Annual Report
Fiscal Year 2021

Utah Office of Inspector General

Medicaid Services

“2021 Fraud, Abuse and Waste Elimination Efforts”

Message from the Inspector General of Medicaid Services

I am pleased to present the SFY 2021 Annual Report of the Utah Office of Inspector General (UOIG or Office) of Medicaid Services to Governor Cox, the State Legislature, and the citizens of Utah. The goal of the UOIG is to eliminate fraud, abuse, and waste in the Medicaid system, thereby saving taxpayer dollars. The UOIG conducts audits and investigations of fee-for-service populations and provides oversight of the managed care programs' special investigations units. Medicaid constitutes one of the largest state expenditures and UOIG staff take their fiduciary responsibility to the taxpayers of Utah seriously.

The Office recouped nearly $4.67 million dollars and saved the taxpayers an additional $21 million in cost avoidance during SFY 2021. The COVID-19 Public Health Emergency, declared in March 2020, continued to present the office with challenges, especially during the first half of SFY 2021. However, as restrictions on investigative processes began to ease, the Office began conducting on-site visits to providers suspected of inappropriate billing practices. Most UOIG employees continue to telework and the Office has adjusted to this new work environment.

During SFY 2022, the UOIG will continue providing oversight of taxpayer dollars expended in Medicaid. The Office will make adjustments as needed, in response to the ongoing public health emergency. The Inspector General encourages all stakeholders to remain vigilant in identifying and reporting fraud, abuse, and waste in the Medicaid system. This year the Office begins reviewing claims related to the COVID-19 response to identify fraud, abuse, and waste that may occur because of the easing of restrictions due to the emergency response. We will continue working closely with all stakeholders to ensure our state and federal tax dollars are spent appropriately in providing necessary treatment and services to Utah Medicaid recipients.

Respectfully,

Gene D. Cottrell

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Inspector General
Office of Inspector General of Medicaid Services

SFY 2021 UOIG Tabulated Data	
Total recoupment:	**$4,674,938**
Recoupment by Cash	**$1,026,766**
Recoupment by Rebilled Claims	**$2,735,727**
Recoupment by Credit Adjustment	**$912,440**
Total recoupment since creation of the Office (2011) (all methods)	**$79,419,712**
Savings through cost avoidance	**$21,236,663**
Total estimated Medicaid savings from cost avoidance*	**$87,985,287**
Number of leads opened	**327**
Medical records requested	**711**
Medical records received	**654**
Transaction Control Numbers (TCN) reviewed	**3618**
Data pulls conducted	**592**
Notices of Recovery sent	**990**
Referrals to other agencies:	**62**
Medicaid Fraud Control Unit	**2**
Department of Workforce Services	**32**
Medicaid Information Bulletins (MIB) reviewed:	**5**
Total Number of MIBs Released by Medicaid	**9**
Number of MIBs Medicaid published without UOIG review	**4**
Number of MIBs Reviewed	**85**
Number of recommendations made	**164**
Medicaid Administrative Rules reviewed	**18**
State Medicaid Plan Amendments reviewed	**11**
External training events:	**4**
Number of participates trained	**788**

* The Office began tracking cost avoidance in 2017. The cost avoidance amount is an estimate and may increase or decrease based on continued observations of the effectiveness of changes brought about through a UOIG Project.

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What is Program Integrity?

The Center for Medicare and Medicaid Services (CMS) defines Program Integrity (PI) in the simplest of terms; "Pay it Right". This simplified definition perfectly underscores the importance of effective Program Integrity and the impact good Program Integrity has on a State's overall Medicaid program. A holistic approach to Program Integrity, by all stakeholders, is critical: the right amount must be paid to properly vetted providers who provide covered, reasonable and necessary services to eligible Medicaid recipients, while effectively identifying and eliminating fraud, abuse, and waste. The Utah State Medicaid Program evolves quickly; therefore, the State's program integrity strategy must keep pace and address challenges as they arise. Paying it right ensures the state uses taxpayer dollars in the most efficient manner while providing adequate medical care for the most vulnerable of the Utah population.

The Code of Federal Regulations, at 42 CFR § 455.12, requires each Medicaid State Plan to meet the requirements of §§ 455.13 through 455.23.[1] The referenced sections include processes for identifying fraud, abuse, and waste, and outline actions the State's PI unit must take upon identifying instances of fraud, abuse, and waste. The Utah State Legislature created the Utah Office of Inspector General of Medicaid Services (UOIG or Office) in 2011, as an independent agency responsible for conducting program integrity on behalf of the taxpayers of Utah. The Inspector General model is an increasingly popular model amongst states for addressing the federal PI requirements, while creating some level of independence from the Single State Agency whose role is to administer the overall Medicaid program. A pair of audits conducted by the Utah State Office of Legislative Auditors (OLAG) in 2009 and 2010 identified that the task of administering the State Medicaid Program and performing program integrity responsibilities can, or have the potential to conflict when the same entity is responsible for both.

