Tax data has its limitations
   d. Goal is sufficient evidence
   e. Scope limitation
      i. Single Audit
      ii. CAFR
   f. Risk? Work of the La Medicaid Fraud Task Force
4. Costly Effect of Reasonable Compatibility Standard

   a. CMS rules
   b. 0% to 25%
   c. Impact is to increase upper income limit above law
Presentation by:

Wesley Gooch, CPA

Special Assistant for Healthcare Audit
• Operating for 2 years

• Projects determined based on risks, allegations, requests, and available resources

• Up to 15 auditors from Financial Audit, Performance Audit, and Investigative Audit
Methodologies

- Data analysis and data matches using the Medicaid Eligibility file
- Program rules by Medicaid provider type
- Data integrity
- Policies, processes, and controls
Data Analysis and Data Matches - Eligibility

• Out of State Residency – October 2016
  o Identified improper payments $943,000
  o Additional possible improper payments $1.5M

• Multiple IDs – March 2017
  o Identified improper payments $1.4M
• Deceased – November 2017
  o Identified improper payments $700,000
• Incarcerated – currently in process
• Dental – March 2017
  o Identified $6.4M that violated program rules
  o Identified another $3.4M that may have violated program rules and $1M that violated rules but were paid due to administrative override.
Laboratory Services – September 2017

- $2.4M in improper payments where the lab provider did not have the required level of certification
- Another $1.7M in improper payments for lab claims using invalid procedure codes
• All-inclusive Code (T1015) – October 2017
  o Identified $150M in encounters were paid a negotiated all-inclusive rate without the detail lines attached to show the rate was earned.
  o Also identified another $845,000 in improper payments that violated policy for the use of T1015.
• Provider Registry – to issue next week, June 2018
  o Multiple issues with the lack of accurate provider information included in the encounter data.
  o Impairs our ability to develop and use provider-focused fraud, waste, and abuse procedures.
Home and Community Based Services – July 2017

- Identified $1.3M in improper payments where previous audit recommendations were not implemented
- Identified $2.5M in improper payments for workers on the registry for abuse, neglect, and misappropriation
• MAGI Verification Plan for Eligibility – May 2018
  o Louisiana used a 25% reasonability compatibility standard while most states that applied compatibility used 10%.
  o Louisiana does not use state or federal tax data. Without tax data, there is not electronic verification source for tax filer status, household size, self-employment income, or unearned income.
Identifying Improper Payments & Cost Saving Opportunities
- NYS Medicaid Program -
Overview of NYS Medicaid

• Government-funded program that provides health care services for low-income New York residents

• For the State fiscal year ended March 31, 2018:
  – About 7.3 million enrollees
  – About $63 billion in annual claim expenditures
  
  (10 years ago: $45 billion for 4 million enrollees)
Using the Right People & the Right Tools to Advance Audits of Improper Payments

Audit teams comprised of individuals with **VARIOUS BACKGROUNDS**; Partner with **EXTERNAL EXPERTS**

- Investment in **HIGH PERFORMANCE** software

- **Audit-identified savings over the last 12 months > $2.2 BILLION**

- IBM SPSS Modeler, SAS JMP – data analysis, data mining, data modeling
- R, Python – free data analytics software
- Oracle SQL
- ESRI ArcGIS – Geographical Information System
- LexisNexis Accurint, Thomson Reuters CLEAR – find people, businesses, assets, affiliations
CONTINUOUS Risk Assessment
(Weekly/Supplemental Claim Reviews)
ALL Levels

• Daily risk assessment
• New to seasoned employees
• Periodic brainstorming sessions
The usual suspects...

- highest paid claims; payment amounts outside the normal reimbursement amount
- duplicate payments (among different billers, beneficiary has multiple id numbers, payments that cover over a span of time)
- services billed in excess of allowed limits
- payments that don’t have discounts applied

Ongoing (Supplemental) Claim Review

Medicaid - more specialized reviews for the types of payments/system you’re auditing...

- claims pay FFS, yet services covered by managed care
- premiums – person not qualified to be in managed care plan
- while beneficiary is inpatient, others billing unlikely services
- newborn inpatient claims – birthweight issues
- long inpatient stays billed at acute care, with little/no ALC
- payments to certain entities are all-inclusive rates; other providers rendering care should bill entity, not Medicaid
- out-of-state claims pay differently

Changes in the program, policies, procedures; activities that are new to the agency (NYS Medicaid updates)

- PARIS
- Data Matches to 3rd Party Sources...

