Annual Report
Fiscal Year 2020

Utah Office of Inspector General

Medicaid Services

“2020 Fraud, Abuse and Waste Elimination Efforts”

Message from the Inspector General of Medicaid Services

I am pleased to present the SFY 2020 Annual Report of the Utah Office of Inspector General (UOIG) of Medicaid Services to Governor Herbert, 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 traditional 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.

SFY 2020 was both productive and challenging for the Office. The Office recouped nearly $9 million dollars and saved the taxpayers over $20 million in cost avoidance. The public health emergency declared in response to COVID-19 created unique challenges the office overcame. The Office moved to 100% telework and suspended provider audits temporarily to allow the provider community to focus on their emergency response. The Inspector General coordinated for the nurse investigators to conduct contact tracing during the initial stage of the State's response to the public health emergency. They conducted that work until mid-August 2020. In the meantime, the rest of the audit continued monitoring the Medicaid program. The data team continued monitoring data for inappropriate billing while also watching for COVID related fraud schemes that began occurring in other states, as reported by our counterparts from those states. The Office returned to nearly normal operations, albeit through telework, the middle of August. The Inspector General anticipates the public health emergency will influence SFY 2021 recoupment because of the nearly five-month suspension of normal operations.

During SFY 2021, 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 loosened 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
Inspector General
Office of Inspector General of Medicaid Services

SFY 2020 UOIG Tabulated Data	
Total recoupment amount:	**$9,565,485**
Recoupment by Cash	**$579,373**
Recoupment by Rebilled Claims	**$3,523,232**
Recoupment by Credit Adjustment	**$2,759,471**
Recoupment by Provider Self-disclosure	**$2,703,409**
Total recoupment since creation of the Office (2011) (all methods)	**$74,754,774**
Savings through cost avoidance	**$21,212,061**
Number of leads opened	**340**
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	**30**
Department of Workforce Services	**32**
Medicaid Information Bulletins reviewed	**10**
Number of MIB articles reviewed	**124**
Number of recommendations made	**244**
Medicaid Administrative Rules reviewed	**30**
Number of Recommendations made	**18**
State Medicaid Plan Amendments reviewed	**12**
Number of Recommendations made	**6**
External training events	**20**
Number of participates trained	**483**

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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 to ensuring the right amount is paid to properly vetted providers who provide covered, reasonable and necessary services to eligible Medicaid recipients, while effectively identifying 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, 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 requirement 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 sometimes 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 investigations of complaints
- Conducting provider audits
- Coordinating Program Integrity efforts across all State Medicaid Programs
- Recovering improperly paid Medicaid funds
- 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.

COVID-19 Impacts

Like most state agencies, reaction to the COVID-19 public health emergency affected Utah Office of Inspector General of Medicaid Services' operations.

Telework

The Inspector General began considering increased telework in December 2019. The UOIG management team experimented using an employee, working from home, to work through how best to implement teleworking throughout the Office. In March 2020, the entire Office began teleworking upon the Governor's declaration of a public health emergency. Management issued and carefully tracked state equipment that employees needed to complete their work from home. The transition to working from home went smoothly for the Office and the Inspector General intends to continue teleworking for the foreseeable future.

Suspension of Recoveries

The Inspector General decided to suspend on-site visits and recoupment operations, including requests for medical records, between March and mid-August 2020. The Inspector General made this decision based on information he received from HHS-OIG that suggested medical facilities needed to "fight the fight" without distraction during the early stages of the public health emergency. The Office continued to monitor anticipated COVID related fraud schemes through data pulls. The Office continues monitoring Medicaid claims related to COVID-19 to identify any fraudulent activity related to the public health emergency.

Temporary Reassignment of Nurse Investigators

Due to the temporary suspension of reviews and investigations, the Inspector General sought ways to keep the nurse investigators productive. The Utah Department of Health needed assistance with contact tracing so the Inspector General coordinated to have the investigators use their nursing skills to assist in the fight against COVID. The investigators performed contact tracing between mid-April and mid-August for approximately 50% of their time. In mid-August, the investigators returned to their normal duties when the Inspector General resumed investigations and reviews.