The goal of the Utah Office of Inspector General of Medicaid Services is to eliminate Medicaid fraud, abuse, and waste. The Office seeks to achieve that goal by:

- Receiving complaints of fraud, abuse, and waste from stakeholders, including the general public
- Conducting preliminary investigations of complaints
- Conducting provider audits
- Coordinating Program Integrity efforts across all State Medicaid Programs
- Recovering paid Medicaid funds that have been improperly paid
- Referring cases to the Medicaid Fraud Control Unit and local law enforcement for criminal investigation
- Conducting performance audits of Single State Agency controls
- Providing oversight of contracted managed care entities
- Educating the provider community and state agencies on emerging fraud trends
- Making recommendations to the Single State Agency for efficiency improvement

UOIG staff take their responsibility to the Utah taxpayer seriously and make every effort to achieve that goal. Although program integrity is every stakeholder's responsibility, ultimate responsibility to implement UOIG recommendations, or not, lies with the Single State Agency who administers the

[1] https://www.law.cornell.edu/cfr/text/42/455.12, accessed on 7 Oct 2020.

State's Medicaid program. Lawmakers and other key stakeholders should always consider program integrity implications when considering changes to the Medicaid program.

SFY 2021 Recoupments

The most visible key performance indicator of the Office's work is recoupment of improper payments to providers. Many factors contribute to improper payments and the Office finds that most improper payments are not fraudulent. Unclear Medicaid policy, ineffective edits in the Medicaid payment system, and provider billing errors may be the cause of improper payments. During an average year, the Office expects to recoup between $3-5 million, consistent with recoveries in states with similar population and Medicaid programs. It is impossible to accurately predict the recoupment amounts the Office will return to the state for future years, due to the unpredictability of future findings.

The UOIG issues Notices of Recovery (NOR) after careful review of leads that include a thorough Medicaid policy review, data analysis and a review of medical records, if needed. During SFY 2021, the UOIG issued 990 NORs. Through the NORs, the UOIG recouped $4,674,938.

The UOIG uses three methods to recoup Medicaid funds: cash collection, claims rebilling, and credit adjustment. In SFY 2021 cash recoupment accounted for 22%, or $1,026,766, rebilled claims recoupment accounted for 47%, or $2,216,509, and recoupment through credit adjustment accounted for 31%, or $1,431,663 (*See Figure 1*).

Occasionally providers discover errors in their own billing practices and voluntarily return Medicaid funds to the program. During SFY 2021, the Office received no recoveries from provider self-reports. Consequently, the UOIG incorporated provider self-reporting into the SFY 2022 training plan.

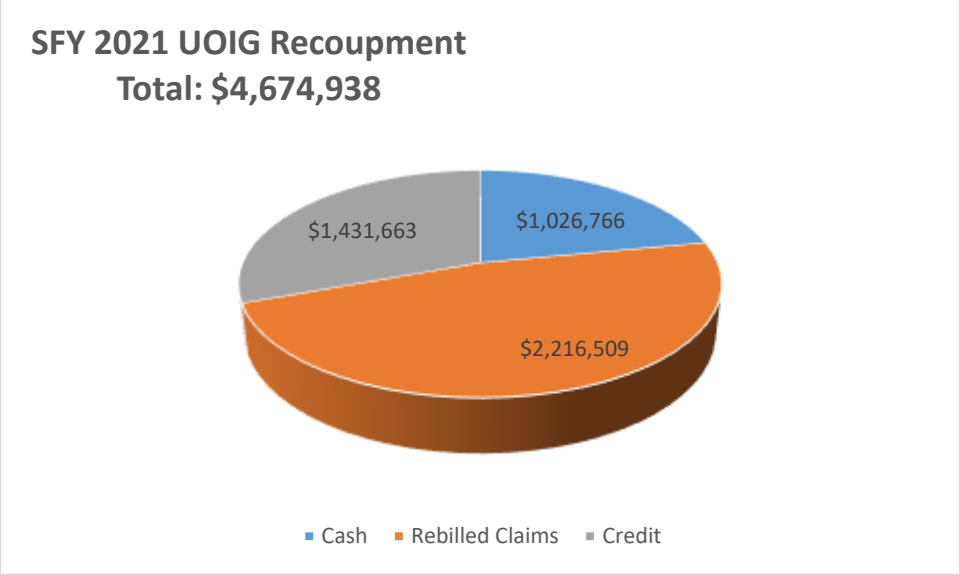

Figure 1. SFY 2020 Recoupments

The UOIG has recouped $79,429,712 since the State Legislature created the Office in 2011.

