OVERSIGHT OF SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (SURS) – MEDICAID PROGRAM INTEGRITY ACTIVITIES

LOUISIANA DEPARTMENT OF HEALTH

PERFORMANCE AUDIT SERVICES
ISSUED DECEMBER 5, 2018

LOUISIANA LEGISLATIVE AUDITOR
1600 NORTH THIRD STREET
POST OFFICE BOX 94397
BATON ROUGE, LOUISIANA 70804-9397

LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

ASSISTANT LEGISLATIVE AUDITOR
FOR STATE AUDIT SERVICES
NICOLE B. EDMONSON, CIA, CGAP, MPA

DIRECTOR OF PERFORMANCE AUDIT SERVICES
KAREN LEBLANC, CIA, CGAP, MSW

FOR QUESTIONS RELATED TO THIS PERFORMANCE AUDIT, CONTACT CHRIS MAGEE, PERFORMANCE AUDIT MANAGER, AT 225-339-3800.

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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

December 5, 2018

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Taylor F. Barras,
Speaker of the House of Representatives

Dear Senator Alario and Representative Barras:

This report provides the results of our performance audit on the Louisiana Department of Health's (LDH) oversight of the Surveillance and Utilization Review Subsystem's (SURS) program integrity activities.

The report contains our findings, conclusions, and recommendations. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of the Program Integrity Section for their assistance during this audit.

Respectfully submitted,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/aa

MEDICAID PROGRAM INTEGRITY

1600 NORTH THIRD STREET • POST OFFICE BOX 94397 • BATON ROUGE, LOUISIANA 70804-9397
WWW.LLA.LA.GOV • PHONE: 225-339-3800 • FAX: 225-339-3870

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Oversight of Surveillance and Utilization Review Subsystem (SURS) – Medicaid Program Integrity Activities
Louisiana Department of Health

December 2018

Audit Control # 40170020

Introduction

We evaluated the Louisiana Department of Health's (LDH) oversight over the Surveillance and Utilization Review Subsystem's (SURS) program integrity activities. As a result of Act 420 of the 2017 Regular Session that established the Task Force on Medicaid Fraud Detection, we conducted this audit to develop recommendations related to Medicaid program integrity functions within LDH and for optimization of data mining for Medicaid fraud detection and prevention.

> SURS program integrity activities include preventing, detecting, and addressing improper payments that result from:
>
> *Fraud,* which is intentional deception or misrepresentation intended to result in unauthorized benefit to oneself or another person.
>
> *Waste,* which is the overutilization, underutilization, or misuse of resources. Waste is not typically an intentional act.
>
> *Abuse,* which includes provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary cost to the Medicaid program or reimbursement for services that are not medically necessary.

Federal regulations[1] require that all states have a surveillance and utilization review subsystem to identify suspicious provider billing patterns. States have the flexibility to design a system that meets the needs of the state. In some states the state Medicaid agency implements SURS while other states outsource the function. In Louisiana, LDH has a contract with Molina Medicaid Solutions[2] (Molina) for the SURS function, which is organizationally within LDH's Program Integrity Section. The Program Integrity Section is also responsible for various other program integrity activities, including provider enrollment, oversight over MCOs, and external audits.[3] However, we focused this audit primarily[4] on LDH's oversight of SURS because this section is responsible for identifying and addressing improper payments that occur due to fraud, waste and abuse. SURS also has the following responsibilities:

- Maintains a database to track cases it opens against Medicaid providers, such as dates the case was opened and closed and the amounts of improper payments identified and recouped.

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[1] 42 CFR Part 456
[2] DXC Technology completed a purchase of Molina in the third quarter of 2018. We refer to the contractor as Molina throughout the report due to this being its name during the scope of our audit.
[3] We did not include these functions in our review because the provider enrollment function is currently being outsourced, external audits are primarily directed by CMS, and managed care oversight was recently reviewed by CMS. See the CMS report and its recommendations here: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/LAfy17.pdf
[4] In some cases, we reviewed LDH functions such as settling cases with providers.

- Analyzes Medicaid claims and encounters[5] to monitor service utilization and to identify improper payments that occur when providers do not meet Medicaid provider requirements or providers have billing errors such as billing for unnecessary or uncovered services.

- Provides case data to LDH to assist in making enforcement decisions and recoup improper payments.

- Refers cases to the Medicaid Fraud Control Unit (MFCU) that may indicate fraud.

