Audit of Inpatient Fee-for-Service Claims Paid Incorrectly

Report Number 2019-03

January 29, 2021

Utah Office of
Inspector General

Gene Cottrell
Inspector General

February 17, 2021

To: Utah Department of Health

Please see the attached report, **Audit of Inpatient Fee-for-Service Claims Paid Incorrectly,** Report 2019-03. An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 3 of this report.

Sincerely,

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

cc: Jon Pierpont, Chief of Staff 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. In the State of Utah, the Department of Health (DOH) is the single state agency responsible for all aspects of Utah's Medicaid state plan including administration and supervision of payment for services delivered under the plan.

DOH contracts with four Accountable Care Organizations (ACOs) to provide services to Utah Medicaid recipients. In 2018, DOH signed contracts for a term of five years with each of the four ACOs, together totaling $6.4 Billion before adjustments or additions, or $1.28 Billion annual average. DOH signed separate, additional contracts in 2020 for the expansion populations.

Utah Office of Inspector General (UOIG) Program Integrity nurse investigators prior to this audit and over the course of several years, identified incorrect payments amounting to $4.41 Million for inpatient Fee-for-Service (FFS) claims paid for services covered by an ACO during CY2015-2019. The nurse investigators initiated recovery. The audit identified another $138,145 of Medicaid incorrect payments for inpatient FFS claims, total $4.55 Million inpatient FFS claims incorrectly paid by Medicaid identified by UOIG.

The incorrect payments occurred when the provider filed FFS claims for hospitalized Medicaid recipients and the Medicaid Management Information System (MMIS) programming bypassed the ACO edit check. Ninety eight percent of the incorrect payments occurred during CY 2015 and July 2018 through December 2019. Only two percent of incorrect payments occurred from January 2016 through June 2018.

This audit initiated to identify the cause of the inconsistent effectiveness of the payment controls and to recommend controls for prevention of incorrect payments.

Audit Objective:

Determine why Medicaid paid the FFS Inpatient Claims identified by UOIG Program Integrity as incorrect payments.

Audit Finding:

Medicaid incorrectly paid $4.55 million of FFS claims for inpatient services covered by ACO capitations during 2015-2019. Title 42 Code of Federal Regulations Part 438.60 prohibits the payment of FFS claims for service covered by an ACO. UOIG recommends Medicaid adopt a more comprehensive, formalized change control process and to self-monitor payment controls on a regular basis. The recommendations improve quality process to the current systems without requiring system upgrades. The recommendations apply also to future implementations such as the Provider Reimbursement Information System for Medicaid (PRISM).

INTRODUCTION

BACKGROUND

DOH Responsibilities and Authorities

Medicaid is a joint state and federal government health insurance program established by Title XIX of the 1965 Social Security Act. Under the authority of Utah State Code 26-1-18, the Utah Department of Health (DOH) is designated the single state agency responsible for administration of Utah Medicaid. As the single state agency DOH is responsible for all aspects of Utah's Medicaid state plan including administration and supervision of payment for services delivered under the plan.

UOIG Responsibilities and Authorities

Under authority of Utah State Code §63A-13-201, the Utah Office of Inspector General (UOIG) operates as an independent entity within the Utah Department of Administrative Services. Under authority of Utah State Code §63A-13-202, the UOIG audits, inspects, and evaluates the functioning of the DOH Division of Medicaid and Health Financing for the purpose of making recommendations to the Legislature and the department to ensure that the state Medicaid program is managed in the most efficient and cost-effective manner possible.

UOIG Memorandum of Understanding (MOU)

The DOH and UOIG work together with top-level interdependencies and functions. The DOH and UOIG created an MOU specifying responsibilities for multiple functions with the most recent version signed August 2017. The MOU specifies, for example: functions and processes, reports, definitions, dates due, financial arrangements to facilitate more effectively the UOIG mission to prevent Fraud, Waste and Abuse of the Medicaid Program.

The MOU attachment B section 6.3 acknowledges the potential need for the parties to develop standard operating procedures (SOP) and the MOU specifies a protocol for developing SOPs.

UOIG Sections

The UOIG is comprised of the Audit Section, the Program Integrity Section and the Mission Support Section. Each having separate management under the Inspector General.

<u>Audit Section</u>

The Audit Section (auditors) reports directly to UOIG administration. The auditors perform audits, evaluations, and inspections. A description of each is included in the Glossary at the end of this report.

The Audit Section operates independently of the Program Integrity Section and reports directly to the Inspector General.

Program Integrity (PI) Section (Certain MOU Specified Program Integrity Functions)

The UOIG Mission Support Data Scientists analyze Medicaid healthcare claims to identify claim behavior indicative of fraud, waste and abuse. Data Scientists forward the resulting data set to the UOIG Program Integrity Nurse Investigators and other special investigators for further research and case development if appropriate. Situations indicating a reasonable suspicion of fraud and abuse receive special investigation technique including site visits and medical reviews. UOIG refers situations of probable cause for fraud to the Utah Medicaid Fraud Control Unit.

Situations of abuse and waste enter a payment recovery process including training the provider in the use of proper billing methods.

The UOIG monitors Fee-for-Service (FFS) claims based on risk analyses, and recovers incorrect payments in accordance with Utah Administrative Services Code Title 63A Chapter 13.

Mission Support Section

The UOIG Mission Support Section performs the functions of Data Science, Accounting, Electronic Records and Archive Retention in support of the Audit and Program Integrity Sections.

Utah Medicaid Contracts Accountable Care Organizations (ACO)

Portions of Utah Medicaid have operated under managed care delivery systems since 1982.[1] Utah Medicaid's Accountable Care Organizations (ACO) are managed care physical health plans authorized by 42 C.F.R. §438 section 1915(b) Choice of Health Care Delivery (CHCD) as a waiver.

Utah Medicaid recipients living in thirteen counties, referred to as mandatory counties must choose health coverage under one of the four ACOs. Recipients not living in the thirteen counties may choose an ACO or remain FFS.

Utah DOH contracts with four ACOs to provide services to Utah Medicaid recipients. In 2018, DOH signed contracts for a term of five years with each of the four ACOs, together totaling $6.4 Billion before adjustments or additions, or $1.28 Billion average, annually. DOH signed separate, additional contracts in 2020 for the expansion populations.

Utah Medicaid utilizes two payment methodologies

Utah Medicaid utilizes two payment methodologies for Medicaid services covered under the state plan: capitation and Fee-for-Service (FFS). Under capitation method, the ACOs receive a fixed monthly capitation payment to provide services covered under the State Plan to eligible

[1] "Managed Care Quality Strategy." 2015. Accessed November 6, 2018. https://docs.google.com/viewer?a=v&pid=sites&srcid=dXRhaC5nb3Z8Y3FtfGd4Ojc5NTU1MzQxZDQ4YTJlZGE.

recipients. The ACOs receive prepaid capitation payments regardless of treatment required—or not required—during the month of capitation coverage.[2] The ACOs compensate providers for delivering contracted Medical services. Under capitation methodology, providers submit their claims for reimbursement to the ACO. Under the FFS payment method a provider bills Medicaid directly for Medical services covered by the state plan.

Federal law prohibits FFS payment for services covered by ACO

Federal law states that the single state agency "must ensure that no payment is made to a network provider other than by the MCO, PIHP, or PAHP for services covered under the contract between the State and the MCO, PIHP, or PAHP." ACO is a type of Managed Care Organization (MCO).[3] Services not covered by the ACO are paid FFS.

