Annual Report
Fiscal Year 2024

Utah Office of Inspector General
Medicaid Services

“2024 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 SFY24 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 protecting 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 $6.49 million dollars and saved the taxpayers an additional $12.42 million in cost avoidance during SFY 2024. The Office opened 347 projects during the year with most of them coming from complaints submitted by the public through the fraud hotline or the online submission tool. The UOIG referred nine cases for criminal investigation to the Medicaid Fraud Control unit, one to the Department of Workforce Services for a recipient fraud investigation and five to other partners for additional investigation. Cases referred to the Fraud Control unit included $92.44 million dollars at risk.

During SF25, 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
Inspector General
Office of Inspector General of Medicaid Services

SFY 2024 UOIG Tabulated Data	
Total recoupment:	**$6,499,792**
Recoupment by Cash	**$2,879,283**
Recoupment by Rebilled Claims	**$138,355**
Recoupment by Credit Adjustment	**$3,482,155**
Total recoupment since creation of the Office (2011) (all methods)	**$112,487,659**
Savings through cost avoidance (SFY24)	**$13,640,211**
Total estimated Medicaid savings from cost avoidance*	**$152,351,454**
Return on Investment Recovery Only (SFY24)	**160.30%**
Return on Investment Cost Avoidance Only (SFY24)	**336.39%**
Total Return on Investment, Recovery + Cost Avoidance (SFY24)	**496.69%**
Average Return on Investment since 2016, Recovery + Cost Avoidance	**807.13%**
Dollars at Risk referred to MFCU for full investigation (SFY24)	**$92,438,174**
Number of Referrals and Projects Opened	**347**

* The Office began tracking cost avoidance in 2016.

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Background

The Utah State Legislature created the Office of the Inspector General of Medicaid Services (Office or UOIG) during the 2011 General Session. The Office began operations on July 1, 2011, and assumed duties and responsibilities associated with Medicaid program integrity.

Understanding Program Integrity

All state Medicaid programs must comply with federal program integrity requirements which include the following:

1. Fraud Control Unit: States must have a Medicaid Fraud Control Unit (MFCU) that is separate from the Medicaid agency to investigate and prosecute fraud.
2. Cooperation: States must cooperate with federal program integrity initiatives, such as the Centers for Medicare & Medicaid (CMS) Medicaid Integrity Program and the Payment Error Rate Measurement (PERM) program.
3. Compliance oversight: States must oversee their plan' compliance with federal and state laws, regulations, and policies.
4. Provider Screening: States must screen all participating providers according to their categorical risk level.

Program integrity activities are meant to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, and abuse from taking place. Because fraud is particularly difficult to detect, its precise magnitude is unknown, though analysis has shown that the great majority of Medicaid providers do not engage in such actions.

Ultimately, parts of Medicaid program integrity are the responsibility of all stakeholders.

When designed and implemented well, program integrity initiatives help to ensure that:

- eligibility decisions are made correctly;
- prospective and enrolled providers meet federal and state participation requirements;
- services provided to enrollees are medically necessary and appropriate; and
- provider payments are made in the correct amount and for appropriate services.

Defining Fraud, Waste, and Abuse

Fraud and abuse are both defined in Medicaid regulations (42 CFR 433.304 and 42 CFR 455.2).

Fraud involves an intentional deception, such as billing for services that were never provided.

Abuse includes taking advantage of loopholes or bending the rules, such as improper billing practices.

Waste, which is not defined in federal Medicaid regulations, includes inappropriate utilization of services and misuse of resources. An example would be duplication of tests that can occur when providers do not share information with each other. Waste is not a criminal or intentional act, but results in unnecessary expenditures to the Medicaid program that might be preventable.

Program Integrity Activities

Depending on their specific mission and scope, federal and state agencies may use a number of tools to identify and address fraud and abuse in the Medicaid program. Specific methods can include:

- data mining to identify possible fraud and abuse for further examination;
- audits to determine compliance with federal and state rules and regulations or to identify fraud and abuse;
- investigations of suspected fraud and abuse;
- enforcement actions (e.g., provider termination, provider exclusion) against those who have committed fraud;
- technical assistance and education for state staff so they are able to prevent and identify fraud and abuse; and
- outreach to and education for the provider and enrollee communities (e.g., how to report suspected fraud, explaining Medicaid rules and requirements.

Many oversight activities focus on identifying and recovering improper payments made to providers, such as payments that should not have been made or that were made in an incorrect amount (this includes both overpayments and underpayments). When an improper payment is identified, the state must return the federal share to CMS.