Impacts on SFY 2021 Recoupments

The Inspector General anticipates recoveries will be lower during State Fiscal Year 2021. It can take 4-6 months to complete a project (review or investigation), from opening the project to final recoupment. The project takes longer if a provider disputes the Office's findings. Since the Office suspended most projects during the pandemic response, there is a five-month gap in recoupments. The Inspector General believes the office will still meet the $3-5 million goal, however, the recoupments will likely trend downward during SFY 2021.

SFY 2020 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 certainly most improper payments are not fraudulent. Unclear Medicaid policy, ineffective edits in the Medicaid payment system and provider billing mistakes may cause an improper payment. During an average year, the Office recoups between $3-5 million, consistent with recoveries in states with similar population and Medicaid programs. It is impossible to predict accurately how much recoupment the Office will return to the state for future years due to the unpredictability of future findings.

The UOIG issues Notices of Recovery after careful review of a lead that includes a thorough Medicaid policy review, data analysis and a review of medical records, if needed. During SFY 2020, the UOIG issued 990 Notices of Recovery. Through the recovery letters, the UOIG recouped $6,862,076.

The UOIG uses three methods of recoupment Medicaid funds: cash collection, claims rebilling, and credit adjustment. In SFY 2020 cash recoupment accounted for 6%, or $579,373, rebilled claims recoupment accounted for 37%, or $3,523,232, and recoupment through credit adjustment accounted for 29%, or $2,759,471.

Occasionally providers discover errors in their own billing practices and voluntarily return Medicaid funds to the program. During SFY 2020, the Office received $2,703,409 in provider self-reported recoveries.

The total recoupment amount for SFY 2020 is $9,565,485. See Figure 1.

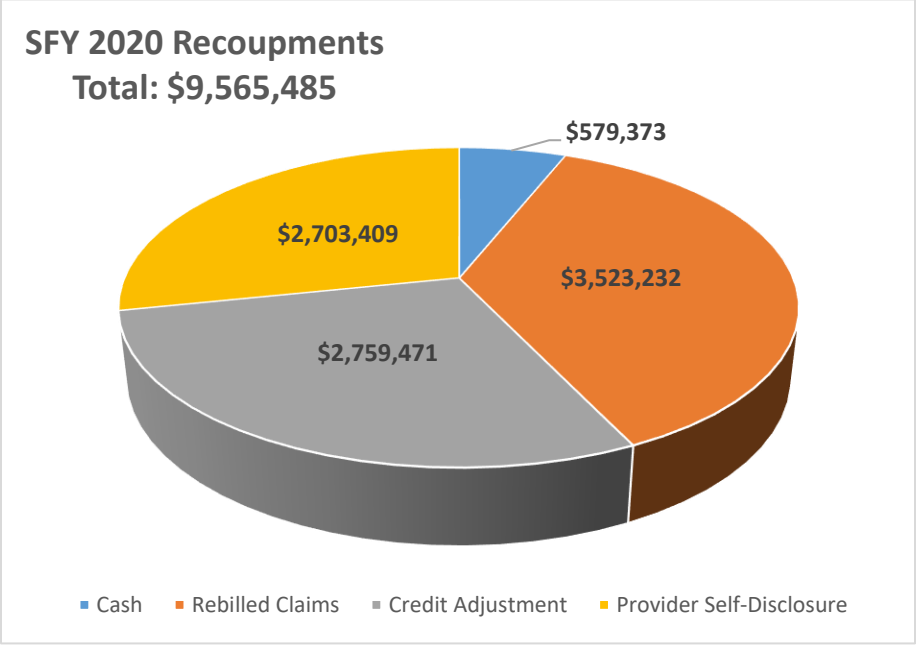


Figure 1. SFY 2020 Recoupments

The Office has recouped $74,754,774 since the State Legislature created it in 2011.

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 change 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 billing appropriately, 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 that other states adopted.

Cost Avoidance Results

The UOIG saved the state $21,212,061 during SFY 2020. Figure 2 shows the cost avoidance trend since UOIG implemented the methodology.