UOIG Nurse Investigators identified $4.41 Million incorrect payment of Inpatient FFS Claims for Dates of Service (DOS) 2015-2019.

UOIG nurse investigators prior to this audit and over the course of several years, identified incorrect payments amounting to $4.41 Million for *inpatient claims paid FFS for services covered by an ACO during CY2015-2019*. The nurse investigators initiated the recovery of the incorrect payments. See Supervisory Review and Recovery Process described below.

Risk Based Identification of Incorrect Payment

The UOIG Mission Support Data Scientists query the Medicaid Data Warehouse for in-patient FFS claims on recipients for whom Medicaid paid ACO capitation covering the same dates of service. The Data Scientists export the linked records to a spreadsheet for Utah OIG nurse investigation.

The nurse investigator verifies the spreadsheet information to ensure services billed FFS the ACO also covered at the time of service. The nurse investigator eliminates FFS claims for services carved-out.[4] The procedures performed by the nurse investigator also include:

- Reviews of the recipient information on the Utah Medicaid Managed Care System (MMCS) to verify ACO coverage, for example:
  - Recipients ACO benefit history
  - Recipients Capitations history
- Reviews of the FFS claims history on the Utah Medicaid Management Information System (MMIS), evaluating the paid FFS claims were within ACO coverage by examining, for example:
  - Diagnosis Codes and descriptions
  - Diagnosis Revenue Group Codes and descriptions
  - Dates of Service
- Reviews of eligibility details provided on the Utah: Electronic Resource and Eligibility Product (e-REP)

[2] Managed Care, 42 C.F.R. § 438.2 (2017), https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-part438.pdf.
[3] Managed Care, 42 C.F.R. § 438.60 (2017), https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-part438.pdf.
[4] Carve-out refers to services specifically stated in the ACO contracts as not covered.

- Documenting the relevant supporting information.
- Reporting incorrect payments with supporting details to the supervisor.

Supervisory Review and Recovery Process

A UOIG PI supervisor reviews the results of the nurse investigators and forwards the detail to UOIG administration for recovery action. UOIG administration issue notices of recovery to providers describing the incorrect payment, required repayment and the provider's right to appeal.

UOIG or Utah Medicaid performs recovery action in the absence of direct repayment or an appeal filed by the provider. Recovery action by UOIG and Utah Medicaid may consist of a financial reversal or "off-set" against provider unpaid claims on the account.

To facilitate reimbursement for services the provider issues billing to the ACO for payment.

Table One
Medicaid incorrect payments for FFS Inpatient (IP) Services for calendar 2015 and forward. UOIG identified the incorrect payments and initiated the recovery process.

Ref	Dates of Service	Medical FFS IP Claims (Other than Newborn)	Newborn FFS IP Claims	Total Incorrect Payments
1	2015: Jan-Dec	$57,393	$271,379	$328,772
2	2016: Jan-Dec	4,067	-0-	4,067
3	2017: Jan-Dec	45,588	14,737	60,325
4	2018: Jan-Dec	641,285	565,177	1,206,462*
5	2019: Jan-Dec	1,599,856	1,212,686	2,812,542
	Total	**$2,348,189**	**$2,063,979**	**$4,412,168**
	Component Percent	53%	47%	100%

*Note: 98% of the $1,206,462 or, $1,180,405 incorrectly paid during the July – December 2018 period.

See Appendices 2-6 for detail by DRG and DRG Description.

Newborn FFS Inpatient Claims

Newborn FFS claim incorrect payments summarized in table one are for newborn babies (newborns) whose mothers enrolled with the ACO prior to the newborn's date of birth. The newborn FFS claims represent payments for services covered by the ACO under the mother's coverage. [5] The incorrect payment occurred when providers issue FFS claims to Medicaid for services covered by the ACO, and Medicaid paid the FFS claims. Medicaid paid the ACO the regular capitation payment and a special lump sum payment called a "Delivery Case Rate"

[5] ACO Contract Article 3.4.2 Eligibility Transmission, Specific Types of Enrollees. (2) Newborn Retroactive Enrollees are newborns whose mothers are enrolled with the Health Plan on the newborn's date of birth. A Newborn Retroactive Enrollee is deemed to be enrolled in the same plan as the mother, retroactively, to the first day of the newborn's birth month.

(DCR). The DCR covered inpatient cost for both the mother and baby. The DCR at January 2019 was $5,928.[6]

Medicaid paid the inpatient FFS claims for the birth of the baby despite the services being included in the ACO coverage provided for the mother and baby under the capitation and DCR payments.

Appendices 2-6 list the incorrect payments by year summarized by Diagnosis Resource Group (DRG) and includes the DRG Description used by the Utah Medicaid DRG Calculator. [7] Appendices 2-6 highlight newborn DRGs 789-795. The table one column labeled "Newborn FFS IP Claims" summarizes FFS claim incorrect payments for DRGs 789 – 795.

Medical Inpatient (IP) FFS Claims

The Medical IP FFS claim incorrect payments include all DRGs listed in Appendices 2-6 except the highlighted, newborn DRGs 789-795. The DRGs not highlighted in Appendices 2-6 sum to the totals in table one, "Medical FFS IP Claims (Other than Newborn)."

The Medical IP FFS incorrect payments represent claims for services covered by the ACO. The DRG Descriptions reported in Appendices 2-6 provide detail of the range of services represented by the incorrect payments.

Finding 1 includes description of causes and recommendations for improvement.

Audit Identified Inpatient FFS Incorrect payments for Detoxification Services for Recipients covered by an ACO

During the course of the audit, the auditor reviewed the DOH contract provisions for 2018 and 2019 with the ACOs for services covered. The audit identified detoxification services provided in a hospital as a service covered by the ACO contract. The audit identified $138,145 of inpatient FFS claims paid incorrectly by Utah Medicaid for DOS September 2018 through December 2019 not previously identified or with a recovery initiated. Medicaid agrees the $138,145 of FFS Claims paid incorrectly and the UOIG has now initiated recovery.

[6] The DOH-ACO contract attachment B article 11.5 states "If a baby is born to an Enrollee, the Contractor is responsible for all inpatient facility and inpatient professional services for both the mother and the newborn Enrollee associated with the birth." Attachment F, Article 2.3 states: "(A) The Department shall reimburse the Contractor a Delivery Case Rate per delivery when the delivery occurs at 22 weeks or later, regardless of viability. The Delivery Case Rate is intended to include all Medically Necessary inpatient and physician expenditures associated with the delivery. The Delivery Case Rate does not include expenses associated with prenatal care. The Delivery Case Rate is in addition to the monthly Capitation Rate for the Enrollee."
[7] https://medicaid.utah.gov/stplan/inpatientdrg/

Table Two Medicaid FFS incorrect payments for ACO Inpatient Detoxification Services					
Dates of Service*	FFS TCN+ Count	Diagnosis-Related Group (DRG) Payments			Incorrect Payments
		895	896	897	
2018: Sept - Dec	2	$6,267		$873	$7,140
2019: Jan – Dec	19	43,000	7,441	80,564	131,005
Sum	21	$49,267	$7,441	$81,437	$138,145

*Dates based on Beginning DOS
+Transaction Control Number

Purpose of this Audit

Table one illustrates the inconsistent condition of the control structure during the DOS CY 2015 through 2019 time period; during CY 2015 incorrect payments of $328,772; CY 2016 through June 2018 (2.5 Years), $90,449; July through December 2018 incorrect payments of $1,180,405 and, CY 2019 $2,812,542.