Duties and Powers of the UOIG as outlined in State Statute

The duties and powers that the Utah Legislature created for the Office are found in Utah Code at 63A-13-202. The list of codified duties and powers are:

1. Inspect and monitor the following in relation to the state Medicaid program:
    a. the use and expenditure of federal and state funds;
    b. the provision of health benefits and other services;
    c. implementation of, and compliance with, state and federal requirements; and
    d. records and recordkeeping procedures.
2. Receive reports of potential fraud, waste, and abuse in the state Medicaid program;
3. Investigate and identify potential or actual fraud, waste, or abuse in the state Medicaid program;
4. Consult with the Centers for Medicaid and Medicare Services and other states to determine and implement best practices for:
    a. educating and communicating with health care professionals and providers about program and audit policies and procedures;
    b. discovering and eliminating fraud, waste, and abuse of Medicaid funds; and
    c. differentiating between honest mistakes and intentional errors, or fraud, waste, and abuse, if the office enters into settlement negotiations with the provider or health care professional.
5. Obtain, develop, and utilize computer algorithms to identify fraud, waste, or abuse in the state Medicaid program.

6. Work closely with the fraud unit to identify and recover improperly or fraudulently expended Medicaid funds;
7. Audit, inspect, and evaluate the functioning of the division for the purpose of making recommendation to the Legislature and the department to ensure that the state Medicaid program is managed:
    a. in the most efficient and cost-effective manner possible; and
    b. in a manner that promotes adequate provider and health care professional participation and the provision of appropriate health benefits and services.
8. Regularly advise the department and the division of an action that could be taken to ensure that the state Medicaid program is managed in the most efficient and cost-effective manner possible.
9. Refer potential criminal conduct, relating to Medicaid funds or the state Medicaid program, to the fraud unit.
10. Refer potential criminal conduct, including relevant data from the controlled substance database, relating to Medicaid fraud, to law enforcement in accordance with Title 58, Chapter 37f, Controlled Substance Database Act.
11. Determine ways to:
    a. Identify, prevent, and reduce fraud, waste, and abuse in the state Medicaid program; and
    b. Balance efforts to reduce costs and avoid or minimize increased costs of the state Medicaid program with the need to encourage robust health care professional and provider participation in the state Medicaid program.
12. Recover improperly paid Medicaid funds.
13. Track recovery of Medicaid funds by the state.
14. In accordance with 63A-13-502:
    a. Report on the actions and findings of the inspector general; and
    b. Make recommendations to the Legislature and the governor.
15. Provide training to:
    a. Agencies and employees on identifying potential fraud, waste, or abuse of Medicaid funds; and
    b. Health care professionals and providers on program and audit policies and compliance.

The office accomplishes each of these responsibilities in a professional manner to ensure that Medicaid Program Integrity is accomplished to ensure the program is protected against taxpayer loss through fraud, waste or abuse. This report will highlight a number of these responsibilities, including outcomes and key performance indicators.

Fraud, Abuse and Waste Reporting

During 2024 the UOIG received 348 allegations through the various reporting tools, which include the fraud hotline, the UOIG website and the MPI.utah.gov email address. Those 348 allegations are mostly comprised of reports from private citizens.

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 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.

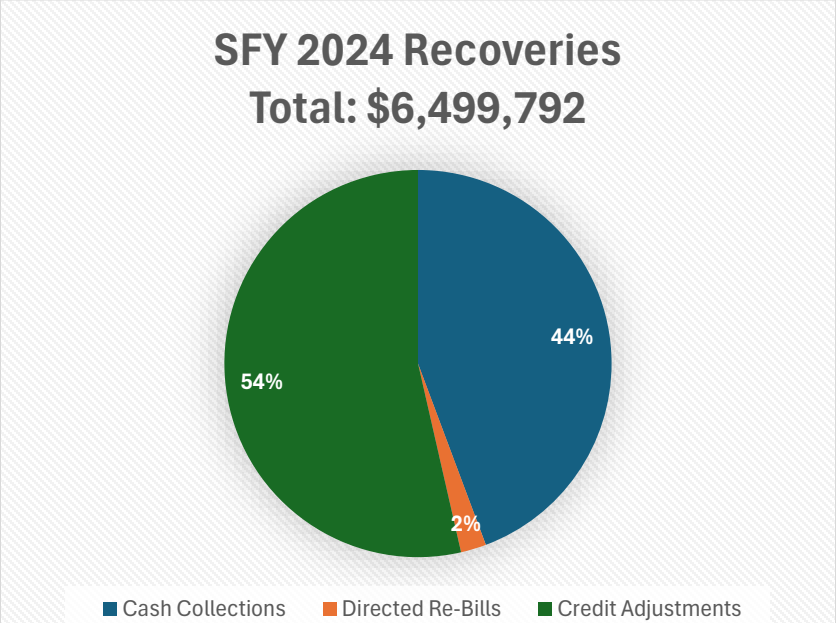

Figure 1: SFY 2024 Recoveries

During SFY 2024 the UOIG recovered $6.50 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.

In the past six fiscal years the UOIG recovered **$38,461,876**.