Managed Care Entity (MCE) Payment Reviews

In January 2021, the Single State Agency, updated the Accountable Care Organization (ACO) contracts to include wording that allowed the UOIG to review and recoup Medicaid claims that the ACO paid inappropriately. The contracts allow the ACO one year to review their own claims and recoup inappropriately paid funds before the UOIG can review the claims. In January 2022, the UOIG will begin reviewing encounter claims that are older than one year. The UOIG developed a standard operating procedure for these types of reviews and requested that the Single State Agency determine the best recovery method for recoupment of claims once the Office identifies the need. The Office submitted that request in May 2021 and as of the publication of this report does not have an answer. The UOIG recommends an offset against future capitated payments, but cannot make that contractual determination on its own.

Due to the four to six month period it takes to conduct an audit or an investigation, the UOIG expects there will be few recoveries from this work in SFY 2022. The Office anticipates ongoing recoveries of this nature starting in SFY 2023.

Cost Avoidance

Cost avoidance is savings to the Medicaid program attributable to actions taken by the UOIG, including recommendations to the Single State Agency that cause positive changes in the program.

The UOIG determines cost avoidance by observing trends prior to a project and then again after completion of the project. To determine cost avoidance, the Office compares the average difference in billing behavior and projects the associated savings over five years. For example, if Provider A is upcoding evaluation and management (E&M) codes and billing Medicaid for $50,000 annually, the Office may perform a recoupment, and simultaneously conduct provider training. The Office then continues to monitor Provider A's billing practices to observe any changes. If Provider A's billed charges drop to $20,000 the following year, due to appropriately billing, the cost avoidance (taxpayer savings) is $30,000 which represents the change in billing behavior by the provider. The UOIG projects $30,000 annually for the next year and continues to monitor the provider, at least annually, to ensure the claimed cost avoidance remains.

The UOIG operationalized the current cost avoidance methodology during 2018 and it became a model adopted by other states.

Cost Avoidance Results

The UOIG saved the state $21,212,061 during SFY 2021. Figure 2 shows the cost avoidance trend since UOIG implemented the methodology. *(See figure 2)*

