# OFFICE OF THE INSPECTOR GENERAL OF MEDICAID SERVICES ANNUAL REPORT

9/14/2012

Inspector General of Medicaid Services

The Office of the Inspector General of Medicaid Services was established on July 1, 2011. It was created to monitor and evaluate the Medicaid program in the state of Utah.

September 14, 2012

TO: Governor Gary Herbert, Senator Lyle W. Hillyard, Chair, Representative Melvin R. Brown, Chair, Senator Kevin T. Van Tassell, Vice Chair, Representative John Dougall, Vice Chair and the Executive Appropriations Subcommittee

SUBJECT: 2012 Annual Report for the Office of Inspector General of Medicaid Services (OIG)

Attached is our 2012 annual report to the Governor and the Executive Appropriations Subcommittee, in compliance with ***Utah Code 63J-4a-502***. This report shows the results from the Office of Inspector General for fiscal year 2012. The OIG was created to serve as an independent oversight mechanism for Utah Medicaid and all Medicaid related spending. This report presents progress achieved since the inception of the office one year ago.

I am available to meet with members of the subcommittee to discuss any item contained in this report and to answer any questions regarding the ongoing efforts of this office to identify waste and abuse of Medicaid funds and the recoupment of those funds.

Sincerely,

Lee Wyckoff, CPA, CIA
Inspector General of Medicaid Services

cc:
President Michael Waddoups
Speaker Rebecca Lockhart
Senator Allen Christensen
Representative Bill Wright
Representative Bradley Last
Derek Miller
Mike Mower
Ally Isom
Kristen Cox
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# Table of Contents

**INTRODUCTION ..... 1**

EXECUTIVE SUMMARY ..... 1

**OIG: AN OVERVIEW OF THE OFFICE ..... 2**

ROLE AND RESPONSIBILITIES ..... 2

STAFF ..... 2

ORGANIZATION ..... 2

OIG IMPACT AND PROGRESS ..... 3

INTERNAL AUDIT TEAM ..... 3

PROGRAM INTEGRITY / MEDICAL REVIEW TEAM ..... 4

DATA MINING, POLICY, AND STRATEGY TEAM ..... 5

**APPENDIX A: SUMMARY OF RECOVERED AMOUNTS ..... 6**

# INTRODUCTION

## EXECUTIVE SUMMARY

The Office of the Inspector General (OIG) was created through legislation during the 2011 general session and became an independent office on July 1, 2011 The OIG serves as an independent oversight mechanism for Utah Medicaid and all Medicaid related spending. Significant progress has been achieved since the creation of the office one year ago.

A summary of critical items we have accomplished in the first year include the following:

- People and infrastructure
  - Developed a new office in a political environment with strong, demonstrated success as measured by return on investment, employee morale, and sustainability of operations
  - Created a case management database and a related process that monitors case progress and assigns resources
  - Implemented a hearing process for administrative appeals, including development of administrative hearing rules and retention of two, part-time administrative law judges (ALJs)
  - Developed a data mining team (2 associates) and a related process that uses creative, real-time data analytics to keep the OIG investigative pipeline full
  - Established
- Savings and Recovery (ROI)
  - Identified **nearly $29 million*** dollars that have been or are in the recovery process, while spending slightly under the $2+ million budget allotted
  - Performed Hospital Utilization Reviews (HURs) as required by statute and reduced outstanding inventory by approximately 1,000 cases; HUR inventory is now current
  - Provided significant policy recommendations to Medicaid and the Department of Health (DOH)
- Partnering with the provider community
  - Conducted routine meetings with the provider community to facilitate patient access to care and appropriate use of that care
  - Hired a Training and Policy Coordinator and conducted over 30 training sessions statewide to educate providers on common fraud, waste, and abuse to reduce future occurrences
  - Communicated with the provider community in an effort to minimize political ramifications of large fraud, waste, and abuse recoveries

*See appendix A

# OIG: AN OVERVIEW OF THE OFFICE

### ROLE AND RESPONSIBILITIES

The mission of the Office of Inspector General of Medicaid Services Audit division is to:

- Ensure compliance with state and federal requirements as they pertain to Medicaid.
- Audit, inspect, and evaluate the functioning of the division to improve Medicaid operations.
- Advise the Department and Division of an action that should be taken to ensure the state Medicaid program is managed in the most efficient and cost-effective manner possible.
- Identify, prevent and reduce fraud, waste and abuse in the state Medicaid program.
- Recoup, reduce costs and avoid or minimize increased costs of the state Medicaid program.
  *See **63J-4a-202***