The proper oversight of the SURS function is critical because LDH outsources this function and is the primary entity responsible for identifying improper payments. The objective of this audit was:

To evaluate LDH's oversight of SURS' program integrity activities.

Our results are discussed in detail throughout the remainder of the report. Appendix A contains LDH's response to the report and Appendix B details our scope and methodology.

[5] An encounter is a distinct set of healthcare services provided to a Medicaid recipient enrolled with an MCO on the date the services were delivered. It is a claim paid for by the MCO but submitted to LDH.

Objective: To evaluate LDH's oversight of SURS' program integrity activities.

We found that LDH needs to strengthen its oversight of SURS program integrity activities. Specifically, we found that:

- **The system SURS uses to track improper payments does not contain accurate or complete information on cases. The database does not include the actual amount of the improper payment identified, and it does not always provide a description of the violation.** The improper payment amount is not accurate because it actually represents the settled amount for those cases involving a settlement and it includes the penalty amount for those cases with fines. In addition, the database is incomplete because 4,472 (68.4%) of 6,540 cases between fiscal years 2012 through 2018 did not have a description of the violation.

- **Since managed care began on February 1, 2012, SURS has focused primarily on improper payments in fee for service claims even though 85.0% of Medicaid recipients and 71.0% of expenditures were for managed care in fiscal year 2017. SURS could strengthen its identification of improper payments in managed care by analyzing data across all MCOs, such as identifying providers who bill for more than 15 hours a day.** Using Medicaid encounter data, we identified 116 providers that billed more than 15 hours of service on at least one day across two or more MCOs, for a total of $2,608,946 in Medicaid payments, which may indicate providers are billing for services not actually provided.

- **The amount of improper payments identified by SURS has decreased in part due to revisions to the Molina contract that reduced the number of cases SURS is required to close each year, and the loss of the Recovery Audit Contractor.** These changes resulted in a decrease in the amount of improper payments identified, from $5.9 million in fiscal year 2015 to $4.2 million in fiscal year 2017.

- **LDH settled with providers in 11 (36.7%) of 30 improper payment cases[6] we reviewed[7] from fiscal year 2012 through 2017 for $321,729 less than the original identified improper payment amounts without documentation justifying the reductions. Of the 11 settled cases, two (18.2%) were settled for less than the Federal Financial Participation (FFP, or federal share), resulting in LDH having to use state funds to pay back the federal government.** While state law allows LDH to settle cases, the law also requires that the settlement amount cover the estimated loss to Medicaid.

[6] Because fiscal year 2018 was not complete at the time of our review, we focused this review on cases from 2012 through 2017. During this time period, there were 5,901 cases opened.
[7] We had to review physical files because the SURS database does not track which cases involve settlements.

Our findings are discussed in more detail in the remainder of the report.

The system SURS uses to track improper payments does not contain accurate or complete information on cases. The database does not include the actual amount of the improper payment identified and does not always provide a description of the violation.

The amount of improper payments in the SURS database is not accurate, because it actually represents the settled amount if cases are settled and includes the penalty amount if cases involve fines. SURS tracks its cases using a database that includes specific information on cases, including case number, case open and close dates, provider name, and location. This database also includes a column for the improper payment "identified" and a column for amount of payment "recouped." According to this database, from fiscal years 2012 through 2018, SURS investigated 6,540 cases with the "identified amount" of improper payments totaling $35,938,930 and recoupments totaling $29,005,617 (80.7%). However, the "identified amount" column in this database is not accurate because it actually represents the settled amount for cases that were settled. Furthermore, LDH does not identify which cases were settled in the database, so it is impossible to know how many cases this issue applies to.

Because settlement amounts are lower than the actual identified improper payment amounts, reports or legislative testimony based on these numbers may be incorrect as it may appear that LDH is recouping a higher percentage of improper payments than it actually recouped. In addition, because the SURS data does not have a separate field for staff to enter settlement amounts, LDH is not able to identify whether a case was settled without pulling actual case files. As a result, LDH cannot accurately report on the actual amount of improper payments it identifies.

In addition to the "identified amount" column being the settled amount, this column also includes penalties if they are assessed to providers. Including penalty amounts in the identified amount makes the identified amount appear higher than what was actually identified by SURS activities. While SURS did recently create a new field to identify the penalty amount for cases beginning in fiscal year 2017, it continues to also include this amount in the "identified amount" column. In addition, SURS did not add this field to cases prior to fiscal year 2017. As a result, LDH cannot accurately report on the true identified improper payment amount for all of its cases or compare across years.