While UOIG informed Medicaid of incorrect payment issues by various emails and more broadly through the PIC, both parties did not meet the expectations of the other. The MOU signed by both UOIG and Medicaid did not specify a Standard Operating Procedure specifying a mutually agreed process to convey summary level incorrect payment information prior to collection.

UOIG preliminary analysis of the January to June 2020, FFS Inpatient Claims indicates corrections to the payment controls decreased the incorrect payments previously identified for inpatient claims. UOIG in this report makes recommendations to improve consistency in the control of payment edits when making adjustments for program changes.

The audit initiated to identify the root cause of the payment control structure inconsistency evidenced by the incorrect payment amounts in table one, to make recommendations that enable Utah Medicaid to implement effective change control and after-change monitoring.

"Pay It Right" versus "Pay and Chase" or Post Payment Review

The CMS Director states, "CMS defines program integrity very simply: 'pay it right.' Make the right payment, to the right plan, for the right people. Program integrity must focus on paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries while taking aggressive actions to eliminate fraud, waste and abuse. Our health care programs are quickly evolving; therefore our program integrity strategy must keep pace to address emerging challenges … prevent rather than chase fraud waste and abuse through smart, proactive measures."[8]

[8] Oct 21, 2019: The Future of Medicare Program Integrity By: Seema Verma, Administrator, Centers for Medicare & Medicaid Services; and Dec 20, 2019 "CMS Announces Enhanced Program Integrity Efforts for the Exchange."

The UOIG performs a post-payment review ("Pay and Chase") of already paid FFS Claims, applying analytical techniques to identify higher risk transactions. UOIG techniques apply only to paid claims. UOIG performs detail, time intensive research establishing incorrect payment of claims.

CMS emphasizes the importance of implementing effective controls and is moving away from its former program known as "Pay and Chase." The September 5, 2019 CMS press release refers to "'CMS' longstanding fight to end "pay and chase" in federal healthcare fraud efforts and replace it with smart, effective and proactive measures.'"[9]

Not all incorrect payments are recoverable, for example: the provider may no longer be a Medicaid provider. If the incorrect payment is recoverable, the cost of administration necessary to recover the incorrect payment adds to the cost of healthcare. The paragraphs above labeled "Risk Based Identification of Incorrect Payment" and "Supervisory Review and Recovery Process" describe the recovery process.

The UOIG initiated this audit to recommend Medicaid focus more attention to the prevention of incorrect payments of FFS inpatient claims for services covered by the ACO.

This is the third[10] in a series of Managed Care Entity (MCE) audits and evaluations relating to the Utah State Auditor's concern regarding the appropriateness of Fee-for-Service (FFS) payments made for Utah Medicaid members enrolled with an ACO.[11] On May 23, 2019, UOIG issued Audit of Dental Managed Care Organization with Fee-for-Service Billings reporting Utah Medicaid incorrectly paid an estimated $584,777 between January 2015 and June 2018. UOIG also conducted an evaluation of the PMHP MCE Capitations and Outpatient FFS Billings. The evaluation did not find outpatient incorrect payments and a report was not issued. Evaluations research potential issues and document the result. An evaluation report does not publish outside of UOIG and does not post to the UOIG website.

OBJECTIVES AND SCOPE

Audit Objective:

Determine why Medicaid paid the FFS Inpatient Claims subsequently identified by UOIG Program Integrity as incorrect payments.

Audit Scope:

The audit scope focused on Medicaid's incorrect payment of FFS inpatient claims for recipients covered by ACO capitations for Dates of Service 2015-2019, specifically:

- ACO contract provisions for 2018 and 2019 for coverages and carve-outs.

[9] https://www.cms.gov/newsroom/press-releases/cms-announces-new-enforcement-authorities-reduce-criminal-behavior-medicare-medicaid-and-chip

[10] The initial report was 2019-02 Audit of Dental MCO and FFS Billings, issued May 23, 2019. The next was an Evaluation (2020-01E) of the Prepaid Mental Health Plans MCE Capitations with FFS Billings completed December 17, 2019.

[11] See WP104.01 State Auditor Letter, to Dr. Joseph Minor, Executive Director, August 31, 2018.

- Medicaid's process of adjusting the payment controls automated edits for the desired outcomes.

METHODOLOGY

The audit relied on the work performed by the UOIG Program Integrity Nurse Investigators for incorrect payment identification totaling $4.41 million for DOS 2015-2019, and for the initiation of incorrect payment recovery.

The audit process was to review for reasonableness:

- the work of the UOIG nurse investigators over inpatient FFS claims; and the
- Medicaid processes and procedures as of, or in effect December 31, 2019 governing and controlling payment of inpatient FFS Claims for Medicaid recipients covered by ACO Services.

The audit methodology included:

- interview the UOIG Data Scientists and review the methodology linking the inpatient FFS Claims with capitations paid for the same dates of service;
- interview the UOIG nurse investigator and review the research procedures used to review the medical history of recipients including diagnoses and treatments billed, capitation payments and suspensions, and removing carve-outs;
- review of supporting information of the incorrect payments identified by the nurse investigators;
- inquire and interview Utah Medicaid representatives;
- review the ACO contracts for 2018 and 2019 regarding covered services.

FINDING 1	Medicaid incorrectly paid $4.55 million in FFS inpatient claims.

The UOIG identified FFS claims incorrectly paid to providers for services covered by the ACOs. Despite the ACOs being the responsible payer, Medicaid improperly paid the $4.55 Million of FFS Claims on the MMIS platform without detection or correction. UOIG identified the incorrect payments and initiated recovery.

UOIG Mission Support Data Scientists analyze categories of risk and the analysis identifies FFS claims for recipients also enrolled in an ACO Plan as potentially unmitigated risk. The UOIG Data Scientists forward the analysis to nurse investigators to determine whether Medicaid correctly paid both the FFS Claim and a capitation payment for the service provided.

UOIG informed Medicaid of incorrect payment issues by emails, copies of NORs and more broadly, through the Program Integrity Committee (PIC).

A. Medicaid incorrectly paid FFS claims for inpatient hospitalization covered by ACO capitations provided 2015 – 2019 causing $4,412,168 incorrect payments.

Medicaid did not maintain effective payment controls for the prevention of incorrect payment.

Medicaid payment controls during 2015 allowed $328,772 of FFS inpatient claims to be incorrectly paid. Payment controls improved and during the following two and a half years 2016 through June 2018 or 30 months, Medicaid incorrectly paid FFS inpatient claims $90,449.

Medicaid again incorrectly paid inpatient FFS Claims during July – December 2018 by nearly $1.2 Million and during CY 2019, $2.8 Million for a total of $4.0 Million incorrect payment of FFS inpatient claims for the 18 months July 2018 through December 2019.

UOIG identified the $4.41 Million (table one - total) of inpatient claims incorrect payments and initiated the recovery process by issuing notices of recovery to providers advising of the:

- incorrect FFS claims resulting in incorrect payments from Utah Medicaid;
- provider actions needed to correct the incorrect payments, including providers voiding the FFS claim or issue a refund to Utah Medicaid;
- providers right to appeal;

In the absence of corrective action or appeal by the provider, UOIG will void the claim and coordinate with Medicaid to apply the incorrect payment “off-sets” against open claims on the provider’s account.

Table one summarizes the incorrect payments based on dates of service to the inpatient and the type of service.

