An Audit of Deficit Reduction Act Section 6032 Compliance Federal Fiscal Year 2022

Report Number A2023-02

June 7, 2023

Utah Office of
Inspector General

Gene Cottrell
Inspector General

June 7, 2023

To: Utah Department of Health

Please see the attached report, An Audit of Deficit Reduction Act Section 6032 Compliance for Federal Fiscal Year 2022**,** Report 202023-02. An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 4 of this report.

Sincerely,

Gene D. Cottrell
Gene Cottrell
Inspector General
Utah Office of Inspector General

cc: Sen. Jacob Anderegg, Social Services Appropriations Subcommittee, Senate Chair
Rep. Raymond Ward, Social Services Appropriations Subcommittee, House Chair
Jon Pierpont, Chief of Staff, Office of Governor Spencer Cox
J. Stuart Adams, President of the Utah Senate
Brad Wilson, Speaker of the Utah House of Representatives
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EXECUTIVE SUMMARY

Medicaid is a joint state and federal government health insurance program established by Title XIX of the 1965 Social Security Act. State Law designates the Utah Department of Health and Human services (DHHS) as the single state agency responsible for administration of the Utah Medicaid program (Utah Medicaid). At the federal level, the Centers for Medicaid and Medicare Services (CMS) is responsible for regulation and oversight of Medicaid. Together, Utah and the federal government jointly fund Utah Medicaid at percentage rates determined by the federal medical assistance percentage (FMAP). Throughout this report, "Medicaid funds" refers to the federal and state taxpayer dollars used to fund Utah Medicaid.

On February 8, 2006, President George W. Bush signed the Deficit Reduction Act of 2005 (DRA) into law. Several provisions in the DRA changed the Medicaid program. One of those changes requires any entity that received payments of at least $5,000,000 annually of Medicaid funds to have written policies and procedures in place. Specifically, Under DRA Section 6032, these entities must establish written policies to provide employees, managers, and contractors with detailed information about the following:

1. False Claims Act;
2. Administrative remedies for false claims and statements;
3. State laws pertaining to civil or criminal penalties for false claims and statements;
4. Whistleblower protections available under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.
5. Policies and procedures for detecting and preventing fraud, waste, and abuse.

State Medicaid programs were required to impose requirement of DRA Section 6032 by January 1, 2007, and amend their State Plan no later than March 31, 2007. The amendments to Utah's Medicaid State Plan (State Plan) are located in Section 4.42 and Attachment 4.42-A. The State Plan requires all entities subject to DRA Section 6032 requirement to verify compliance by attestation and/or annual audit. The Utah Office of Inspector General (UOIG) performs ongoing compliance verification pursuant to the Memorandum of Understanding (MOU) between DHHS and UOIG.

Audit Objectives:

1. Determine if entities that received or paid at least $5,000,000 of Medicaid funds, during federal fiscal year (FFY) 2022 complied with DRA Section 6032.
2. Determine if Utah Medicaid implemented the prior recommendations.

Audit Findings:

No non-compliant issues were discovered. No findings are reported for second year of the three year audit cycle.

INTRODUCTION

BACKGROUND

Since January 1, 2007, entities that receive or pay at least $5,000,000 of Medicaid funds annually under the State Plan, or any waiver of the State Plan, are required to comply with the DRA, Section 6032. Entities that meet the $5,000,000 threshold are required to establish written policies for all employees, managers, and contractors that provide detailed information about:

- False Claims Act
- Administrative remedies for false claims and statements[1]
- State laws that provide civil or criminal penalties for making false claims and statements
- Whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs
- Policies and procedures for detecting, and preventing fraud, waste, and abuse.

Additionally, employee handbooks must include a special discussion of the items listed above.

Compliance Oversight: 3 Year Cycle

As part of the implementation process, CMS required each state with a Medicaid program to amend their State Plan to define the manner and methodology of DRA Section 6032 Compliance oversight. Attachment 4.42-A of the Utah State Plan defines a 3-year cycle for DRA Section 6032 compliance. During the first year of the compliance cycle, all entities that meet the $5,000,000 threshold are required to complete compliance attestation. In the subsequent two years, new entities paying or receiving at least $5,000,000 of Medicaid funds annually are required to complete compliance attestation. Attachment 4.42-A also defines an annual audit of all entities that meet the $5,000,000 threshold. Entities selected for review are required to produce copies of written policies and procedures and handbooks for compliance review.

Roles and Responsibilities

DHHS delegates responsibility for "performing compliance review and conducting audits to ensure entities comply with the requirements of Section 6032 of the Deficit Reduction Act of 2005 as described in the Utah Medicaid State Plan Section 4.42 and Attachment 4.42-A" to UOIG through a Memorandum of Understanding (MOU)"[2]

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[1] In 1986, Congress enacted the Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812.The PFCRA provides administrative remedies for false claims and statements when the liability is $150,000 or less and the Department of Justice declines to pursue FCA remedies. Importantly, while PFCRA and FCA are complementary laws and similar in many respects, they are two different federal laws.

[2] "Utah Department of Health and Human Services Memorandum of Agreement." August 2017.

FUNDING SOURCE

Utah receives matching payments from the federal government to pay for health care coverage and long term services for Utah Medicaid recipients. The matching payment rates, the federal medical assistance percentage (FMAP), are set every fiscal year. Federal matching payments range from 50-100%.

OBJECTIVES AND SCOPE

Audit Objectives:

1. Determine if entities that received or paid at least $5,000,000 of Medicaid funds, during federal fiscal year (FFY) 2022 complied with DRA Section 6032.
2. Determine if Utah Medicaid implemented the prior recommendations.