Although the SURS database contains a field to document a description of the violation, this field did not contain a specific description for 4,472 (68.4%) of 6,540 cases opened between fiscal years 2012 through 2018. The SURS database contains a field called "Case Issue" which includes information regarding the reason why the case was opened, such as "Billing Duplicate Services" or "Billing Established Patients as New Patients". However, we found that this field was not populated in 2,790 cases (42.7%), and in another 1,682 (25.7%) cases, the case issue was listed as "All Other Issues." As a result, LDH cannot identify the most

prevalent violations. Knowing what violations are the most common and result in the largest improper payment is an important tool in knowing which cases have the highest return on investment, knowing where to target program integrity efforts, and for identifying where providers may need additional training. Exhibit 1 shows the top five identified case issues as noted in the SURS data.

Exhibit 1
Top 5 Identified Violations
SURS Data 2012 through 2017

Case Issue*	Number	Percent of Cases
Blank	2,790	42.7%
All Other Issues	1,682	25.7%
Billing Inpatient and Outpatient Services/Billing Ambulatory Surgical Care and Outpatient Services (Hospital)	174	2.7%
Billing for Services after Recipient's Date of Death (Physician)	156	2.4%
Billing for Duplicate Services (Physician)	101	1.5%

*Categories of services associated with each issue are noted in parentheses.
Source: Prepared by legislative auditor's staff based on information provided by SURS.

Recommendation 1: LDH should require that Molina/SURS develop a separate field to track settlement amounts and ensure that the SURS case tracking system includes the actual identified amount.

Summary of Management's Response: LDH agreed with this recommendation and stated that it has worked with DXC, formerly Molina, to add a field for the settlement amount so that it can be tracked separately from the overall identified amount.

Recommendation 2: LDH should establish more specific categories for "Case Issues" and ensure that Molina/SURS populate the "Case Issue" field, which would provide information that could be used in planning future program integrity activities.

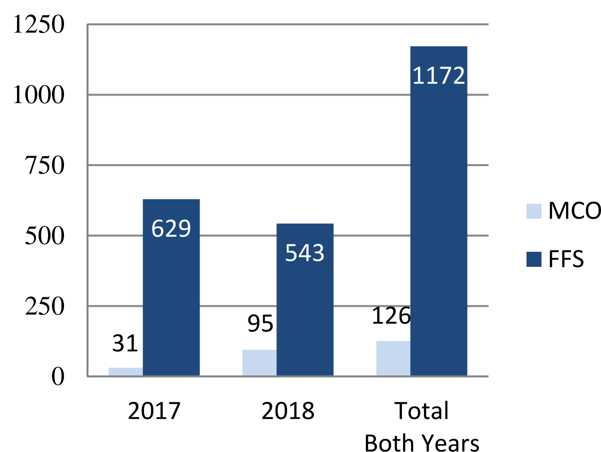
Summary of Management's Response: LDH agreed with this recommendation and stated that while the current database was not designed for planning future program integrity activities, it will update the current list of categories, as appropriate, within the limits of its current system and require that a category for "Case Issues" be selected for every database entry.

Since managed care began on February 1, 2012, SURS cases have focused primarily on improper payments in fee for service claims, even though 85.0% of Medicaid recipients and 71.0% of expenditures were for managed care in fiscal year 2017. SURS could strengthen its identification of improper payments in managed care by analyzing data across all MCOs, such as identifying providers who bill for more than 15 hours a day, which may indicate providers are billing for services not actually provided.

SURS closed only 31 (4.7%) of 660 cases in fiscal year 2017 and 95 (14.9%) of 638 cases in fiscal year 2018 on managed care providers. Although 85.0% of Medicaid recipients and 71.0% of Medicaid expenditures[8] were for managed care in fiscal year 2017,[9] SURS primarily focused its efforts on fee-for-service (FFS) providers. According to LDH staff, SURS will always need to spend a portion of its time analyzing FFS providers since it is the only entity that does so. Exhibit 2 shows the number of MCO cases in comparison to FFS cases opened during fiscal years 2017 and 2018.