B. Medicaid incorrectly paid $138,145 of FFS claims for inpatient detoxification treatment covered by ACO capitations during September 2018 through December 2019.

The audit reviewed the 2018 and 2019 ACO Contract provisions for covered services.

The auditor observed ACO contracts include treatment for detoxification provided in a hospital as a covered service.[12] The UOIG Nurse Investigators stated inpatient FFS claims for detoxification services were not included in the risk based data analysis. The auditor requested the Lead UOIG Data Scientist run a query of the FFS Claims for inpatients covered by an ACO receiving detoxification treatment. The query identified a total of $138,145 of FFS claims for inpatient detoxification treatment covered by ACO capitations during September 2018 through December 2019.

Medicaid agreed with the UOIG finding ACO capitations include coverage for inpatient detoxification services and the $138,145 of FFS claims paid incorrectly.[13]

Medicaid believes payment controls implemented February 6, 2020 corrected the payment control for similar claims.

A and B: Cause and Effects

1. Payment Control Edits

Medicaid believes the broken payment edit (described below) that allowed the incorrect payment of $4.41 million inpatient FFS Claims described in section A above also caused incorrect payment of the $138,145 of FFS claims for inpatient detoxification treatment. Table two provides additional detail for the detoxification treatment.

Utah Medicaid and the Department of Technology Services (DTS) configured a series of MMIS edit settings, payment controls that FFS inpatient claims must pass before MMIS issues payment. The payment control edits require change simultaneous with Medicaid program assistance changes. Medicaid directs and approves changes to the MMIS edit settings using a document system called the "Division Operations Tracker" (DOT).

<u>DOT Process</u>

Medicaid Bureau staff or subject matter experts (SME) initiate a DOT describing an issue and then request the Medicaid Director's Office to establish priority. DTS receives the DOT and assigns the issue to a programmer to resolve. The DTS programmer works closely with the Medicaid staff to identify the problem and determine the appropriate edit fix. DTS and Medicaid work together to test the fix and by mutual agreement the fix is scheduled for production.

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[12] Attachment C Effective January 1, 2018 Article 1.3.19 Treatment for Substance Use (A) Medical detoxification provided in a hospital for substance use disorders is a Covered Service.

[13] Medicaid on June 12, 2020 Stated: *based on the review of the program manager and DTS review within their test environment, these claims meet criteria for coverage by the ACO and should not have been paid by FFS. The test also proves that the fix that was implemented is working and we should no longer have this same issue with medical detox claims that are the responsibility of the ACO.*

DOT Implementation

DTS stated that the process is according to what the developer (programmer) indicates on the DOTs following.

Medicaid Bureau of Managed Healthcare (BMHC) informed the auditor that DOT 102162 implemented to fix the payment control break down causing the CY 2018 and 2019 incorrect payments. DOT 102162 references 100040 and DOT 103942 references 102162.

The below exemplify DOTs intended to fix payment problems. Although Medicaid indicates there were additional DOTS, the result did not achieve the intended outcome and significant incorrect payments occurred. The documentation on the DOTs state:

- DOT 102162 initiated by BMHC implemented February 6, 2020. The DOT states: '"The ACO edit is not posting on inpatient claims. Related to DOT 100040 (See Appendix One Exhibit A). [Name Redacted] has found the issue and said, "It is probably due to the changes I made in the [ACO] programming to handle line items logic."'

  DOT 102162 does not refer to test performance, or the test details.

- DOT 103942 initiated by BMO with an emergency implementation date of May 14, 2020, to fix a problem by the edit change implemented three months earlier by DOT 102162. The DOT states:

  "FFS and X-Over claims for Outpatient and Inpatient continue to process with payment for ACO eligible Medicaid members. Edits are not posting to these claims. The issue continues post implementation of DOT 102162." Moreover:

  "Back about a year ago the logic was changed drastically for posting [ACO] edits to the line level instead of the claims level. … In [DOT] 102162 [Name Redacted] modified the logic so it would post to inpatient hospital claims, but didn't add outpatient hospital claims at that time."

See Appendix One Exhibits A, B, C for additional details.

DOT Quality Control and Opportunities for Improvement

DTS:

DTS issued Change Control (CC) Document Version 1.0 July 2013 and the current revision 2.3 issued December 2019. The CC Document guides DTS programmers and documents the prescribed quality control (QC design).

The DTS CC Document section four specifies roles and responsibilities specific to Medicaid, to DTS, and the roles and responsibilities shared by both Medicaid and DTS. The DTS CC Document specifies Medicaid the role of providing user test cases and test criteria.

DOTs 102162 and 103942 illustrate changes to payment control edits do not always perform as expected, sometimes with unintended results following implementation to production.

Medicaid:

Medicaid does not have a Division wide Statement of Procedures (SOP) for DOTs to define a cohesive process, to assign roles and responsibilities within and between Bureaus, or to specify guidelines or policy to Bureaus regarding full and complete "user test cases and test criteria."

BMHC does not document a policy, process or procedure related to DOTs quality assurance to guide the selection of comprehensive data test-sets by BMHC staff.

Medicaid explains a team approach operates for selecting user test cases. Medicaid did not provide documentation of how teams determined and comprehensively selected applicable user test cases to test the adequacy of the payment control change and its effect on the payment of various types of claims prior to "go live" production of the edit.

The Bureau of Medicaid Operations (BMO) provided the auditor a Desktop Procedures for approval of programming changes" (Desktop Procedures), dated June 14, 2012 and a Project Team Assignment Tracker (PTAT) issued September 6, 2019. However, The Desktop Procedures and the PTAT do not include policy, guidelines or criteria regarding the adequate selection of use cases and test criteria.

2. Medicaid' Communication Issues with ACOs and Providers[14]

Medicaid explains incorrect payments also result when recipients regain eligibility after the first of a month and the system retro-activates coverage on the same ACO Plan assigned during a recent prior eligibility. The system auto-enrolls recipients for (re)eligibility, capitation payment generates and ACO eligibility reinstates for the whole month. However, prior to re-instating coverage on the ACO back to the first of the current month, a Medicaid provider views a status of FFS coverage and the provider issues FFS claims to Medicaid. If Medicaid pays the FFS claims prior to the capitation payment, the FFS claims pay and the capitation covering the same dates of service also pay.

Medicaid states situations causing an ACO re-enrollment and capitation payment for a full month (retroactive to first of current month) performed after the first of that month include:

a. ACO Re-enrollment - this happens when a member enrolled with an ACO, loses Medicaid eligibility and then re-activates (for any of many reasons). There is timing logic involved with how the system decides if a client is re-enrolled.
b. Spenddown Program - clients who meet the spenddown later in the month will cause an ACO enrollment and capitation payment when the spenddown requirement fulfills.
c. Newborns - enrollment follows the mother and a baby born [for example,] on 5/31/2020 enrolls effective 5/1/2020 at some time after reporting the actual birth.
d. Miscellaneous system glitches.

Medicaid did not formally communicate with providers or ACO Plans a process to prevent the incorrect payments. Medicaid states:

[14] See email May 6, 2020 discussion Medicaid managers conducted with the Assistant Division Director of Operations.

> "Providers are doing what they are supposed to do and until we can communicate an official process to providers we feel that any past claim recovery could create an undue hardship for providers. We have created a workgroup to explore and implement official solutions to this issue. Once we have procedures/processes in place, we will share the expectations with UOIG."

