Annual Report
Fiscal Year 2023

Utah Office of Inspector General

Medicaid Services

“2023 Fraud, Abuse and Waste Elimination Efforts”

Message from the Inspector General of Medicaid Services

The Utah Office of the Inspector General of Medicaid Services (UOIG) presents the SFY23 Annual Report to Governor Cox, the State Legislature, and the citizens of Utah. The UOIG's goal 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 Utah's largest state expenditures and UOIG staff take their fiduciary responsibility to the taxpayers of Utah seriously.

The Office recouped $3.13 million dollars and saved the taxpayers an additional $21.7 million in cost avoidance during SFY 2023.

During SF24, the UOIG will continue providing oversight of taxpayer dollars expended in Medicaid. The UOIG will remain vigilant for ongoing and emerging fraud schemes that negatively impact the state's ability to provide safe and adequate care to the vulnerable population that Medicaid serves. The Inspector General encourages all stakeholders to remain vigilant in identifying and reporting fraud, abuse, and waste in the Medicaid system. 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.

It is our great honor to continue serving the taxpayers of the great State of Utah.

Respectfully,

Gene D. Cottrell

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Inspector General
Office of Inspector General of Medicaid Services

SFY 2023 UOIG Tabulated Data	
Total recoupment:	**$3,131,538**
Recoupment by Cash	**$210,259**
Recoupment by Rebilled Claims	**$217,239**
Recoupment by Credit Adjustment	**$2,704,040**
Total recoupment since creation of the Office (2011) (all methods)	**$105,987,867**
Savings through cost avoidance (SFY23)	**$21,747,823**
Total estimated Medicaid savings from cost avoidance*	**$138,711,243**
Return on Investment Recovery Only (SFY23)	**102.08%**
Return on Investment Cost Avoidance Only (SFY23)	**708.90%**
Total Return on Investment, Recovery + Cost Avoidance (SFY23)	**810.98%**
Average Return on Investment since 2016, Recovery + Cost Avoidance	**845.93%**
Dollars at Risk referred to MFCU for full investigation (SFY23)	**$18,608,208**

* The Office began tracking cost avoidance in 2016.

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Recoveries

The Utah Office of the Inspector General of Medicaid Services (UOIG or Office) recovers funds that are inappropriately billed by providers. The cause of most recoveries are errors in billing by providers, most commonly due to miscoding or misinterpretation of Medicaid policy. If a provider does not have a history of inappropriate billing and if the claims do not present a pattern of fraud a recovery action is undertaken to recoup the inappropriately billed Medicaid funds.

The Recovery action includes a detailed review of Medical records that support the billing of Medicaid Services. The UOIG requests those records from the provider. Those records are then reviewed by the UOIG staff for accuracy, completeness and appropriateness of coding.

During an average year the UOIG expects to recover between $3-5 million.

The UOIG conducts recoveries using three techniques:

- **Cash Collection** is done through checks drafted by the provider to cover the amount of the recovery.
- **Directed rebilling of claims**. In many instances inappropriately billed claims can be voided and rebilled correctly. The amount of recovery is calculated using the difference between the inappropriately billed claims and the corrected claims. This recovery technique is the most desirable of the three, as it also serves as a training opportunity for the provider.
- **Offsets against future payments.** Offsets are a claims system process where a debt is entered into the system and future payments are adjusted until the debt is satisfied. Frequently when the Office uses offsets it is because the provider requests it as a way to refund inappropriately billed claims. However, the Office may impose offsets if a provider refuses to participate in the recovery process. An example of such refusal is a Provider's failure to submit requested medical records in a timely manner.

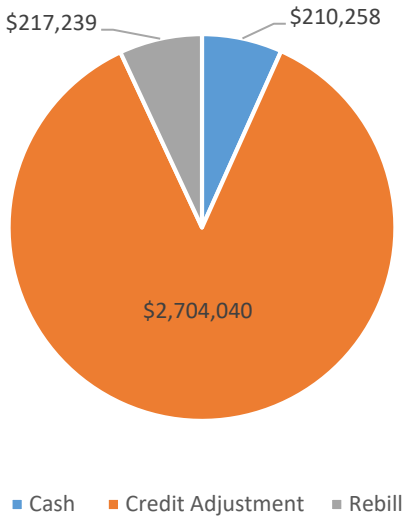

Figure 1. SFY23 Medicaid Recoveries

During SFY 2023 the UOIG recovered $3.13 million dollars of inappropriately billed claims. Importantly, these recovery amounts do not include fraud-related recoveries at outlined in the next section of this report.

Administrative review rights accompany every Notice of Recovery the Office issues in accordance with Administrative Rule R30-2.

Figure 2 shows UOIG recoveries for the past six years. In all cases, recoveries are guided by Medicaid Policy and Correct Coding Initiatives. The decrease in 2023 recoveries is due, in part, to the implantation of the new Medicaid claims management system, commonly called PRISM. PRISM implementation left the Office partially blind to Medicaid data for the last quarter of the

fiscal year. That condition is being worked through in coordination with the Single State Agency, but will likely continue to have some impact into SFY2024. The Inspector General cautions against setting arbitrary recovery goals which have potential to artificially inflate recoveries.