According to LDH, certain requirements in the original managed care contracts limited its ability to analyze managed care cases. Specifically, managed care contract requirements from February 1, 2012, through January 31, 2018, restricted SURS' ability to open cases that involved a review of medical records and instead gave the MCOs exclusive rights to review and recover for 365 days. However, these restrictions did not prohibit SURS from opening cases generated from data analysis, such as review of National Correct Coding Initiative (NCCI) edits.[10] Effective January 31, 2018, LDH amended the managed care contracts and removed this restriction, which means LDH is now allowed to audit and investigate providers within the MCO's network for a five-year period from the date of service of a claim. In addition, LDH may recover from the provider any improper payments identified by LDH or SURS and retain them.

Exhibit 2
Managed Care vs. FFS Cases
Fiscal Years 2017 and 2018



Source: Prepared by legislative auditor's staff using information from Medicaid data.

[8] This represents private provider program expenditures only and excludes public, uncompensated care costs, and buy-in programs.
[9] This information was presented by LDH to the Joint Legislative Commission on Budget in October 2017. The current Medicaid annual report was not yet available at the time of this report for us to present updated figures.
[10] The purpose of NCCI edits is to prevent improper payment when incorrect code combinations are reported.

Although MCOs are responsible for identifying fraud, waste, and abuse within their own network of providers, it is important for SURS to also review managed care encounter data since it has access to encounter data from all five MCOs. SURS maintains a database of three years of FFS claims and MCO encounters, which allows it to review aberrant billing patterns or trends across MCOs that could suggest potential improper payments. SURS uses the JSURS system to conduct data analytics, which includes identifying patterns of potential overbilling, identifying deceased Medicaid recipients, and identifying overlapping services. Because SURS is responsible for safeguarding against unnecessary or inappropriate use of Medicaid services, it is essential that SURS review data from both FFS claims and MCO encounters.

LDH could strengthen its analyses of managed care providers by requiring that SURS look at the potential for high-risk billing patterns across the MCOs, such as individual providers who bill across multiple MCOs for more than 15 hours a day. The Attorney General's office and MCOs' Special Investigation Units[11] have identified behavioral health providers as a high-risk provider group. Because MCOs do not have access to the encounter data of other MCOs, they are unable to look for patterns such as providers who bill for potentially unreasonable amounts of time across MCOs. SURS has access to all Medicaid claim and encounter data and therefore is able to perform data analyses that could identify potential improper payments across MCOs. Using Medicaid encounter data, we identified 110 individual behavioral health providers[12] that billed more than 15 hours of service on at least one day across two or more MCOs, which accounted for $2,608,946 in Medicaid payments. Of these 110 individual behavioral health providers, 34 (30.9%) billed for more than 24 hours in one day, which accounted for $1,638,914 in Medicaid payments. Exhibit 3 illustrates three examples of how providers may have billed for more time than may be reasonable in a 24-hour period, across MCOs.

Exhibit 3
Providers Billing Over 15 Hours
Fiscal Years 2012 through 2017

Provider	Day	Hours Billed to MCO 1	Hours Billed to MCO 2	Hours Billed to MCO 3	Total Hours Per Day
1	1	5.50	8.00	7.00	**20.50**
	2	7.00	6.75	8.50	**22.25**
	3	2.75	10.25	5.25	**18.25**
2	1	1.00	12.50	6.00	**19.50**
	2	0.50	15.25	5.50	**21.25**
	3	1.00	12.00	8.75	**21.75**
3	1	15.25	4.00	2.75	**22.00**
	2	8.75	14.00	4.75	**27.50**
	3	9.00	4.50	3.00	**16.50**

Source: Prepared by legislative auditor's staff using information from Medicaid data.

[11] These are the units in each MCO that identify and investigate improper payments.
[12] Our analysis focused on behavioral health providers that were performing services under an individual National Provider Identifier (NPI) number. This analysis excludes health care organizations, which may be comprised of independent providers under a parent NPI, and thus bills services provided under the group NPI.

According to LDH, it joined the Healthcare Fraud Prevention Partnership (HFPP) – a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations[13] – in April 2017. The HFPP fosters a proactive approach to combat healthcare fraud through data and information sharing and sent LDH its first results in August 2018, which included an analysis of providers billing unreasonable hours.

Recommendation 3: LDH should require that SURS increase its analysis of managed care encounter data.