Audit Scope:

The scope of the audit covered FFY 2022 for entities that received or paid at least $5,000,000 of Medicaid funds under the State Plan, or any wavier of the State Plan. FFY 2022 is year two of the three year cycle described in Attachment 4.42-A of the Utah State Plan for DRA Section 6032 compliance. See Appendix B.

METHODOLOGY

UOIG performed two methods of compliance verification defined in Attachment 4.42-A of the State Plan: compliance attestation and audit.

The UOIG conducted fieldwork between January and May of 2023. Initial fieldwork included review of federal and state laws; Section 4.42 and Attachment 4.42-A of the State Plan; federal policy guidance; Section 5.2 of the Memorandum of Understanding between the DHHS and the UOIG.

Using the Medicaid Data Warehouse, UOIG obtained a list of entities that received at least $5,000,000 of Medicaid funds during the audit scope period. The UOIG reviewed all of the entities by tax identification number that received at least $5,000,000. For the annual compliance audit, the UOIG reviewed a 10% sample from the entities that matched the $5,000,000 threshold. Every entity that reached the $5,000,000 threshold in the second year of the three year audit cycle, but was not part of the 10% audit sample, participated in the required compliance attestation for the second year of the current 3-year compliance cycle.

The UOIG mailed notice letters to the entities selected for the compliance audit and required the entities to complete a compliance attestation within the 45 days required by the state plan. Any entity that did not respond within 30 days would have received a courtesy follow-up phone call or email. The UOIG reviewed the attestations of compliance to verify that the document included a signature. Finally, the UOIG would have reviewed the documents provided by entities in response to the compliance audit. For this audit cycle only one entity was selected for audit. That entity, UOIG later learned had discontinued operations. The

entity was also placed on the do not contact list because it was under investigation by the Medicaid Fraud Control Unit.

Prior Audit Findings and Recommendations:

1. Medicaid's revision to R414-1-31 lacks Section 6032 measures for entities audited and found noncompliant. Finding from Audit A2022-02 dated June 15, 2022. Medicaid agreed with all recommendations in the finding. Utah Medicaid indicates it was submitted for Public comment in February 2023. Updated Public comment period changed to June 2023, Planned MIB in July 2023. No implementation date is noted.
2. Medicaid does not have an SOP for taking corrective action for DRA noncompliance or partial compliance. Finding from Audit A2022-02 dated June 15, 2022. Medicaid agreed with all recommendation in the finding. Utah Medicaid indicates it would be submitting for Public comment in February 2023. Updated Public comment period changed to June 2023, Planned MIB in July 2023. No implementation date is noted.
3. The Medicaid website and provider manuals do not include DRA Section 6032 requirements, guidance or tools to assist implementation by providers. Finding from Audit A2022-02 dated June 15, 2022. Medicaid agreed with all recommendations in the finding. Utah Medicaid indicates a Medicaid Information Bulletin (MIB) article will be issued in July 2023. Updated Public comment period changed to June 2023, Planned MIB in July 2023. No implementation date is noted.
4. Utah Medicaid's directions and Guidelines for DRA Compliance are incomplete. Audit A2021-01 dated June 10, 2021. Utah Medicaid indicates it was submitted for Public comment in February 2023. Updated Public comment period changed to June 2023, Planned MIB in July 2023. No implementation date is noted.

CONCLUSION

The UOIG determined that 10 new entities reached the threshold and received or made payments of Medicaid funds totaling at least $5,000,000 during FFY 2022. After further random assessment, UOIG concluded that one entity would receive a letter of audit and 9 entities would receive letters of attestation, during the second year of the 3 year cycle.

The 9 entities that received letters of attestation returned the certifications within the deadline, and were in compliance with all requirements.

The one entity that was chosen by random selection for the audit process did not return any information. It was discovered after the mailing of the letter that the provider had discontinued business without notifying Utah Medicaid. The provider had also been placed on a "Do not contact" list. The audit portion was then discontinued.

No non-compliant issues were discovered. No findings are reported for second year of the audit cycle.

Appendix A: Utah Medicaid State Plan, Section 4.42

Revision: HCFA-PM-92-2 (HSQB)
March 1992

Page 79y(1)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: UTAH

SECTION 4 - GENERAL PROGRAM ADMINISTRATION (Continued)

Citation
1902(a)(68) of the Act,
P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for profit or not for profit, which receives or makes payments under a State Plan approved under Title XIX or under any waiver of such plan totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: UTAH

SECTION 4 - GENERAL PROGRAM ADMINISTRATION (Continued)

Citation
1902(a)(68) of
the Act,
P.L. 109-171
(section 6032)

4.42 Employee Education About False Claims Recoveries (Continued)

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) "A contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies, which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: UTAH

SECTION 4 - GENERAL PROGRAM ADMINISTRATION (Continued)

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1902(a)(68) of the Act,
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4.42 Employee Education About False Claims Recoveries (Continued)

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Revision: HCFA-PM-92-2 (HSQB) Page 79y(2)
March 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: UTAH

SECTION 4 - GENERAL PROGRAM ADMINISTRATION (Continued)

Citation
1902(a)(68) of the Act,
P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries (Continued)

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GLOSSARY OF TERMS

Term	Description
CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act of 2005
FFY	Federal Fiscal Year (October 1 to September 30)
FMAP	Federal Medical Assistance Percentage
DHHS	Utah Department of Health and Human Services
MIB	Medicaid Information Bulletin
MOU	Memorandum of Understanding
UOIG	Utah Office of Inspector General

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UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General of Medicaid Services will protect taxpayer dollars by identifying fraud, abuse and waste risks and vulnerabilities in the State Medicaid Program and by taking action to mitigate or eliminate those risks.

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