In the past six fiscal years the UOIG recovered **$31,962,083**.

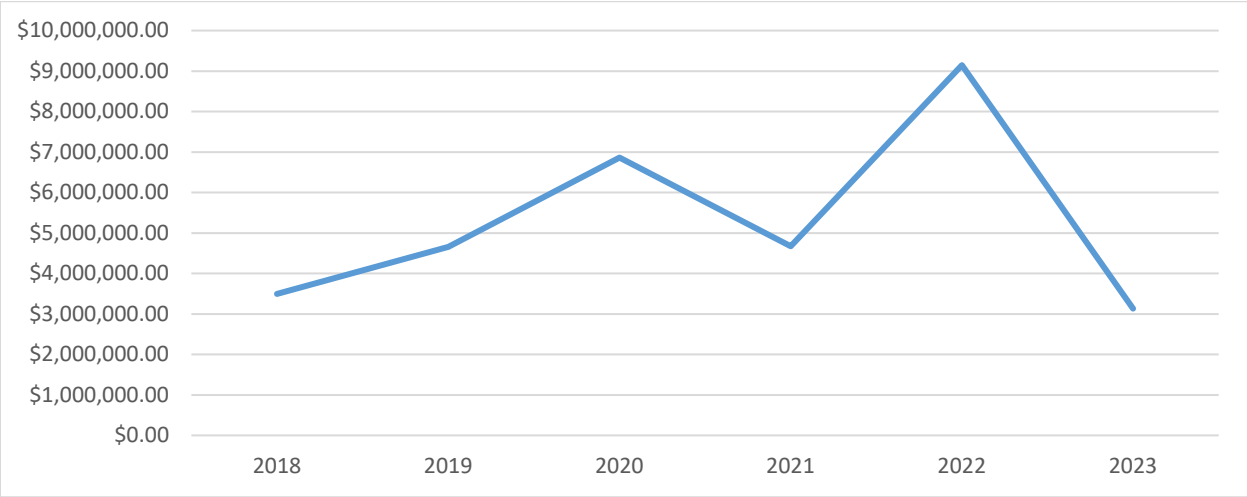

Figure 2. UOIG Recoveries for the past six years

Fraud Investigations

The UOIG does not have prosecutorial authority. The responsibility for conducting full criminal investigations and prosecution of providers lies with the Medicaid Fraud Control Unit (MFCU) and for recipients with the Department of Workforce Services Investigation Unit. The UOIG's role in fraud is outlined in 42 CFR § 455. Once the Office receives an allegation of fraud, from any source, it conducts a preliminary investigation. The purpose of the preliminary investigation is to determine if a fraud referral is credible and warrants a full criminal investigation.

The Office of Inspector General refers all credible allegations of fraud to MFCU for full investigation. MFCU reviews the referral and can choose from three courses of action. They can accept the referral and begin their full investigation, they can reject the referral, or they can send the referral back to the UOIG for further development. In instances where MFCU rejects the referral, they send it back to UOIG who conducts other administrative actions.

During SFY2023, the UOIG received 294 complaints on the fraud hotline.

During SFY2023, the UOIG referred eight providers to MFCU for full investigation. The dollars at risk for those 8 cases is projected at $18,608,208.

Initiatives to Identify Medicaid Abuse and Waste

The Office conducts initiatives that are designed to identify Abuse and Waste within the Utah State Medicaid program. Initiatives include performance audits, evaluations, provider assessments, and medical record reviews.

Abuse. CMS defines this type of abuse as, "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program".

Waste. CMS does not adequately define waste. However, Utah Code 63A-13-102(13) defines waste as, "(a) "Waste" means the act of using or expending a resource carelessly, extravagantly, or to no purpose. (b) "Waste" includes an activity that: (i) does not constitute abuse or necessarily involve a violation of law; and (ii) relates primarily to mismanagement, an inappropriate action, or inadequate oversight".

Abuse primarily occurs from billing errors by providers. Overtime those errors can become common practice. The UOIG uses Medicaid record reviews to ensure services provided to Medicaid recipients are performed, billed correctly using correct coding, and then paid appropriately through the Medicaid claims system. Abuse can become Fraud if a provider continues improper billing practices after the UOIG takes administrative action.

Waste can occur at any level of the Medicaid program. It is important that laws and policies are clear and give providers adequate guidance when submitting claims for rendered services. Waste may also occur if processes lack adequate controls or have adequate controls that are not adhered to. The UOIG conducts performance audits of programs to test controls in order to ensure taxpayer dollars are not expended wastefully.

During SFY2023 the UOIG conducted six performance audits. Those audits are available for review on the UOIG website at oig.utah.gov.