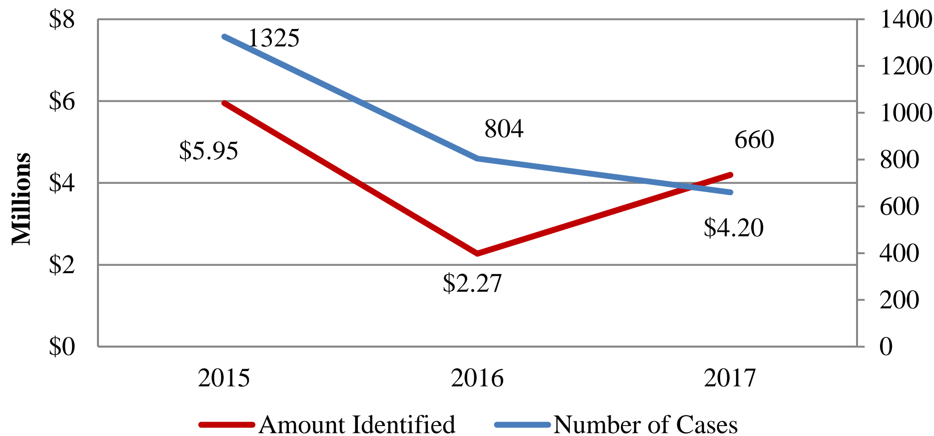
Summary of Management's Response: LDH agreed with this recommendation and stated that SURS had a greater than 200% increase in closed managed care provider cases from fiscal year 2017 to fiscal year 2018 due to increased analysis of managed care encounter data.

The amount of improper payments identified by SURS has decreased in part due to revisions to the Molina contract that reduced the number of cases SURS is required to close each year, and the loss of the Recovery Audit Contractor.

LDH revised its contract with SURS to decrease the number of cases it was required to close. As a result, the number of cases and the amount of improper payments LDH identified has decreased. From fiscal year 2012 through 2015, LDH required that SURS close a minimum of 900 cases to review for improper payments per year. Because of budget constraints, LDH revised the contract effective for fiscal year 2016, and now SURS is contractually required to close a minimum of 600 cases per year. SURS opens cases from a variety of sources, including complaints, outside referrals, external audits, requests for explanation of medical benefits (REOMB), and data mining. However, contract reductions, staff remaining constant, and elimination of the Recovery Audit Contractor (RAC) have all contributed to the decrease in identified improper payments from $5.9 million in fiscal year 2015 to $4.2 million in fiscal year 2017, as shown in Exhibit 4.

[13] As of October 26, 2018, there were 113 partners in the HFPP, including 31 state and local partners, 61 private payers, 9 Federal agencies, and 12 associations.

Exhibit 4: SURS Identified Amounts
Fiscal Years 2015 through 2017



LDH also no longer contracts with a RAC, which has contributed to a decrease in the amount of improper payments identified. RACs are required by CMS and used by other states to identify and correct improper Medicaid payments through the collection of overpayments and reimbursement of underpayments made on Medicaid claims. Each state is able to design and operate its Medicaid RAC, including the types of audits conducted. RACs are paid on a contingency basis, meaning they only collect fees on overpayments that are recovered and underpayments that are corrected. While the RAC identified and recovered $415,108 from 102 cases in fiscal year 2014 and $1,236,576 from 160 cases in fiscal year 2015, Act 568 of the 2014 legislative session prevented RACs in Louisiana from auditing MCOs.[14] Due to this prohibition, LDH received a waiver from CMS to not have a RAC due the majority of the Medicaid program being managed care.

In addition, the number of SURS cases opened based on results from its data analytics activities decreased from 503 (50.2%) of 1,004 cases in fiscal year 2012 to 237 (37.1%) of 638 cases in fiscal year 2018. According to CMS, data analytics offers several advantages, including a positive return on investment that can exceed traditional methods and strengthened program integrity safeguards throughout the Medicaid agency. While SURS has developed 51 data analyses to detect fraud, waste, and abuse in the Medicaid program, there is no risk-based schedule that outlines when these different analyses should be conducted. However, LDH has recently entered into a contract with Alivia Technologies to provide a return-on-investment assessment to inform LDH on the types of analytics and cases that should be pursued. This analysis will incorporate information from the SURS database, as well as outcomes from investigations performed by the Attorney General's office. As noted earlier, data in the SURS database on cases and the amount of improper payments is not always complete and reliable, so the contractor who is assessing return on investment should account for that in its analysis.