### STAFF

| | | | |
|---|---|---|---|
| **Inspector General** | **Lee Wyckoff, CPA, CIA, CISA, CISSP, CFE** | | |
| Data Analysts | Mark Gaskill, MFT | Administrative | Gene Cottrell |
| | Sam Vanhous, PHD | | Ann Carrillo |
| Auditor Manager | Broc Christensen, MA | Legal | Stephen Alderman, JD |
| Auditors | Doug May, CIA, EMBA | | Lena Ward, JD |
| | T. Jason Mott, CPA, CFE | | Carol Clawson, JD |
| | David Stoddard | PI Manager | Noleen Warrick |
| | Deepa Ramkumar, CPA, CISA | Policy and Training | Michael Green, MS, JD |
| | Kevin Anderson | PERM/Pharmacy | John Slade, CRT |
| Nurse Manager | Toni Shepard, RN, BSN, CPC, IQCI | | Kylene Hilton |
| Nurse Investigators | Marian West, RN, BSN, CPC, CPC-H | | Kathy Cordova |
| | Sally Valdez, RN, MPA | | Terra Shockey |
| | Shanna Anderson, RN | | Isabella Wright |
| | Dean Healey, RN, BS, MSNc | | Audrey Curtis |
| | Burdean Wirtz, RN, MSN, SSW | | Dani Ibrahim, BS, CPhT |
| Physicians | John Hylen, MD, MPH | | |
| | Dr. George Smith, MD, DFAPA | | |

### ORGANIZATION

The OIG organization is based on a matrix or cross-functional organizational structure. While there are clear reporting lines and a clear mission for each team, there are responsibilities that transcend the various teams. Strong communication across the organization is the basis for efficiency in that we can accomplish more with fewer people and with less duplication of effort. From a top-down view, the Office is divided into three groups as follows:

- Internal Audit Team
- Program Integrity/ Medical Review Team
- Data Mining, Policy, and Strategy Team

## OIG IMPACT AND PROGRESS

### INTERNAL AUDIT TEAM

The purpose of the Audit Team is to function as an overall preventive control. The group's objective is to prevent fraud, waste, and abuse through proactive measures. Examples include recommending policy improvements to Medicaid and the DOH and reviewing areas of high organizational risk, such as project implementations, major initiatives, external reporting, or significant budget items. Through a historical analysis of payments recovered by the Program Integrity Function, the Audit Team's goal is to reduce the number of incorrect payments **before** they are made. The Internal Audit Team is comprised of audit professionals with expertise in accounting, fraud investigations, internal control structures and process improvement.

During FY2012, the Audit Department hired an additional four (4) auditors, bringing the total number of auditors to six (6). They released seven (7) reports, performed an internal review of the OIG's financial database, and reviewed federally excluded providers. The seven audit reports resulted in 26 recommendations; 25 or 96% of those recommendations are agreed to by audit clients and have specific implementation deadlines.

Some key outcomes from these audits include:

- Performance audit on the *Baby Your Baby* program demonstrated that controls needed improvement. By shortening the eligibility period (adopted recommendation), Medicaid will save approximately $500,000 per year on a prospective basis. As recommended, controls and oversight of the program have been consolidated, with oversight by one person, decreasing the risk of abuse.
- An audit of Provider Enrollment helped reduce the likelihood of fraud by strengthening the requirements for Medicaid provider eligibility. Medicaid also agreed to eliminate many of the out-of-state providers active in the claims system, who are not frequently used by Utah Medicaid recipients.
- The Provider Sanctioning report recommended a concise plan and strong policy for sanction reporting. The audit also recommended more discretion in sanctioning providers who acted inappropriately.

As of 6/30/2012, the OIG had partnered well with Medicaid and DOH management to identify emerging risks. Any discussions held with Medicaid management as they developed their action plans could be described as healthy tension. The Inspector General has recently become concerned because of one nearly completed audit where Medicaid management has contributed to an element of excess tension.

### Audit Plan

The Audit Team has enhanced their audit plan to include many high risk business processes. They prioritize audits based on risk rating and available resources and expertise. They adjust the audit plan throughout the year based on feedback from audit clients, changing organizational priorities, and a real-time evaluation of Medicaid's risk profile. Audit Management routinely meets with DOH and Medicaid Management and has also extended the scope of the audit plan to include broad-based Medicaid spending (Department of Workforce

Services (DWS), Department of Human Services (DHS)). There are currently nine audits in process and 37 audits on the risk prioritized audit plan.

### Follow-Up Reviews

The Audit Team is now a year old and beginning to follow up on issued audit reports and the corresponding management action plans. This practice helps achieve organizational change by fostering an environment of accountability. It is also a necessary component of operating in accordance with Generally Accepted Government Auditing Standards (GAGAS). This will allow the office to monitor DOH and Medicaid compliance with implementation dates for management action plans.