Outcomes

UOIG administrative actions result in a number of outcomes and may include a combination of outcomes. Audits, provider assessments, and claims reviews may result in one of the following outcomes:

- Recovery, Rebill, or Cash Recovery as outlined in the recovery section of this report.
- Training is often used as the least intrusive approach to correcting inappropriate billing. If a provider's billing practices are deemed low to mid risk the Office issues training letters. If the billing practice is deemed mid to high risk the office conducts on-site training to correct the behavior. The benefits of training are captured in the Office's cost avoidance calculations.

In every case recovery instance the provider is given an opportunity to request reconsideration in a settlement conference. At any time during the reconsideration process, either party may request to take the matter to hearing.

Stakeholder Training

One of the UOIG's responsibilities under Utah Code 63A-13 is the training of stakeholders on the identification and reporting of Medicaid fraud, abuse, and waste. During SFY23 the Office added training opportunities for Medicaid staff, providers and managed care entities. The UOIG especially focused its training efforts on the Prepaid Mental Health Plans (PMHP); an area that previously was not trained.

During SFY23 the Office participated in 20 training sessions and trained 1,381 stakeholders. The Office is willing to present training relevant to fraud identification and reporting to any stakeholder that is interested.

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 appropriate 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 $21,747,824 during SFY23. Figure 2 shows the cost avoidance trend since UOIG implemented the methodology.

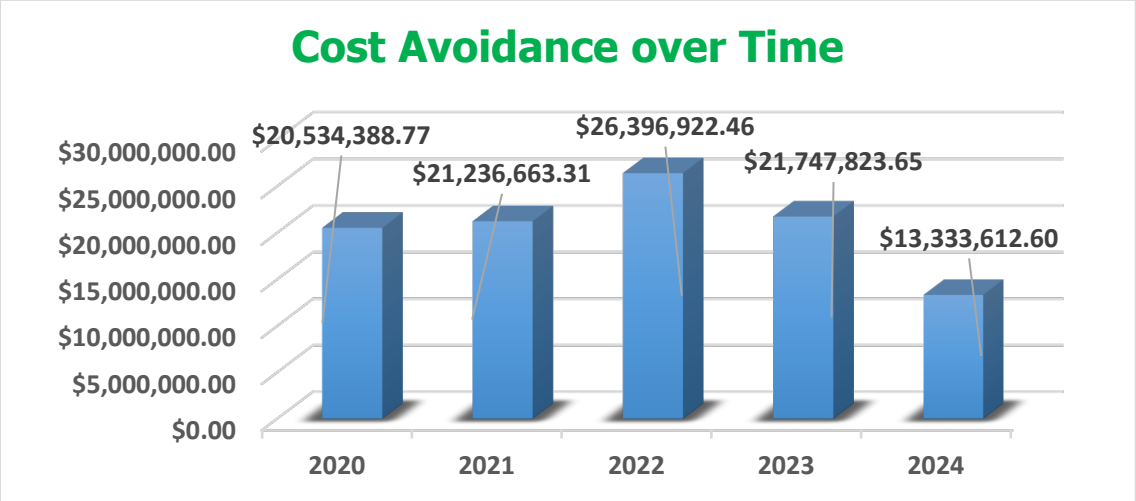

Figure 3. Cost Avoidance Over Time

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 and Human Services

(DHHS) is the Single State agency responsible for administering the Medicaid Program, as designated in the Utah State Medicaid Plan. The UOIG works closely with the Medicaid Agency to coordinate many program integrity projects, while seeking to remain professionally independent. Medicaid 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) 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 the 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 Agency 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. For example, during SFY21, 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 currently has 25 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.

Case Management Procurement

The UOIG requested, and was authorized, funding for the procurement of a new case management system and fraud detection solution. The procurement of that product is being accomplished through a NASPO contract and is expected to be finalized in October 2024. Current UOIG processes are very manual and the procurement of this solution will significantly streamline case management. Additionally, the fraud detection tool will allow constant monitoring of data to more quickly identify potential fraud within the Medicaid system. The Inspector General anticipates the procurement will increase Office efficiency by at least 20%.

Concerns

Balance Billing

The UOIG observed a sharp increase in reports of balance billing in SFY23. When providers' bill a balance, that Medicaid does not cover, to the recipient, the recipient frequently ends up in collections. The Office received 29 complaints of balance billing during SFY23, and that trend is continuing upward during the first part of SFY24. Medicaid policy is very clear on the prohibition of balance billing and the Office resolved 100% of these issues in favor of the recipient. The Office will continue to address these balance billing issues as they are received and will conduct pattern analysis to determine if certain providers are repeat offenders. Targeted training will be conducted, if needed.

The Emergence of AI

There is very little doubt in Program Integrity communities that the emergence of artificial intelligence is going to be a challenge in the near future. While AI has great potential to aide in the fight against Medicaid fraud, it also has equal potential to be used to enhance the effectiveness of known fraud schemes. UOIG leadership is monitoring communications across the country to identify emerging use of this technology early. UOIG Staff are attending training to stay current with ongoing discussions surrounding this topic and will be diligent in thwarting trends as they emerge in Utah.

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 2024, 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.