Federal law prohibits payment for services covered by the ACO and hence recovery of incorrect payment becomes mandatory.[15]

UOIG Data Scientists in March 2020, queried the FFS Inpatient Claims for dates of service during October 2019 for Medicaid recipients on an ACO Plan. The results indicated approximately 32% of the total FFS IP claims paid before the capitation payment, 60% of the total claims dates of service preceded the capitation payment.[16]

Summary Effects

Tables one and two illustrate the inconsistent condition of the control structure during the DOS 2015 through 2019 time period; during CY 2015 incorrect payments of $328,772, CY 2016 through June 2018 (2.5 Years) much less, $90,449, July through December 2018 much higher incorrect payments of $1,180,405 and, CY2019 $2,812,542. In addition, FFS Claims for inpatient detox services paid incorrectly amounting to $138,145.

Incorrect payment prevented by edits avoids the additional cost of "Pay and Chase" especially considering incorrect payments are not always recoverable and at best, increases the cost of healthcare administration when compared to claims paid correctly. [17] [18]

UOIG preliminary analysis of the January to June 2020, FFS Inpatient Claims indicates corrections to the payment controls decreased the incorrect payments previously identified for inpatient claims. UOIG in this report makes recommendations to improve consistency in the control of payment edits when making adjustments for program changes.

Medicaid expressed interest during the audit to receive summary level information from UOIG prior to recovery initiation. The MOU signed by both UOIG and Medicaid did not specify a Standard Operating Procedure that includes summary level information.

The recommendations below do not require system upgrades. The recommendations apply a formalized approach to achieve due care when performing payment control edit changes.

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[15] Managed Care, 42 C.F.R. § 438.60 (2017), https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-part438.pdf.

[16] Percent based on claim count, not claim dollar amount. Date of query is important since FFS claims are not "at rest", may potentially change, until generally up to three years after date of service. If involved in a false claim or other predication of fraud it could be longer than the three years.

[17] The Centers for Medicare & Medicaid Services (CMS) began several initiatives to prevent or identify improper payments before CMS processes a claim. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MCRP-Booklet-Text-Only.pdf

[18] The CMS Administrator states, "CMS defines program integrity very simply: 'pay it right.' Make the right payment, to the right plan, for the right people." Oct 21, 2019: The Future of Medicare Program Integrity By: Seema Verma, Administrator, Centers for Medicare & Medicaid Services; and Dec 20, 2019 "CMS Announces Enhanced Program Integrity Efforts for the Exchange."

The recommendations below apply to the current process and any future system implementation such as PRISM.

Recommendations

1.1 We recommend Medicaid document through a Division wide SOP the Bureau and inter-Bureau roles and responsibilities for DOTs. Include policy or guidelines covering the items DTS relies on Medicaid to provide, i.e. user test cases and test criteria as stated in the DTS Change Control Document.

1.2 We recommend Medicaid develop an algorithm query and regularly monitor FFS Claims linked to capitations for recipient services covered by the ACO. Medicaid will then have knowledge of automated payment issues if presently occurring, make corrections and directly recover incorrect payments. UOIG will continue to perform post payment review.

1.3 We recommend Medicaid communicate with the ACO Plans and providers solutions for individual process issues listed in Cause and Effects number two above. Solutions for each issue may be available at different times based on complexity. For example, some hospitals have already implemented a solution to prevent issuance of FFS claims to Medicaid for newborn babies covered by an ACO Plan.

1.4 We recommend Medicaid and UOIG discuss modifications to the MOU that includes an SOP for reporting summary level information of incorrect payments prior to collection.

APPENDIX ONE	Division Operations Tracker (DOT) Exhibits A, B, C

Exhibit A: DOT 100040

Report: Task0100

Utah State Department of Health
Project Tracker
Task Detail

Date: 05/19/2020 10:28:36
Run By: XXXXX
Page 1 of 2

Issue No: **100040** Title: **ACO Carve Out Logic - Paid FFS Claims**

Creation Date: **10/09/2019**
Submit By: **XXXXXXX,XXXX**
Submit Team: **BMHC APPROVAL**
Type: **DISCREPANCY/MODIFICATION**
Category: **CLAIMS**
Severity: **2 - BY NEXT RUN OF PROCESS - PAYMENTS NOT WORKING CORRECTLY**
Required by Date: **10/31/2019**
Implementation Date:
Status: **COMPLETED**

Emergency: **NO** Emergency Implement Date:
Approved: **YES** Approved By: **XXXXXXX,XXXX**
Approved Date: **10/09/2019**
Assigned To: **XXXXXX,XXXX**
Assigned Team: **PROD_SUPPORT_DTS**

Description of Issue:

OIG has identified claims that have paid FFS where the member was enrolled in an ACO for the date of service. Please research and identify what criteria these claims are meeting to bypass the ACO edits.

Example TCN's:

24 TCNs Redacted

Completion Notes

Exhibit B: DOT 102162

Report: Task0100 | Utah State Department of Health Project Tracker | Date: 05/19/2020 10:22:14

Task Detail

Run By: XXXX

Page 1 of 2

Issue No: 102162 Title: **FFS paying ACO inpatient claims**

Creation Date: **01/23/2020**

Submit By: **XXXXXXXX**

Submit Team: **BMHC APPROVAL**

Type: **DISCREPANCY/MODIFICATION**

Category: **CLAIMS**

Severity: **1 - IMMEDIATE RESPONSE (1 DAY) - SYSTEM NOT WORKING**

Required by Date: **01/24/2020**

Implementation Date: **02/06/2020**

Status: **COMPLETED**

Emergency: **YES** Emergency Implement Date: **01/24/2020**

Approved: **YES** Approved By: **XXXXXXXXXXX**

Approved Date: **01/23/2020**

Assigned To: **XXXXXXX**

Assigned Team: **PROD_SUPPORT_DTS**

Description of Issue:

The ACO edit is not posting on inpatient claims. Related to DOT 100040. XXX has found the issue and said "
It is probably due to the changes I made in the aco programming to handle line items logic.
From what I can see, the inpatient claims just fell all the way through the logic and
everything that fell through posted the edit. But when we added the line item logic
I had to change the way it posted and without realizing it caused them to no longer
post."

Completion Notes

BACKGROUND:
See description.

REQUIREMENTS:
Add the logic in the ACO editing area after any other inpatient carve out check to deny the inpatient hospital claims to the ACO.

ANALYSIS:
The change needs to be made in HL801635 at the end of the ACO processing.

ACTIONS:
XXXXXX added logic to deny the inpatient hospital claims to the ACOs.

Mainframe Details

Object Type	Object Name	Init	Cntrl #	Action
Cobol w/changes	HL801635	GW	154832	Update

Install Instructions

Backout Instructions:

Exhibit C: DOT 103942 Page 1 of 2

Report: Task0100 | Utah State Department of Health Project Tracker | Date: 05/19/2020 08:00:53

Task Detail

Run By: XXXXX

Page 1 of 2

Issue No: 103942 Title: **FFS and X-OVER's PAYING ACO OUTPATIENT AND INPATIENT CLAIMS**

Creation Date: **04/16/2020**

Submit By: **XXXX,XXXXX**

Submit Team: **BMO APPROVERS**

Type: **DISCREPANCY/MODIFICATION**

Category: **CLAIMS**

Severity: **2 - BY NEXT RUN OF PROCESS - PAYMENTS NOT WORKING CORRECTLY**

Required by Date: **05/08/2020**

Implementation Date: **05/14/2020**

Status: **IMPLEMENTED**

Emergency: **NO** Emergency Implement Date: **05/08/2020**

Approved: **YES** Approved By: **XXXXXX**

Approved Date: **04/16/2020**

Assigned To: **XXXXXX**

Assigned Team: **PROD_SUPPORT_DTS**

Description of Issue:

FFS and X-Over claims for Outpatient and Inpatient continue to process with payment for ACO eligible Medicaid members. Edits are not posting to these claims. The issue continues post implementation of DOT 102162.