LDH's Business Analytics section also performs data analyses similar to what SURS has conducted in the past. For example, this section analyzed behavioral health providers with suspicious billing patterns and transportation providers providing rides for medical services

[14] The RAC recovered $17,150 in fiscal year 2016 as it was phased out.

without a medical claim. Even though the purpose of these analyses was to identify potential improper payments, neither of these analyses were shared with SURS. Because LDH has limited resources, it should ensure that all sections within LDH coordinate data analytics activities. According to LDH, in October 2017 it established a data steering committee consisting of the different sections involved in program integrity activities. This group meets on a monthly basis to discuss what data work should be conducted.

Recommendation 4: LDH should prioritize its data analytics activities based on risk and the results of its return on investment analysis. Developing these priorities into a formal plan that outlines who is responsible for what types of analysis may help improve coordination.

Summary of Management's Response: LDH agreed with this recommendation and stated that it has contracted with a vendor to develop a tool to assist the data mining steering committee with setting priorities and coordinating analytic activities.

LDH settled with providers in 11 (36.7%) of 30 improper payment cases we reviewed from fiscal year 2012 through 2017 for $321,729 less than the original identified improper payment amounts without documentation justifying the reduction. Of the 11 settled cases, two (18.2%) were settled for less than the Federal Financial Participation (FFP, or federal share), resulting in LDH having to use state funds to pay back the federal government.

When SURS identifies improper payments, LDH can issue various enforcement actions, such as recoupments and penalties, as well as giving providers the opportunity for an informal hearing and/or appeal.[15] Although Louisiana R.S. 46:437.5 allows for the settlement of cases, the law requires that the "settlement shall ensure that the recovery agreed to by both parties covers the estimated loss sustained by the medical assistance program."

LDH settled with providers in 11 (36.7%) of 30 improper payment cases we reviewed from fiscal year 2012 through 2017 for $321,729 less than the original identified improper payment amount without written justification of why that amount was reduced. Because SURS' database does not have a field that indicates if cases were settled, we reviewed a targeted selection[16] of 30 case files and found that 11 (36.7%) of them resulted in a reduced

[15] 50 LA ADC Pt. 1, § 4203 grants providers that have received a notice of sanction or notice of withholding of payment the opportunity for an informal hearing, while the right for an administrative appeal is outlined in 50 LA ADC Pt. 1, § 4211.

[16] From fiscal years 2012 through 2017, there were a total of 5,902 cases in the SURS database. However, as noted in the first finding, this database does not identify cases that were settled so we had to review a targeted selection of physical case files. We selected a variety of cases for our review, such as those who were assessed penalties, those that were not, those where the identified and recouped amounts were the same, and those where there was no recoupment.

improper payment amount without written justification to support how the reduction covered the estimated loss to the Medicaid program. Of the 11, 4 (36.4%) were reduced internally by SURS through informal hearings, and 7 (63.6%) were settled formally with written agreements by LDH's legal staff. Exhibit 5 summarizes each of these 11 cases, including the original identified improper payment amount and the settlement amount.

Exhibit 5
Results from Targeted Selection Review of Settlements
Fiscal Years 2012 through 2017

Provider Type	Original Identified Amount	Settled Improper Payment Amount	Difference	Settled By
Dental	$43,962	$35,170	$8,793	Legal
Hospice	$90,068	$63,048	$27,020	Legal
Personal Care Services	$29,015	$19,150	$9,865	Program Integrity
Personal Care Services	$1,596	$1,117	$479	Program Integrity
Personal Care Services	$69,109	$55,288	$13,821	Legal
FQHC	$368,286	$290,000	$78,286	Legal
Dental	$358,201	$214,921	$143,281	Legal
Personal Care Services	$17,831	$10,000	$7,831	Program Integrity
Hospice	$74,858	$44,915	$29,943	Legal
Dental	$8,847	$6,636	$2,212	Legal
Dental	$794	$596	$199	Program Integrity
Total	**$1,139,650**	**$817,921**	**$321,729**	

Note: The totals may not equal the sum of the cases due to rounding.
Source: Prepared by legislative auditor's office from information from our file review of cases.

As the exhibit shows, these cases were settled for $321,729 less than the original identified improper payment amount. However, none of these cases included documentation of how LDH concluded that reducing the improper payment amount still covered the estimated loss, as required by law. In some of the cases settled by staff in the Program Integrity Section, the reduced improper payment amount was negotiated with the provider. In the cases settled formally with LDH legal staff, the agreement noted that the case was settled "in recognition of the time, energy, and resources necessary" to resolve the dispute. While settling these cases in lieu of going to court may be cost-effective, LDH needs to document its justification for the reduction, including how the reduced amount covers the losses to the Medicaid program.