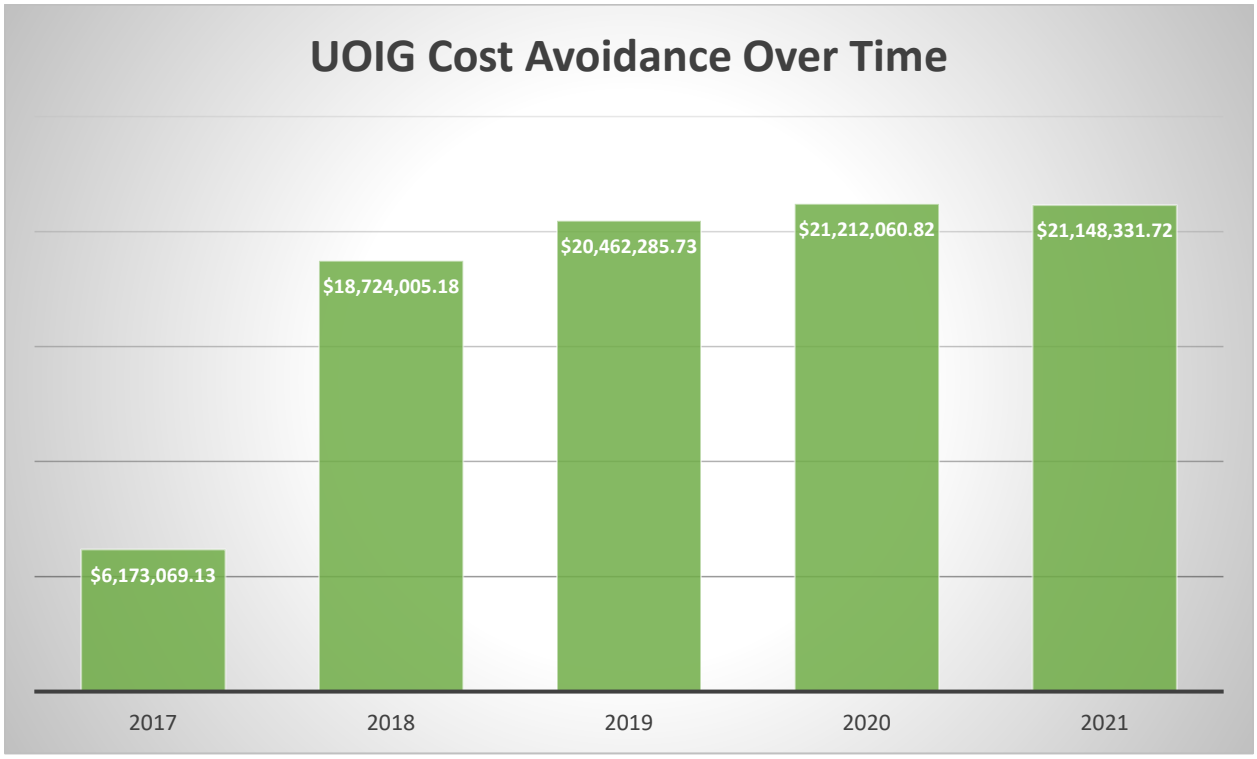


Figure 2. Cost Avoidance Over Time

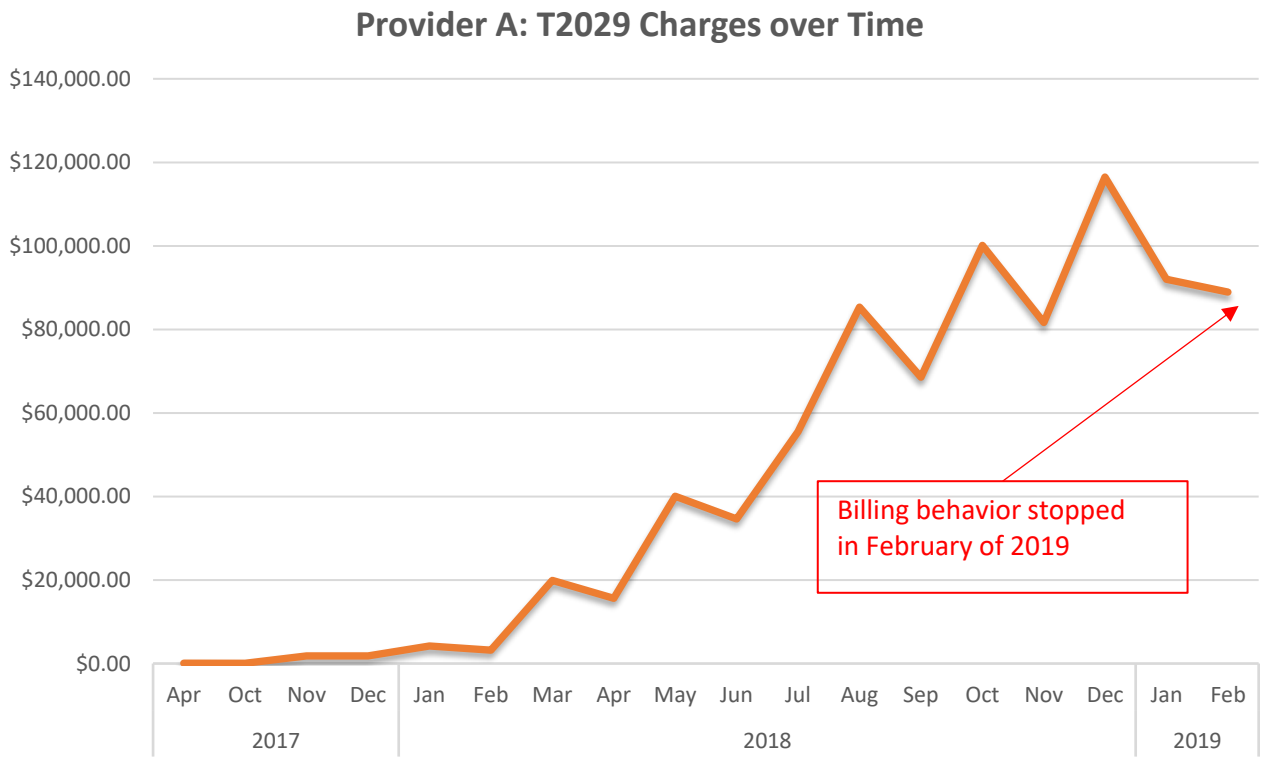
Cost Avoidance Examples

The following examples do not account for all of the cost avoidance claimed in SFY 2020, but represent the methodology applied to calculate the total. While some of these examples did not occur in SFY 2020, they are still under observation by the Office.

Example 1: Durable Medical Equipment Provider

In 2018, the UOIG discovered a durable medical equipment provider was billing excessively for specialized medical equipment using code T2029. The UOIG conducted a review and recoupment that resulted in stopping all claims from this provider during SFY 2020.