Examples:
Inpatient PT01
5 TCNs redacted

Outpatient PT01
7 TCNs Redacted

Outpatient PT53
11 TCNs Redacted

Completion Notes

BACKGROUND:
See description above.

REQUIREMENTS:
Figure out why outpatient hospital and inpatient hospital claims are not posting the aco edits.

ANALYSIS:
The logic to post the aco edit doesn't have logic to bypass outpatient hospital claims except for when they have a psych revenue code. Back about a year ago the logic was changed drastically for posting aco edits to the line level instead of the claims level. The prior logic must have posted to the outpatient and inpatient hospital claims by default. When the changes were made to post edits at the the line it was not known by the programmer that by default they would post. In dot 102162 XXXXXX modified the logic so it would post to inpatient hospital claims, but didn't add outpatient hospital claims at that time.

It was also discovered that all of the inpatient claims that were given to XXXX to use as tests all had what we call claim suspensions on them. This is put in by the bureau of managed care when a client goes into a nursing home. If the client is in an ACO and has a claim suspension for the time period of the claim, then the ACO edits are bypassed and the claim is paid FFS.

ACTIONS:
XXX XXXX modified the logic to add a check for outpatient hospital along with the current logic to check for inpatient hospital claims to post the edit if the client is

Exhibit C: DOT 103942 Page 2 of 2

Report: Task0100 | Utah State Department of Health Project Tracker **Task Detail** | Date: 05/19/2020 08:00:53 | Run By: XXXX | Page 2 of 2

BMO Lead:
XXXXXXX@utah.gov

in an ACO.

Mainframe Details

Object Type	Object Name	Init	Cntrl #	Action
Cobol w/changes	HL801635	ME	104400	Update
Install Instructions				
Backout Instructions:				

Notes

Status Changed From IN PROGRESS to WAITING ON SUBMITTER
Status WAITING ON SUBMITTER Email sent on 04/30/2020 to XXD@UTAH.GOV XXD@utah.gov
XXD@utah.gov XXD@utah.gov XXX@utah.gov XXD@UTAH.GOV XXD@UTAH.GOV
XXD@utah.gov XXD@utah.gov XXD@utah.gov XXD@utah.gov XXD@utah.gov
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Status Changed From WILL IMPLEMENT WITH NEXT RELEASE to IMPLEMENTED
Status Changed From WAITING ON SUBMITTER to WILL IMPLEMENT WITH NEXT RELEASE
Status WILL IMPLEMENT WITH NEXT RELEASE Email sent on 05/08/2020 to XXD@UTAH.GOV XXD@utah.gov
XXD@utah.gov XXD@utah.gov XXD@utah.gov XXD@UTAH.GOV XXD@UTAH.GOV
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Status Changed From IMPLEMENTED to WILL IMPLEMENT WITH NEXT RELEASE
Task Entered With Status of APPROVED
Task Entered With Status of APPROVED
Status APPROVED Email sent on 04/27/2020 to XXD@utah.gov XXD@UTAH.GOV XXD@utah.gov
XXD@utah.gov XXD@utah.gov XXD@utah.gov XXD@UTAH.GOV XXD@UTAH.GOV
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Status Changed From APPROVED to IN PROGRESS
Status IN PROGRESS Email sent on 04/27/2020 to XXD@UTAH.GOV XXD@utah.gov XXD@utah.gov
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XXD@utah.gov XXD@utah.gov XXD@utah.gov XXD@UTAH.GOV XXD@utah.gov XXM@utah.gov
Status Changed From WILL IMPLEMENT WITH NEXT RELEASE to IMPLEMENTED

APPENDIX TWO	DOS 2015: January – December Incorrect Payments by DRG

The table below summarizes the incorrect payments for calendar year 2015, by DRG and DRG description. The highlighted rows represent the FFS inpatient claims for delivery of babies whose mothers were covered prior to inpatient admission and for whom regular capitations and a special lump sum were paid.

DRG	DRG Description	Incorrect Payments
194	Simple Pneumonia And Pleurisy With Complication Or Comorbidity (CC)	$5,710
393	Other Digestive System Diagnoses With Major Complication Or Comorbidity (MCC)	8,649
765	Cesarean Section With CC or MCC	4,472
766	Cesarean Section Without CC or MCC	3,324
774	Vaginal Delivery With Complicating Diagnoses	2,678
775	Vaginal Delivery Without Complicating Diagnoses	8,729
776	Postpartum And Post Abortion Diagnoses Without O.R. Procedure	5,243
789	Neonates, Died Or Transferred To Another Acute Care Facility	42,984
790	Extreme Immaturity Or Respiratory Distress Syndrome, Neonate	13,193
791	Prematurity With Major Problems	47,793
792	Prematurity Without Major Problems	16,727
793	Full Term Neonate W Major Problems	52,113
794	Neonate With Other Significant Problems	11,699
795	Normal Newborn	86,870
871	Septicemia Or Severe Sepsis Without MV >96 Hours With MCC	18,587
	Grand Total	**$328,772**

APPENDIX THREE	DOS 2016: January – December Incorrect Payments by DRG

The table below reports the incorrect payment for calendar year 2016, only one claim, by DRG and DRG description.

DRG	DRG Description	Incorrect Payments
918	Poisoning & toxic effects of drugs w/o Major Complication Or Comorbidity	$4,067

APPENDIX FOUR	DOS 2017: January – December Incorrect Payments by DRG

The table below summarizes the incorrect payments for calendar year 2017, by DRG and DRG description. The highlighted rows represent the FFS inpatient claims for delivery of babies whose mothers were covered prior to inpatient admission and for whom regular capitations and a special lump sum were paid.

DRG	DRG Description	Incorrect Payments
025	Craniotomy And Endovascular Intracranial Procedures With Major Complication Or Comorbidity (MCC)	$25,894
299	Peripheral Vascular Disorders With MCC	6,463
643	Endocrine Disorders W MCC	9,239
793	Full Term Neonate With Major Problems	4,621
794	Neonate W Other Significant Problems	6,774
795	Normal Newborn	3,342
918	Poisoning And Toxic Effects Of Drugs Without MCC	3,992
	Total	$60,325

APPENDIX FIVE	DOS 2018: January – December Incorrect Payments by DRG

The table below summarizes the incorrect payments for calendar year 2018, by DRG and DRG description. The highlighted rows represent the FFS inpatient claims for delivery of babies whose mothers were covered prior to inpatient admission and for whom regular capitations and a special lump sum were paid.