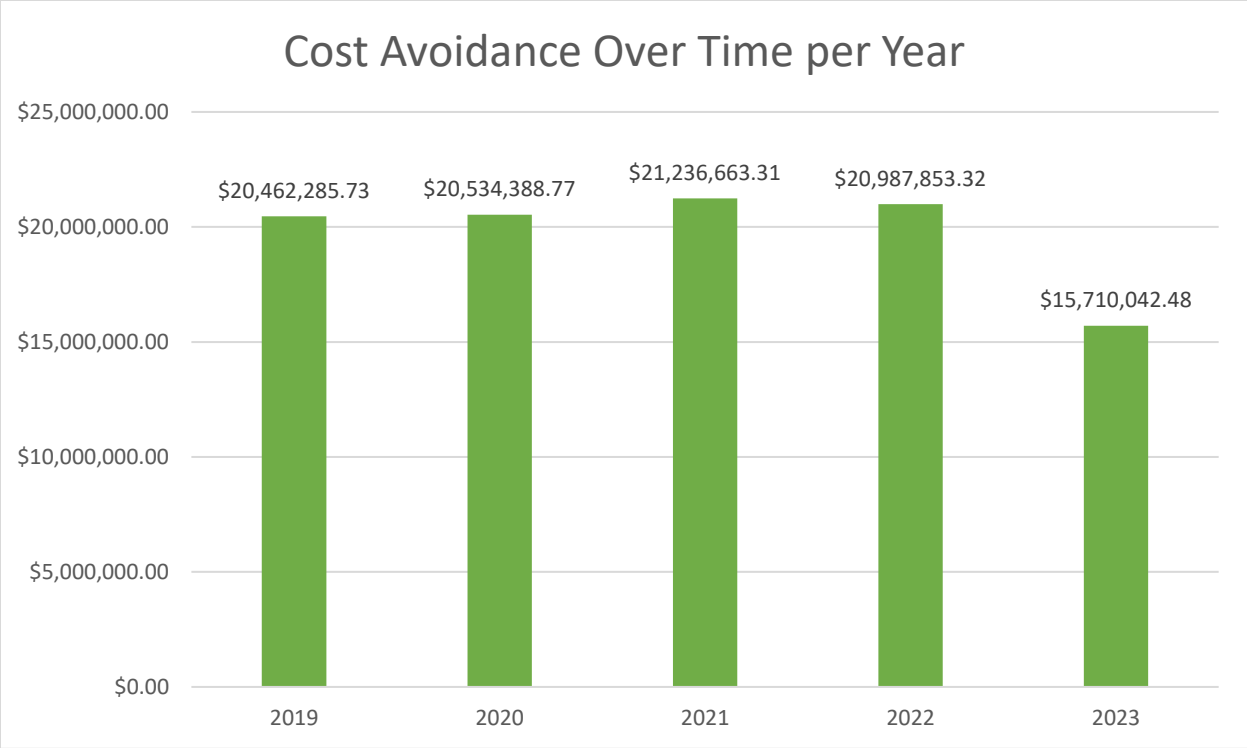

Figure 2. Cost Avoidance Over Time

The UOIG estimates $87,985,287 in cost avoidance savings to the State Medicaid program since it started tracking cost avoidance in 2017. This estimate does not include projected savings for any years beyond SFY 2021.

Audit Activities

The UOIG conducts financial and performance audits in accordance with Utah Code 63A-13-202. The Inspector General classifies audits into two categories: provider audits/reviews, and audits of the State's Medicaid program.

Provider Audits/Reviews

The Office performs provider audits and reviews to ensure Medicaid contracted providers comply with Medicaid policies. Provider audits focus on medical necessity, proper documentation, appropriate medical coding and billing. The UOIG usually conducts this process as a desk audit where the office requests records from the provider, reviews the records, and determines if the provider used appropriate coding to bill Medicaid. UOIG Nurse Investigators review claims at the transaction control number (TCN) level and during SFY 2021 they reviewed 3,618 TCNs. The Office issued 990 Notices of Recovery based on TCN reviews.

Performance Audits and Evaluations

The UOIG conducts performance audits and evaluations of all Medicaid programs in accordance with Utah Code 63A-13-202(h). The purpose of performance audits and evaluations is to ensure the State Medicaid program operates in the most efficient and cost-effective way. This legislatively-assigned role

is undoubtedly the most contentious with the Single State Agency. However, testing program controls is an essential element of identifying waste in the Medicaid program. During SFY 2021 the UOIG Audit Section completed four performance Audits. The audit results included 23 policy recommendations and 2 observations. Medicaid accepted 21 of the recommendations and partially accepted two. They accepted both observations. Additionally, the audit section completed two provider audits with one resulting in a fraud referral to the Medicaid Fraud Control Unit.

Interested parties may find copies of audits on the UOIG website at, https://oig.utah.gov .

Program Integrity Coordination Efforts

The Office coordinates PI efforts with various stakeholders. While the State Legislature intends that the Office remain completely independent, the reality is that, the Department of Health is the Single State agency responsible for administering the Medicaid Program. The UOIG works closely with the Division of Medicaid and Health Finance (DHMF) to coordinate many program integrity projects, while seeking to remain professionally independent. DHMF does not direct the work of the Office, but coordination is key to successful Program Integrity. In addition to DMHF, other state agencies such as the Department of Workforce Service (DWS) and the Department of Human Services (DHS) are critical in identifying fraud, abuse, and waste within the Medicaid program. The Office also meets monthly with the Attorney General's Medicaid Fraud Control Unit (MFCU) to discuss fraud referrals and status of ongoing investigations.

In addition to state agencies, the Office coordinates with contractors who play a key role in the State's Program Integrity efforts.

Managed Care Entities (MCE)

The Utah State Medicaid Authority manages about 80% of Medicaid through contracts with Managed Care Entities (MCE). Each MCE contractually maintains a program integrity unit, or special investigations unit (SIU), to address fraud, abuse and waste identification and reporting. The UOIG and MFCU meet quarterly with the individual SIUs to discuss concerns and to share information about evolving fraud schemes. The UOIG also hosts a quarterly combined meeting of all SIUs to present training and exchange information amongst the various groups.

Western Region Unified Program Integrity Contractor (UPIC-W)

The Centers for Medicaid and Medicare Services (CMS) incorporated a new contractor program designed to assist states in their Program Integrity efforts. The Western Region contractor is Qlarant, which covers all western states including the Pacific Island territories. DOH opted not to create a data feed to Qlarant, but the Office refers some projects to Qlarant and assists in ad hoc data pulls for those projects. The advantage of utilizing the UPIC-W is that the contractor helps strengthen areas where the Office may not have particular expertise. The Office holds monthly meetings with Qlarant to receive updates regarding referred projects and to discuss emerging fraud trends. UPIC contractors are free to the States and are therefore, a cost effective tool in the State's fight against Medicaid fraud, abuse, and waste. During SFY 2021, the UOIG completed the first project with Qlarant. The Office referred a review of Utah hospice providers to Qlarant, which resulted in a recovery of $175,000. The UOIG has four additional projects underway with Qlarant.