Provider A: Durable Medical Equipment Provider



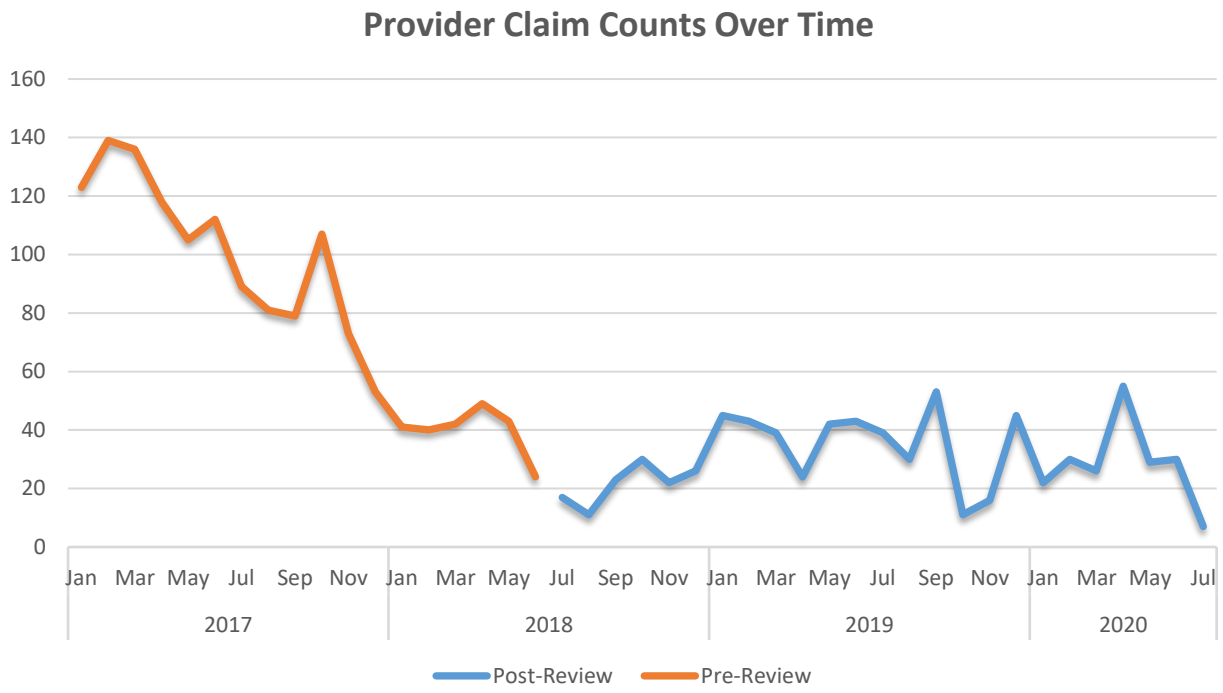
- This provider billed primarily for one code T2029 (Specialized Medical Equipment)
- Since it is an unspecified code, the cost per unit can vary
- There is no customary cost, and while this is appropriate, the company billed excessively
- The UOIG stopped the behavior as of March of 2019, no billings occurred during SFY 2020. The UOIG still has this provider in the surveillance program to ensure continued compliance when they start billing again.

Cost Avoidance:	Count	Reimbursements
Pre Review	1246	$798,856
Post Review	0	$0.00
Difference	1246	$798,856
Monthly Difference:	104	$66,571
Yearly Difference:	1246	$798,856
Five Year Projection:	6230	$3,994,279

Example 2: Mental Health Provider

In 2018, the UOIG conducted a provider audit of a mental health provider whose billing spiked the previous year and appeared as an outlier when compared to their peer group. During the course of the provider audit, the UOIG determined that non-enrolled providers were providing the services and billing under the enrolled provider's name. The additional claims forced the provider into the outlier status. The OIG conducted a recoupment and training and continued to monitor this provider through SFY 2020. The provider's billing pattern returned to normal within the peer group.