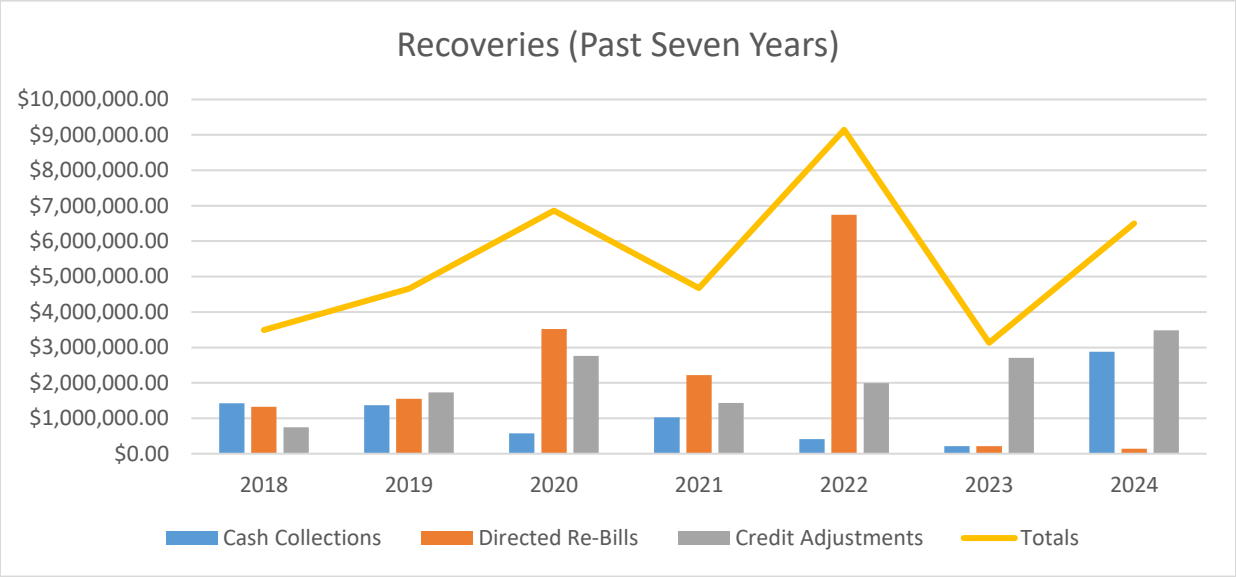

Figure 2. UOIG Recoveries over the previous seven years

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 for other administrative remedies.

During SFY2024, the UOIG opened 347 projects based on referrals from the fraud referrals or from internally identified areas of risk.

During SFY2024, the UOIG made nine referrals to MFCU for full investigation. The dollars at risk for those nine cases is projected at $92,438,173.82.

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 to ensure taxpayer dollars are not expended wastefully.

Audits are available for review on the UOIG website at oig.utah.gov.

Outcomes

UOIG administrative actions result in several possible 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 move the matter to administrative 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 SFY24 continued building it's training program. 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 lacked effective fraud training.

During SFY24 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 throughout the country.

Cost Avoidance Results

The UOIG saved an additional $13,640,210.80 during SFY24. Figure 2 shows the cost avoidance trend since UOIG implemented the methodology.

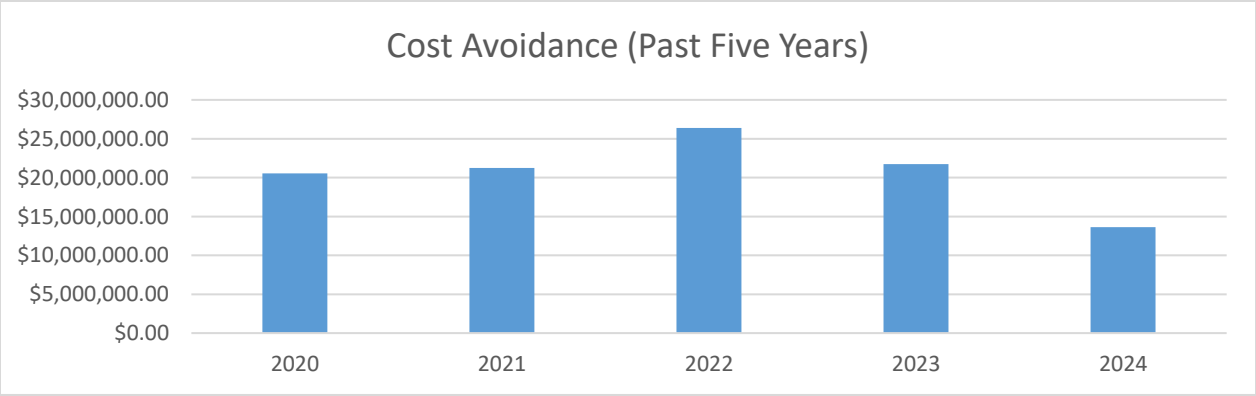

Figure 3. Cost Avoidance Over Time

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 85% 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 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.

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.

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 2025, 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.