Health Fraud Prevention Partnership (HFPP)

During SFY 2021, the UOIG joined the Health Fraud Prevention Partnership. This partnership is a CMS contracted third party that seeks to identify and address fraud schemes across multiple jurisdictions. It includes Program Integrity Units, MCE SIUs, and law enforcement at all levels from multiple states. The HFPP conducts studies of emerging fraud trends using data from all partners, and releases white papers based on their findings. If the HPFF identifies Utah as a possible target of an emerging fraud trend, they notify the state's Program Integrity unit so they can take appropriate action. Participation in HFPP is free to state partners and a valuable resource for identifying emerging trends.

Data and Records Usage

Utah State Code authorizes the UOIG's access to records and data held by "state executive branch entities; all local government entities, and all providers" to help identify and eliminate fraud, abuse, and waste in the Medicaid program. While some entities question the Office's access to records, the Inspector General feels that current access is adequate to accomplish the Office's mission.

The UOIG's data scientists, nurse investigators and auditors use medical records and available databases to confirm medical necessity, correct coding, and proper payment of claims submitted to the Division of Medicaid and Health Financing. Additionally, the UOIG's two data scientists build algorithms to monitor specific providers or provider groups to identify outliers that may require additional review.

During SFY 2021, the Office pulled data from available Medicaid sources 592 times.

Fraud Referrals

The UOIG makes fraud referrals in two categories: provider fraud and recipient eligibility fraud. The Office refers provider fraud to the Attorney General's Medicaid Fraud Control Unit (MFCU). Recipient eligibility fraud is referred to the Department of Workforce Services who make eligibility determinations and investigate instances of fraud where the recipient received Medicaid eligibility through fraudulent claims. The total number of fraud referrals in SFY 2020 were two to MFCU and 30 to DWS.

Fraud, Abuse and Waste Training Opportunities

The UOIG continually seeks training opportunities. The Office classifies training as external or internal.

Internal Training

The UOIG conducts internal training to improve auditing and investigative skills and to keep staff informed about emerging fraud schemes. UOIG management select staff to attend national and local fraud conferences and then return to report and instruct others in the Office, as applicable.

External Training

Providers, provider groups, professional organizations and other state agencies are examples of external groups the Office trains. External training serves two purposes: inform and improve. All Medicaid stakeholders carry responsibility for identifying and reporting of Medicaid fraud, therefore, the Office conducts external training on those processes. The Office also provides training on how to improve poor

billing practices within the provider community. During SFY 2021, the Office conducted four external training events and trained 788 attendees. Training opportunities decreased during much of SFY 2021 due to the ongoing public health emergency so the UOIG created a training plan, described below, to increase fraud identification and reporting awareness.

Training Plan

During SFY 22, the UOIG introduced a new training program designed to instruct a broader audience in fraud identification and reporting. The first two training events occurred in September 2021 with over 250 participants attending online training sessions. Participants included members of the provider community, Managed Care Entities, and state partners. Members of the Kentucky Program Integrity Unit also attended as they start building their own, similar training program. The Office will continue offering quarterly training sessions in this online format. Stakeholders who wish to participate in this training can visit the UOIG website at https://oig.utah.gov for additional information.

Program and Policy Review

The UOIG conducts reviews of Medicaid Information Bulletins (MIB), Department Administrative Rules, Medicaid provider manuals, State Implementation Plans and State Plan Amendments to identify conflicts between those documents in accordance with Utah Code 63A-13-202(2)(b and c). The UOIG submits recommendations for clarification to DMHF when they identify conflicting policy. These reviews protect the Medicaid Program by ensuring providers understand their responsibilities as a Medicaid provider.

During SFY 2021, Medicaid released nine MIBs, but only submitted five to the UOIG for review prior to issuing them. The UOIG reviewed 85 articles within the five MIBs it reviewed and made 164 recommendations. The UOIG also reviewed 11 State Plan Amendments and 18 Administrative Rules for conflicts.

Conclusion

UOIG Employees take great pride in their work of safeguarding taxpayer dollars through oversight of Utah State's Medicaid program. Through vigilance, cooperation with stakeholders, and tireless effort the Office will continue seeking its goal of eliminating fraud, abuse and waste.

During SFY 2022, the Office will continue refining processes and continue improving the skills necessary to achieve that goal. It is our pleasure to serve the great State of Utah.