Of the 11 improper payment cases we reviewed that were settled, two (18.2%) were settled for less than the Federal Financial Participation (FFP, or federal share) that is required to be refunded to the federal government. As a result, LDH had to use state funds to pay back the federal government. The FFP is the Federal Government's share of a state's Medicaid expenditures. When improper payments are identified and recovered, the state is required to return that portion of the payment that relates to federal share regardless of whether this amount is recovered. When less money than the federal share is recovered, the state must pay the difference with state funds. LDH financial staff stated that they calculate the FFP based on the amounts listed in memos sent by the Program Integrity Section. In these two cases, the memos provided by Program Integrity reported the identified improper payment amount, as well

as the FFP portion. Exhibit 6 summarizes the financial impact to the state noted in these two cases.

Exhibit 6 Impact to State When Cases Settled Below FFP					
Provider	**Total Identified Improper Payment**	**Federal Financial Participation (FFP)**	**Settlement Amount**	**Loss to State**	
Provider A	$90,068	$67,335	$63,048	Federal Share	$4,288
				State Share	$22,733
				Total Loss	**$27,020**
Provider B	$74,858	$56,724	$44,915	Federal Share	$11,809
				State Share	$18,134
				Total Loss	**$29,943**
Totals	**$164,926**	**$124,059**	**$107,963**		**$56,964**

Note: The totals may not equal the sum of the cases due to rounding.
Source: Prepared by legislative auditor's staff using information in SURS files.

In the remaining nine cases that were settled, memos from Program Integrity only provided the settled amount instead of the actual identified improper payment. This means that LDH's calculation of FFP was based on the settled amount which potentially resulted in LDH not repaying the correct FFP amount to the federal government.[17] Because we were only able to review nine cases, it is likely that this issue is greater than what we identified. Therefore, it is critical that LDH require the use of a standard format that includes all needed information so that the FFP can be calculated correctly.

Recommendation 5: LDH should develop criteria to use when settling cases that outline how it will ensure that the settled amount covers the estimated losses to Medicaid.

Summary of Management's Response: LDH agreed with this recommendation and stated that it will develop a settlement policy that considers the estimated losses to Medicaid.

Recommendation 6: LDH should develop a standard format to ensure that memos sent to LDH financial includes the actual identified improper payment so the correct FFP can be calculated.

Summary of Management's Response: LDH agreed with this recommendation and stated that the memo format that Program Integrity submits to LDH Fiscal will be modified to include the actual identified improper payment so that the correct FFP can be calculated.

[17] Because the FFP changes depending on the time period in which services were provided and the population served, we were unable to calculate the FFP for these cases. The FFP was calculated in the case files for the other two examples.

Recommendation 7: LDH should review case files to ensure it correctly calculated the FFP on cases involving settlements.

Summary of Management's Response: LDH agreed with this recommendation and stated that it will conduct retrospective reviews of FFP calculations on cases involving settlements that resulted in less than 75% of the initial claim and as resources permit.

APPENDIX A: MANAGEMENT'S RESPONSE

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health

Office of Management and Finance

November 28, 2018

Daryl G. Purpera, CPA, CFE
Legislative Auditor
P.O. Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Surveillance and Utilization Review Subsystem's (SURS) program integrity activities

Dear Mr. Purpera:

Thank you for the opportunity to respond to the findings of your Medicaid audit on LDH's Surveillance and Utilization Review Subsystem's (SURS) program integrity activities. The Bureau of Health Services Financing (BHSF), which is responsible for administration of the Medicaid program in Louisiana, is committed to ensuring the prevention, detection and recovery of fraud, waste and abuse in the Medicaid program through program integrity activities.

We have reviewed the audit findings and provide the following response to the recommendations documented in the report.

Recommendation 1: LDH should require that Molina/SURS develop a separate field to track settlement amounts and ensure that the SURS case tracking system includes the actual identified amount.

LDH Response: LDH agrees with this recommendation. LDH has worked with DXC, formally Molina, to add a field for the settlement amount so that it can be tracked separately from the overall identified amount.

Recommendation 2: LDH should establish more specific categories for "Case Issues" and ensure that Molina/SURS populate the "Case Issue" field, which would provide information that could be used in planning future program integrity activities.

LDH Response: LDH agrees with this recommendation. The current SURS database was designed to track open and closed cases, not for planning future program integrity activities. However, within the limits of the current system, we will reevaluate the current list of categories and update as appropriate. Additionally, we will require that a category for "Case Issues" be selected for every database entry.

