An Audit of the Deficit Reduction Act (DRA) compliance for Federal Fiscal Year 2016

[Report Number 2017-04]

June 9, 2017

Utah Office of
Inspector General

Gene Cottrell
Inspector General

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To: Utah Department of Health

Please see the attached report, Audit of Deficit Reduction Act (DRA) compliance for Federal Fiscal Year 2016, (Report 2017-04). 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 Cottrell
Inspector General
Utah Office of Inspector General

cc: Joseph Miner, Nathan Checketts, Shari Watkins, Emma Chacon, Aaron Eliason, Melanie Henderson, Tonya Hales & Janica Gines

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EXECUTIVE SUMMARY

Background

The Utah Office of Inspector General (OIG) conducts an annual audit of Medicaid providers who receive at least $5,000,000 annually from Medicaid, based on the federal fiscal year. The purpose of the audit is to ensure that Medicaid providers have policies and procedures in place to comply with Section 6032 of the Deficit Reduction Act (DRA). Section 4.42 of the Utah State Plan outlines the requirement of the audit with the required compliance to Section 6032 of the Deficit Reduction Act. The Utah OIG verifies establishment of policies and procedures regarding employee and management education on the False Claims Act and reporting fraud, waste and abuse protection for those that report the information.

Audit Objectives

Conduct an audit of Medicaid Providers for determination of compliance to Section 6032 of the Deficit Reduction Act as required under the State plan 4.42 and Attachment 4.42-A.

Audit Scope

The scope of the audit will cover Federal Fiscal Year 2016, Medicaid payments to providers of $5,000,000 or more.

Conclusion

All audited providers or providers that received letters of attestation complied with the requirements of the Deficit Reduction Act and State Laws for the scope of the audit.

INTRODUCTION

BACKGROUND

The Utah Office of Inspector General (OIG) conduct an annual audit of Medicaid providers who receive at least $5,000,000 annually for Medicaid, based on the federal fiscal year. The purpose of the audit is to ensure that Medicaid providers have policies and procedures in place to comply with Section 6032 of the Deficit Reduction Act (DRA).

Section 4.42 of the Utah State Plan outlines the requirements of the audit with the required compliance to Section 6032 of the Deficit Reduction Act.

Each provider should establish policies and procedures regarding employee and management education of the False Claims Act and reporting of fraud, waste, and abuse. The providers should also establish policies and procedures providing for the protection under the law of those that report violations.

The State Plan requires providers who receive at least $5,000,000 submit attestations stating that they have policies and procedures to comply with Section 6032 of the DRA and any other applicable state laws. The attestation cycle includes three years, 2016 is the second year in the three-year cycle. The State plan also requires that the Utah OIG randomly select providers then audit their policies and procedures to ensure they meet the requirements.

OBJECTIVES AND SCOPE

Audit Objectives:

The primary objective of the audit is to:

- Conduct an audit of provider compliance to Deficit Reduction Act and Utah State Plan 4.42 and Attachment 4.42-A.

Audit Scope:

The scope of the audit covered providers who received Medicaid annual payments of $5,000,000 or more during the federal fiscal year 2016. Providers subject to attestation for 2016 were required to sign the “Letter of Attestation”.

METHODOLOGY

To comply with the audit requirements of the Section 4.42 of the Utah State Plan, Utah OIG preformed the following:

- Used Medicaid's data warehouse to determine all providers that received at least $5,000,000 annually from Medicaid in the prior federal fiscal year.
- Randomly selected 10% of the query from the prior period for the annual audit.
- Sent letters to the selected providers requesting the required information.
- Received the requested information back from the providers and verified for compliance.

The second phase of the requirement is sending a letter of attestation to providers who have reached the $5,000,000 in payments during the prior federal fiscal year. To collect the attestations the Utah OIG preformed the following:

- Used Medicaid's data warehouse to determine which providers have reached the required $5,000,000 payment criteria based on the data query and analysis.
- Sent a letter of attestation to providers that reached the criteria for the first time during the federal fiscal year.
- Received the letters of attestation from the providers and verified for signatures.

The Utah OIG audited five Medicaid providers based on the data query and analysis. The five audited providers are South Davis Community Care Center, Molina Chip, Molina, University of Utah Hospital, and University of Utah Medical Group.

The Utah OIG determined, based on the data query and analysis that five providers newly reached the $5,000,000 payment amount during the federal fiscal year. Utah OIG sent "Letters of Attestation" to and received completed letters from the following: Sandy Health and Rehabilitation, Gold Cross Ambulance, Genoa Healthcare of Utah Pharmacy, Ashley Regional Medical Center, and Country Life Care Centers.

CONCLUSION

Five Medicaid providers that were included in the audit had policies and procedures that complied with the False Claims Act and State laws pertaining to the Deficit Reduction Act.

Five Medicaid providers that were required to attest to the requirements of the False Claims Act and State laws pertaining to the Deficit Reduction Act, signed letters attesting to compliance.

All providers were determined to comply with the requirements of the False Claims Act and State laws pertaining to the Deficit Reduction Act.

GLOSSARY OF TERMS

The first use of each term is described in the report. The glossary is included to help ensure easer reading.

Term	Description
DRA	Deficit Reduction Act
OIG	Utah Office of Inspector General

ATTACHMENT: Letter of Attestation

ATTESTATION OF COMPLIANCE

Date of Notice: April 04, 2017
Due date: May 22, 2017

Case number: 17-0432

For Federal Fiscal Year (FFY): 2016
(Attest for the previous FFY, for example Oct 1, 2015-Sept 30, 2016 is FFY2016.)

Provider/entity name: _____

NPI: _____ Utah provider number: _____

Address: _____
Street

_____
City State Zip Code

I hereby acknowledge that, as a condition for receiving payments exceeding $5 million per federal fiscal year, I am familiar with the requirements of the Section 4.42 of the State Plan and 19 U.S.C. § 1902(68). I hereby attest that I have examined the above-named provider/entity's policies and procedures and have found them to be in compliance with these requirements to educate employees and contractors concerning false claims.

I understand that the above-named provider/entity must continue to comply with these provisions to remain eligible for payment under the Utah Social Security Act Medical Assistance Program. I hereby declare that the information contained in this written statement is true and correct to the best of my knowledge and I understand that any false statements I make that I do not believe to be true may subject me to criminal punishment as a class B misdemeanor pursuant to Utah Code Ann. §76-8-504.

_____ _____
Signature of authorized entity representative Date

_____
Print or type name and title

Fax or email the completed form to:

Email:
dhooper@utah.gov

Fax:
(801) 538-6382
ATTN: Dennis Hooper

U.S. Postal Service:
Utah Office of Inspector General
Attn: Dennis Hooper
PO Box 143103
Salt Lake City, Utah 84114-3103

UPS, FedEx, etc.:
Utah Office of Inspector General
Attn: Dennis Hooper
288 North 1460 West
Salt Lake City, Utah 84116-3231

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

UTAH OIG CONTACT

Dennis Hooper CIGA
Auditor

Neil Erickson
Audit Manager

UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General will enhance the integrity of the Utah State Medicaid program by preventing fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting a high quality of patient care.

ADDRESS

Utah Office of Inspector General
Martha Hughes Cannon Health Building
288 N 1460 W
Salt Lake City, Utah 84116

OTHER

Website: http://www.oig.utah.gov/
Hotline: 855.403.7283