## PROGRAM INTEGRITY / MEDICAL REVIEW TEAM

The Program Integrity and Medical Review Team focus on the post-payment review and recovery of Medicaid payments that are high risk, outliers or statutorily required. By partnering with the Data Mining Team, Program Integrity has significantly increased their efficiency and capacity by focusing more directly on areas of risk. This function is mandated by Federal law, but their newly adopted methodology has caused their return on investment to increase exponentially. Their team is comprised of medical professionals (nurses/doctors), medical administrators and eligibility experts.

Audits conducted by the Program Integrity / Medical Review team have identified amounts for recovery of $28.9 million dollars in one-time state and federal Medicaid funds during fiscal year 2012. This amount includes $3.48 million dollars that were identified by the Medicaid Fraud Control Unit (MFCU) and ultimately collected by the OIG.

The increasing effectiveness and accuracy of the team can be seen in several areas. There has been a significant reduction in the number of cases that providers are appealing. Because the original notices of recovery are based on strong legal and policy interpretation, the proclivity of providers to pursue an appeal process has been diminished.

Two key performance measures are presented below:

| Performance Measure | FY 2012 | FY 2013 Target |
|---|---|---|
| Approximate Return on Investment | 906 % | 500 % |
| Approximate Recoveries per FTE | $ 733,565 | $ 404,656 |

The main measurement is a return on investment (ROI) for the OIG unit. Based on collections for fiscal year 2012, and an estimate of the overall collectible amount currently in administrative hearing or noticed to the provider, the unit produced an ROI of approximately 906%.
Program Integrity refers suspected fraud case to the Medicaid Fraud Control Unit (MFCU) on a routine basis as they are identified. The OIG has routine meetings with the MFCU and has partnered well to help identify blatant cases for prosecution. Currently, the OIG is going through preparation to refer approximately five (5) cases to MFCU.

## DATA MINING, POLICY, AND STRATEGY TEAM

The Data Mining, Policy, and Strategy team consists of two data analysts and one policy expert. The Data Mining, Policy and Strategy team focuses on using creative, real-time data analytics to identify areas of high risk. Having an inventory of high risk areas allows Program Integrity to focus their time and efforts where they can make an immediate impact and achieve a high ROI.

Potential problems or questions identified by the Data Mining, Policy, and Strategy Team are prioritized using preliminary risk evaluation, including policy and legal implications, risks to providers and recipients, and potential return on investment. Analytic, investigative, and medical research resources are allocated to cases based on this preliminary evaluation.

The methodology used for data pulls is one supported by the Centers for Medicare and Medicaid Services (CMS) and consists of the following:

1. **Case Concept Development** – Identify problem or question related to waste, abuse or fraud
2. **Algorithm Development** (Data Pulls) – Identify the data universe/population
3. **Sampling** – Select the focus group
4. **Statistical Analysis** – Evaluate the focus group(s)
5. **Model Development** – Apply findings to other populations or problems
6. **Artificial Intelligence & Fuzzy Logic** – Make connections to other problems/questions in the absence of direct linkages
7. **Other Data Mining and Analysis Methods** – High-level fishing and other creative brainstorming

The Policy Team also provides training to the provider community and other agencies. The OIG has conducted 30 training sessions to all provider types statewide. The OIG has lectured on fraud, waste and abuse to the Division of Child and Family Services (DCFS) and The Utah Division of Services for People with Disabilities (DSPD). These training seminars focus on how to identify and report suspected or actual fraud, waste and abuse. Moreover, the training gives examples of best practices & procedures and how the OIG works procedurally if the provider has an interaction with the office.

### Looking Forward

Medicaid is proposing a transition to a capitated health care delivery model for the majority of Utah's Medicaid recipients in FY 2013. This transition will shift Medicaid from a claims based to a capitated reimbursement model.

Capitated reimbursement results in encounter data versus individual reimbursement claims data. This transition will require the OIG Data Mining, Policy and Strategy Team to adjust our analytic approach. The team's focus will shift from a payment analysis model to a quality of care, access to care and a case risk adjustment analysis focus. The OIG has prepared for this transition by hiring an expert on Utah's managed care community and associated quality measures (HEDIS and CHAPS) (see 2nd FTE/ data miner discussion above). In addition, the Data Mining, Policy and Strategy Team will be utilizing additional software analytic tools that will aid in the evaluation and oversight of the encounter data and performance measures.

Appendix A: Summary of Recovered Amounts

| | |
|---|---|
| **Cash Collected** | 7,532,652 |
| **Cash Being Collected by DOH Through Offset** | 2,660,249 |
| **In Hearing Process as of 6/30/2012** | 18,339,703 |
| **Noticed, but Not Collected as of 6/30/2012** | 398,788 |
| | 28,931,392 |