Provider B: Mental Health Provider



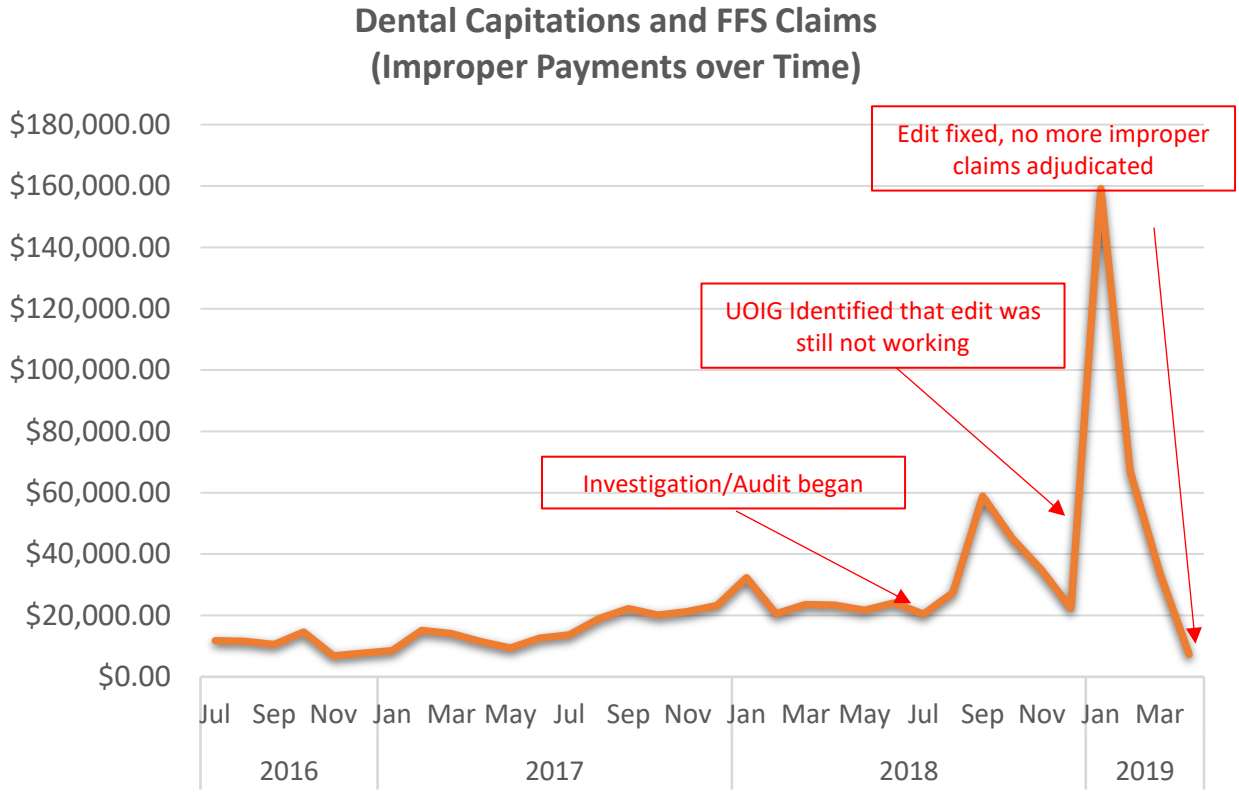
- This provider billed for services they did not complete
- Other providers (Non-Medicaid enrolled) performed the services and billed under the enrolled providers name.
- This behavior stopped during the investigation. The peak behavior occurred in 2017
- The UOIG continued to monitor this provider during SFY 2020 to ensure the provider continued following correct billing practices

Cost Avoidance:	Count	Reimbursements
Pre Review	1454	$221,826
Post Review	559	$113,671
Difference	895	$108,155
Monthly Difference:	50	$6,009
Yearly Difference:	597	$72,103
Three Year Projection:	1790	$216,309
Five Year Projection:	2983	$360,515

Example 3: Dental Capitations

In July 2018, the UOIG conducted an audit of Medicaid's dental services. The State covers most Medicaid dental claims through two Dental Managed Care Organizations. Providers who perform dental services should bill the managed care entity (MCE), but the Office discovered that Medicaid edits were allowing the providers to bill their services as fee-for-service claims. Essentially Medicaid paid claims paid twice, once as a capitated rate to the MCE and then again as a fee-for-service claim. The Office worked with Medicaid to recover the inappropriately paid claims and recommended fixing the system edits. This is a good example of the need for post action monitoring because when Medicaid fixed the edit it was not correct and allowed additional billing to occur. However, once the Office identified the problem increased they notified Medicaid, Medicaid fixed the edit, and this behavior completely stopped. The Office continues to monitor this project.

Dental Capitations:
Billed Medicaid Incorrectly



- Dental claims are typically paid for by the Dental Managed Care Organization
- UOIG found that there were many claims that should not have been paid Fee-For-Service and should have been paid for by the Dental Managed Care Organization
- This pattern of behavior was found to be occurring from 2015 forward
- This project is currently being monitored in 2020, to ensure the issue does not occur in the future.

Cost Avoidance:	Count	Reimbursements
Pre Review	11545	$549,313
Post Review	0	$0.00
Difference	11545	$549,313
Monthly Difference:	962	$45,776
Yearly Difference:	11545	$549,313
Five Year Projection:	57725	$2,746,565

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 and audits of the State's Medicaid program.