- incarcerated individuals
- payments to entities who should not be receiving gov’t payments/lack credentials – Do Not Pay Lists
- deceased payees, beneficiaries – VERIS & DMF
- improper coordination of payments with other payers (Medicare...)-Medicaid is last payer

Obtain notifications when system payment controls are:

- added or modified (review claims to see if program logic built correctly – often errors)
- turned off (interesting claims to review!)
OSC Edits

Eliminate improper payments before they occur:

- Improper coordination of benefits
- Payment amounts greater than certain amounts
- ...and others
High-Risk Indicators / Billing Statistics

~ Fraud ~

• Team brainstorming to create “High-Risk Indicators” (summary billing statistics by provider that capture billing behavior, represent potential billing risks)
• Over 50 Variables to be used for peer analysis
  • Average amount paid per day
  • Maximum amount paid per day
  • Average amount paid per patient visit
  • Maximum amount paid per patient visit
  • Average number of procedures performed per patient visit
  • Maximum number of procedures performed per patient visit
  • Average number of patients seen per day
  • Maximum number of patients seen per day
  • Total number of distinct (unique) patients treated
  • Total denied claims
  • .....
## High-Risk Indicators

<table>
<thead>
<tr>
<th>Eye Care Providers</th>
<th>Avg amount paid/day</th>
<th>Max amount paid/day</th>
<th>Avg amount paid/patient visit</th>
<th>Max amount paid/patient visit</th>
<th>Avg # of procedures performed / patient visit</th>
<th>Max # of procedures performed / patient visit</th>
<th>Avg # of patients seen/day</th>
<th>Max # of patients seen per day</th>
<th>(40+ other Variables)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider A</td>
<td>$417</td>
<td>$650</td>
<td>$20</td>
<td>$60</td>
<td>2</td>
<td>3</td>
<td>20</td>
<td>26</td>
<td>...</td>
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<tr>
<td>Provider B</td>
<td>$550</td>
<td>$601</td>
<td>$35</td>
<td>$120</td>
<td>3</td>
<td>5</td>
<td>21</td>
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<tr>
<td>Provider C</td>
<td>$500</td>
<td>$543</td>
<td>$25</td>
<td>$100</td>
<td>2</td>
<td>4</td>
<td>20</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Provider D</td>
<td>$1,650</td>
<td>$1,900</td>
<td>$44</td>
<td>$190</td>
<td>5</td>
<td>6</td>
<td>40</td>
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<td></td>
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<tr>
<td>...Provider 1,001</td>
<td>...</td>
<td></td>
<td></td>
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</tbody>
</table>
Uncover Patterns in the Data

• The High-Risk Indicators are run through models
• Providers in each group are similar to one another
• **Look further into groups and remove “noise.” Refine the analysis by removing certain providers. Re-run it!**
• Interested in outliers
Questions?

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Medicaid Audits:
http://www.osc.state.ny.us/audits/auditAgencyList.htm#tocLinkH
Improving Efforts to Detect and Prevent Medicaid Improper Payments

Kip Memmott, Director
Kathy Davis, Staff Auditor
Eli Ritchie, Staff Auditor
MISSION

Protect the public interest while helping improve Oregon government.

We conduct Financial, Municipal, Performance and Information Technology audits.

We are a staff of 62 auditors.
Medicaid Audit & Auditor Alert

NSAA 2018
AWARD FOR EXCELLENCE
Special Project Award

Oregon Spends One-third of the State Budget on Medicaid
Payment Methods

Fee for Service (FFS)

Managed Care (Capitation)
New Systems, New Challenges

Cover Oregon: $248 million state exchange to be jettisoned in favor of federal system

At least the $9.9 million ad campaign was catchy ;)}
Audit Objective

• Determine if the Oregon Health Authority could improve processes to prevent, detect, and recover improper Medicaid payments
• Follow-up on Auditor Alert
Inspired by Massachusetts

- Dedicated team of analytics super users to analyze Medicaid claims
- Found hundreds of millions in question costs
What we did
Big Money Big Data

One billion dollars in $100 bills

200,000 Sheets of paper
Auditor Alert

Secretary of State: Oregon could be wasting millions by keeping ineligible people on Medicaid

Updated on May 17, 2017 at 6:09 PM Posted on May 17, 2017 at 7:48 AM

Oregon removes nearly 55,000 people from Medicaid after they failed eligibility checks

Updated Sep 1, 2017; Posted Aug 31, 2017
Key Findings

• Questionable payments FFS/CCO
• Gaps in controls to prevent improper payments
• No proactive detection of improper payments in managed care

<table>
<thead>
<tr>
<th>Improper Payments Detected in 2016, self-reported by CCOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; $100</td>
</tr>
<tr>
<td>7</td>
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</tbody>
</table>

Number of CCOs
Takeaways

• Scope
• Understanding the data and Medicaid
• Data matching
• Auditor Alert
Questions and Answers

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