DRG	DRG Description	Incorrect Payments
101	Seizures w/o MCC	$5,998
103	Headaches w/o MCC	3,648
153	Otitis media & URI w/o MCC	2,724
175	Pulmonary embolism w MCC	7,601
189	Pulmonary edema & respiratory failure	24,681
195	Simple pneumonia & pleurisy w/o CC/MCC	3,310
202	Bronchitis & asthma w CC/MCC	14,234
203	Bronchitis & asthma w/o CC/MCC	8,779
207	Respiratory system diagnosis w ventilator support 96+ hours	125,744
229	Other cardiothoracic procedures w CC	27,121
343	Appendectomy w/o complicated principal diag w/o CC/MCC	3,953
391	Esophagitis, gastroent & misc digest disorders w MCC	4,255
418	Laparoscopic cholecystectomy w/o c.d.e. w CC	7,020
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	7,987
639	Diabetes w/o CC/MCC	2,837
640	Nutritional & misc metabolic disorders w MCC	56,741
641	Nutritional & misc metabolic disorders w/o MCC	3,193
642	Inborn errors of metabolism	6,731
689	Kidney & urinary tract infections w MCC	9,833
699	Other kidney & urinary tract diagnoses w CC	39,527
760	Menstrual & other female reproductive system disorders w CC/MCC	33,100
774	Vaginal delivery w complicating diagnoses	6,287
787	Cesarean Section W/O Sterilization W MCC	4,200
788	Cesarean Section W/O Sterilization W CC	16,568
789	Neonates, died or transferred to another acute care facility	12,127
791	Prematurity w major problems	135,827
792	Prematurity w/o major problems	6,383
793	Full term neonate w major problems	180,787
794	Neonate w other significant problems	112,645
795	Normal newborn	117,408
805	Vaginal Delivery W/O Sterilization/D&C W MCC	7,812
806	Vaginal Delivery W/O Sterilization/D&C W CC	19,974
807	Vaginal Delivery W/O Sterilization/D&C W/O CC/MCC	70,996
832	Other Antepartum Diagnoses W/O O.R. Procedure W CC	6,710
853	Infectious & parasitic diseases w O.R. procedure w MCC	35,876
871	Septicemia or severe sepsis w/o MV 96+ hours w MCC	1,398

DRG	DRG Description	Incorrect Payments
880	Acute adjustment reaction & psychosocial dysfunction	6,290
885	Psychoses	8,274
886	Behavioral & developmental disorders	3,360
895	Alcohol/drug abuse or dependence w rehabilitation therapy	12,532
918	Poisoning & toxic effects of drugs w/o MCC	41,991
	Total (98% of Incorrect payment Amounts occurred August -December)	$1,206,462

APPENDIX SIX	DOS 2019: January – December Incorrect Payments by DRG

The table below summarizes the incorrect payments for calendar year 2019, by DRG and DRG description. The highlighted rows represent the FFS inpatient claims for delivery of babies whose mothers were covered prior to inpatient admission and for whom regular capitations and a special lump sum were paid.

DRG	DRG Description	Incorrect Payments
024	Cranio W Major Dev Impl/Acute Complex CNS PDX W/O MCC	$48,644
026	Craniotomy & Endovascular Intracranial Procedures W CC	16,875
027	Craniotomy & Endovascular Intracranial Procedures W/O CC/MCC	18,808
070	Nonspecific Cerebrovascular Disorders W MCC	15,701
072	Nonspecific Cerebrovascular Disorders W/O CC/MCC	49,700
084	Traumatic Stupor & Coma, Coma >1 Hr W/O CC/MCC	5,306
087	Traumatic Stupor & Coma, Coma <1 Hr W/O CC/MCC	9,018
101	Seizures W/O MCC	12,308
153	Otitis Media & URI W/O MCC	2,788
167	Other Resp System O.R. Procedures W CC	9,553
178	Respiratory Infections & Inflammations W CC	26,385
189	Pulmonary Edema & Respiratory Failure	36,290
194	Simple Pneumonia & Pleurisy W CC	4,369
195	Simple Pneumonia & Pleurisy W/O CC/MCC	9,209
202	Bronchitis & Asthma W CC/MCC	8,281
206	Other Respiratory System Diagnoses W/O MCC	3,766
207	Respiratory System Diagnosis W Ventilator Support 96+ Hours	44,962
247	Perc Cardiovasc Proc W Drug-Eluting Stent W/O MCC	13,292
252	Other Vascular Procedures W MCC	17,489
264	Other Circulatory System O.R. Procedures	11,441
270	Other Major Cardiovascular Procedures W MCC	116,486
271	Other Major Cardiovascular Procedures W CC	50,487
281	Acute Myocardial Infarction, Discharged Alive W CC	20,913
313	Chest Pain	28,004
328	Stomach, Esophageal & Duodenal Proc W/O CC/MCC	4,315
340	Appendectomy W Complicated Principal Diag W/O CC/MCC	22,719
354	Hernia Procedures Except Inguinal & Femoral W CC	20,665
371	Major Gastrointestinal Disorders & Peritoneal Infections W MCC	17,910
374	Digestive Malignancy W MCC	15,945
377	G.I. Hemorrhage W MCC	10,186
438	Disorders Of Pancreas Except Malignancy W MCC	9,208
464	Wnd Debrid & Skn Grft Exc Hand, For Musculo-Conn Tiss Dis W CC	12,613
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity W/O MCC	$13,050
481	Hip & Femur Procedures Except Major Joint W CC	10,863
494	Lower Extrem & Humer Proc Except Hip,Foot,Femur W/O CC/MCC	6,405
517	Other Musculoskelet Sys & Conn Tiss O.R. Proc W/O CC/MCC	7,912

DRG	DRG Description	Incorrect Payments
552	Medical Back Problems W/O MCC	5,046
603	Cellulitis W/O MCC	3,554
637	Diabetes W MCC	6,894
639	Diabetes W/O CC/MCC	2,837
640	MISC DISORDERS OF NUTRITION, METABOLISM, FLUIDS/ELECTROLYTES W MCC	5,495
641	Nutritional & Misc Metabolic Disorders W/O MCC	6,385
683	Renal Failure W CC	6,721
690	Kidney & Urinary Tract Infections W/O MCC	4,621
723	Malignancy, Male Reproductive System W CC	80,326
768	Vaginal Delivery W O.R. Proc Except Steril &/Or D&C	3,301
769	Postpartum & Post Abortion Diagnoses W O.R. Procedure	94,619
776	Postpartum & Post Abortion Diagnoses W/O O.R. Procedure	21,146
785	Cesarean Section W Sterilization W/O Cc/MCC	3,961
787	Cesarean Section W/O Sterilization W MCC	74,699
788	Cesarean Section W/O Sterilization W CC	85,744
789	Neonates, Died Or Transferred To Another Acute Care Facility	90,962
790	Extreme Immaturity Or Respiratory Distress Syndrome, Neonate	71,170
791	Prematurity W Major Problems	446,777
792	Prematurity W/O Major Problems	26,791
793	Full Term Neonate W Major Problems	191,638
794	Neonate W Other Significant Problems	140,600
795	Normal Newborn	244,748
805	Vaginal Delivery W/O Sterilization/D&C W MCC	13,826
806	Vaginal Delivery W/O Sterilization/D&C W CC	28,400
807	Vaginal Delivery W/O Sterilization/D&C W/O CC/MCC	246,464
832	Other Antepartum Diagnoses W/O O.R. Procedure W CC	12,050
833	Other Antepartum Diagnoses W/O O.R. Procedure W/O CC/MCC	6,319
847	Chemotherapy W/O Acute Leukemia As Secondary Diagnosis W CC	6,250
853	Infectious & Parasitic Diseases W O.R. Procedure W MCC	35,801
871	Septicemia Or Severe Sepsis W/O MV 96+ Hours W MCC	11,737
880	Acute Adjustment Reaction & Psychosocial Dysfunction	4,200
882	Neuroses Except Depressive	8,674
884	Organic Disturbances & Mental Retardation	10,211
885	Psychoses	5,846
897	Alcohol/Drug Abuse Or Dependence W/O Rehabilitation Therapy W/O MCC	20,591
917	Poisoning & Toxic Effects Of Drugs W MCC	33,833
948	Signs & Symptoms W/O MCC	4,196
982	Extensive O.R. Procedure Unrelated To Principal Diagnosis W CC	14,243
		$2,812,542