Recommendation 3: LDH should require that SURS increase its analysis of managed care encounter data.

LDH Response: LDH agrees with this recommendation. As indicated in the report, SURS had a greater than 200% increase in closed managed care provider cases from 31 cases closed in FY 2017 to 95 cases closed in FY 2018. This was the result of increased analysis of managed care encounter data, which LDH will continue to do to identify fraud, waste, and abuse.

Recommendation 4: LDH should prioritize its data analytics activities based on risk and the results of its return on investment analysis. Developing these priorities into a formal plan that outlines who is responsible for what types of analysis may help improve coordination.

LDH Response: LDH agrees with this recommendation. In November 2017, LDH Program Integrity began discussions with a vendor to develop a custom solution to assist with prioritizing fraud, waste and abuse case openings based on return on investment. A contract was executed in June of 2018 and the project will be completed by the end of 2018. This tool will assist the data mining steering committee with setting priorities and coordinating analytic activities.

Recommendation 5: LDH should develop criteria to use when settling cases that outline how it will ensure that the settled amount covers the estimated losses to Medicaid.

LDH Response: LDH agrees with this recommendation. LDH will develop a settlement policy that considers the estimated losses to Medicaid. It is current LDH Program Integrity protocol to only entertain a settlement when it is in the best interest of the State and Medicaid.

Recommendation 6: LDH should develop a standard format to ensure that memos sent to LDH financial include the actual identified improper payment so the correct FFP can be calculated.

LDH Response: LDH agrees with the recommendation. The memo format that Program Integrity submits to LDH Fiscal will be modified to include the actual identified improper payment so that the correct FFP can be calculated.

Recommendation 7: LDH should review case files to ensure it correctly calculated the FFP on cases involving settlements.

LDH Response: LDH agrees with the recommendation. It will conduct retrospective reviews of FFP calculations on cases involving settlements that resulted in less than 75% of the initial claim and as resources permit.

The Department would also like to highlight the substantial changes noted in your report that demonstrate Medicaid's ongoing efforts to improve our detection of fraud, waste, and abuse, including:

- Amending our MCO contracts effective January 31, 2018, to remove restrictions against opening SURS cases in managed care (p.6)
- Voluntarily joining the cross-agency Healthcare Fraud Prevention Partnership (HFPP) in April 2017 to take a proactive data sharing approach (p.7)
- Contracting with Alivia Technologies in May of 2018 to generate expert analyses of proper analytics and risk stratification policies (p.9)
- Creation of a data steering committee in October 2017 to assist with coordination of analytics across Medicaid (p.9)

You may contact Michael Boutte, Medicaid Deputy Director, at (225) 342-0327 or via e-mail at Michael.Boutte@la.gov with any questions about this matter.

Sincerely,

Cindy Rives
Undersecretary

CR/mb

APPENDIX B: SCOPE AND METHODOLOGY

This report provides the results of our performance audit of the Louisiana Department of Health's (LDH) Program Integrity section. We conducted this performance audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This audit primarily covered the time period of July 1, 2012, through June 30, 2017, although we analyzed time periods outside of that scope for certain analyses. Our audit objective was:

To evaluate the LDH's oversight of SURS program integrity activities.

We conducted this performance audit in accordance with generally-accepted *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. To answer our objectives, we reviewed internal controls relevant to the audit objectives and performed the following audit steps:

- Reviewed relevant federal and state laws, regulations, policies, and procedures
- Interviewed agency staff at LDH in each of Program Integrity's key functional divisions
- Attended quarterly meetings held with MCOs to observe LDH's communications and oversight over MCO Program Integrity activities.
- Developed and conducted a survey that was sent via email to all 50 states' Program Integrity units to gather information regarding effective practices, trends, and data mining activities and received 10 completed responses (20%) and five (10%) partial responses.
    - We received completed responses from: Arizona, Tennessee, Oklahoma, Alaska, North Dakota, South Dakota, Wisconsin, Utah, Ohio, Missouri, and California
    - We received partially completed surveys from Oregon, Maryland, Alabama, Indiana, and Maine.
- Reviewed a targeted selection of 30 SURS files at Molina to gather information regarding SURS practices. Files were chosen to include varying provider types, providers with multiple cases, and a range of identified improper payment amounts.

- Analyzed Medicaid claim and encounter data to analyze specific behavioral health services to identify high-risk providers.