GLOSSARY OF TERMS

Term	Description
ACO	Accountable Care Organization, a type of MCO
BDOS	Beginning Dates of Service
BMHC	Medicaid's Bureau of Managed Healthcare
BMO	Bureau of Medicaid Operations
CC	Complications and Comorbidity
CMS	Centers for Medicare & Medicaid Services
DCR	Delivery Case Rate refers to a lump sum payment additional to the regular capitation payment, and covers the in-patient costs of pregnancy labor and delivery, for mother and baby. The DCR is $5,928 at January 2019 and forward.
DOH	Utah Department of Health
DOT	Division Operations Tracker: This is the online document used by Medicaid to request changes to the MMIS payment controls. DTS and Medicaid documentation of changes to the payment controls on the DOT.
DRG	Abbreviation for Diagnosis Related Group. A diagnosis-related group (DRG) is a patient classification system that standardizes prospective payment to hospitals and encourages cost containment initiatives. DRGs categorize patients with respect to diagnosis, treatment and length of hospital stay. The assignment of a DRG depends on the following variables: principal diagnosis, secondary diagnosis(es), surgical procedures performed, comorbidities and complications, age and sex, discharge status.
DTS	Utah Department of Technology Services. DTS personnel are located at DOH and work directly with DOH employees.
FFS	Fee-for-Service. This refers to the traditional billing of claims by providers of healthcare directly to the payer, in this case Medicaid.
MMCS	Medicaid Managed Care System

MMIS	Medicaid Management Information System
MCC	Major Complications and Comorbidity
MCE	Managed Care Entity (Generic)
MCO	Managed care organization
MOU	Memoranda of Understanding, agreement.
PI	Program Integrity
PIC	Utah Medicaid Program Integrity Committee.
PIHP	Prepaid Inpatient Health Plan
PAHP	Prepaid Ambulatory Health Plan
PRISM	Provider Reimbursement Information System
PTAT	Project Team Assignment Tracker
SME	Subject Matter Expert is the responsible party for the particular function or subject.
SOP	Standard Operating Procedure
TCN	Transaction Control Number
UOIG	Utah Office of Inspector General
Audit	UOIG performs audits to report findings, recommendations and obtain DOH Medicaid corrective action commitments to recommendations.
Evaluation	UOIG performs evaluations to study particular topics of Utah Medicaid documenting results internal to UOIG only. UOIG does not issue an evaluation report outside of UOIG.

MANAGEMENT RESPONSE

State of Utah
SPENCER J. COX
Governor
DEIDRE M. HENDERSON
Lieutenant Governor

Utah Department of Health
Executive Director's Office

Richard G. Saunders
Executive Director

Heather R. Borski, M.P.H., M.C.H.E.S.
Deputy Director

Division of Medicaid and Health Financing
Nate Checketts
Director, Division of Medicaid and Health Financing

February 16, 2021

Gene Cottrell
Inspector General
Office of the Inspector General of Medicaid Services
P.O. Box 14103
Salt Lake City, Utah 84114

Dear Mr. Cottrell:

Thank you for the opportunity to respond to the audit titled *Audit of Inpatient Fee-for-Service Claims Paid Incorrectly* (Report Number 2019-03). We appreciate the effort and professionalism of you and your staff in this review. Likewise, our staff spent time collecting information for your review, answering questions, and planning changes to improve the program. We believe that the results of our combined efforts will make a better, more efficient program.

We concur with the recommendations in this report. The Department of Health is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Emma Chacon
Emma Chacon (Feb 16, 2021 16:26 MST)

Emma Chacon
Operations Director, Medicaid and Health Financing

UTAH DEPARTMENT OF HEALTH
288 North 1460 West, Box 143101 • Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 • medicaid.utah.gov

Response to Recommendations

Recommendation 1.1

> *We recommend Medicaid document through a Division wide SOP the Bureau and inter-Bureau roles and responsibilities for DOTs. Include policy or guidelines covering the items DTS relies on Medicaid to provide, i.e. user test cases and test criteria as stated in the DTS Change Control Document.*

Department Response:

The Department concurs with this recommendation. The Division has started discussing the need for a broader approach to DOT creation and implementation in order to avert unintended consequences and better ensure the programming results in the intended outcome. The Division will create an SOP that outlines inter-Bureau roles and responsibilities as well as expectations related to the role DTS plays in DOT programming and implementation.

Contact: Eric Grant, Assistant Division Director, Division of Medicaid and Health Financing, 801 538-7099
Implementation Date: 4/1/2022

Recommendation 1.2

> *We recommend Medicaid develop an algorithm query and regularly monitor FFS Claims linked to capitations for recipient services covered by the ACO. Medicaid will then have knowledge of automated payment issues if presently occurring, make corrections and directly recover incorrect payments. UOIG will continue to perform post payment review.*

Department Response:

The Department agrees with this recommendation. The Department will convene a workgroup to review the necessary resources and any systems requirements for the development and implementation of this recommendation. The Department will continue to rely on the UOIG to exercise its role as the organization responsible for Medicaid program integrity including post-payment review of managed care plan billing and reimbursement.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: 4/1/2022

Recommendation 1.3

We recommend Medicaid communicate with the ACO Plans and providers solutions for individual process issues listed in Cause and Effects number two above. Solutions for each issue may be available at different times based on complexity. For example, some hospitals have already implemented a solution to prevent issuance of FFS claims to Medicaid for newborn babies covered by an ACO Plan.

Department Response:

The Department concurs with this recommendation. The Department has convened a workgroup to develop official communication to providers and managed care entities on cost-avoidance processes and preventing incorrect payments to providers. The Department will solicit UOIG feedback on proposed correspondence to ensure consistency with messaging between the Department and the UOIG.

Contact: Greg Trollan, Bureau Director, Bureau of Managed Health Care, 801-538-6088
Implementation Date: 4/1/2022

Recommendation 1.4

We recommend Medicaid and UOIG discuss modifications to the MOU that includes an SOP for reporting summary level information of incorrect payments prior to collection.

Department Response:

The Department concurs with this recommendation. The Department will review this recommendation in the Program Integrity Committee and map out a plan for updating the MOU to support better coordination in the collection of incorrect payments. As part of this work, the Department and UOIG will develop an SOP that delineates roles, responsibilities, and procedures for this particular activity.

Contact: Eric Grant, Assistant Division Director, Division of Medicaid and Health Financing, 801 538-7099
Implementation Date: 4/1/2022

EVALUATION OF MANAGEMENT RESPONSE

Utah Medicaid Management concurs with the findings and recommendations of this report. Management designated a responsible person to implement changes within a reasonable deadline. Management's response is adequate.

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

UTAH OIG CONTACTS

Ron Sufficool
Lead Auditor

Neil Erickson
Audit Manager

UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General of Medicaid Services, on behalf of the Utah Taxpayer, will comprehensively review Medicaid policies, programs, contracts and services in order to identify root problems contributing to fraud, waste, and abuse within the system and make recommendations for improvement to Medicaid management and the provider community.

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