Provider Audits/Reviews

The Office performs provider audits 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 provider audits 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 2020 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 of the office 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. Interested parties may find copies of audits on the UOIG website at, https://oig.utah.gov .

Medicaid Provider Self-Reports

Providers occasionally identify overpayments through their own internal audit processes. When they identify funds that need returned to the Medicaid program the UOIG works with them to recover those funds. SFY 2020 marks the highest amount recovered through provider self-reports, $2,735,393.30, since the creation of the Office in 2011. The Inspector General commends the providers' efforts in upholding their fiduciary responsibility to Utah State taxpayers.

Program Integrity Coordination Efforts

The Office coordinates PI efforts across 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. 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 helps strengthen areas where the Office may not have particular expertise. The Office holds monthly meetings with Qlarant to receive updates regarding ongoing 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.

Data and Records Usage

Utah State code authorizes the UOIG 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 Office uses medical records and databases to confirm medical necessity, correct coding and proper payment of claims submitted to the Division of Medicaid and Health Financing. Additionally, the UOIG employs two data scientists who build algorithms to monitor specific providers or provider groups to identify outliers that may require additional review.

During SFY 2020, the Office requested 711 medical records and received 654. When providers do not provide the records upon request, the Office evaluates the billed charges based upon evidence available. Therefore, failure to supply the requested records normally results in a total recoupment of paid Medicaid funds.

During the SFY 2020, the Office pulled data from available Medicaid sources 592 times.

Fraud Referrals

Historically the UOIG made fraud referrals in two categories; provider fraud and eligibility recipient fraud. The Office refers provider fraud to the Medicaid Fraud Control Unit (MFCU) and recipient eligibility fraud to the Department of Workforce Services who makes eligibility determinations and investigates instances of fraud where the recipient received Medicaid eligibility through fraudulent claims. In the past, the Office struggled with recommendations to local law enforcement regarding recipient fraud, other than eligibility. In 2018, MFCU received guidance from the Health and Human Services Office of Inspector General that clarified their ability to prosecute recipient fraud cases when

the recipient caused a false claim. For example, a drug-seeking recipient who presents at an emergency department without medical necessity causes a false claim in the system. Under the new guidance, MFCU can receive and investigate referrals regarding recipients when the referral meets certain criteria. The UOIG referred 26 such cases to MFCU for the first time during SFY 2020.

The total number of fraud referrals in SFY 2020 were:

To MFCU: 30

To DWS: 32

Training Opportunities

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

External Training

External training is training the Office provides to entities outside of the Office. Providers, provider groups, professional organizations and other state agencies are groups the Office trains. External training serves two purposes; inform and improve. All Medicaid stakeholders carry responsibility for identification and reporting of Medicaid fraud, therefore, the Office trains on how to do that. The Office also trains to improve poor billing practices within the provider community. During SFY 2020, the Office conducted 20 external training events; training 483 attendees.

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 and train the rest of the Office.

Program and Policy Reviews

The Office reviews Medicaid Provider Manual updates and Medicaid Information Bulletins (MIB) in accordance with Utah Code 63A-13-202(2)(b-c) in order to identify inconsistencies and to make recommendations to Medicaid for clarification. In addition to Manual and MIB reviews, the Office also reviews Administrative Rule Amendments and State Medicaid Plan Amendments (SPA) to help ensure clarity to the provider community. The Inspector General agrees that emergency changes do not always offer time for the Office to conduct a thorough review and those documents are normally released prior to a full review. However, the Inspector General notes that increasingly the Division bypasses the normal review process.

Reviews conducted

Number of MIBs Reviewed	10
Number of articles reviewed	124
Number of recommendations made	244
Number of articles without a recommendation	38
Recommendations related to a policy or regulatory conflict	147
Recommendations regarding provider compliance concerns	180
Number of repeat recommendations	26
Number of Administrative Rules Reviewed	30
Number of recommendations made	18
Number of State Plan Amendments Reviewed	12
Number of recommendations made	6

Results of Reviews

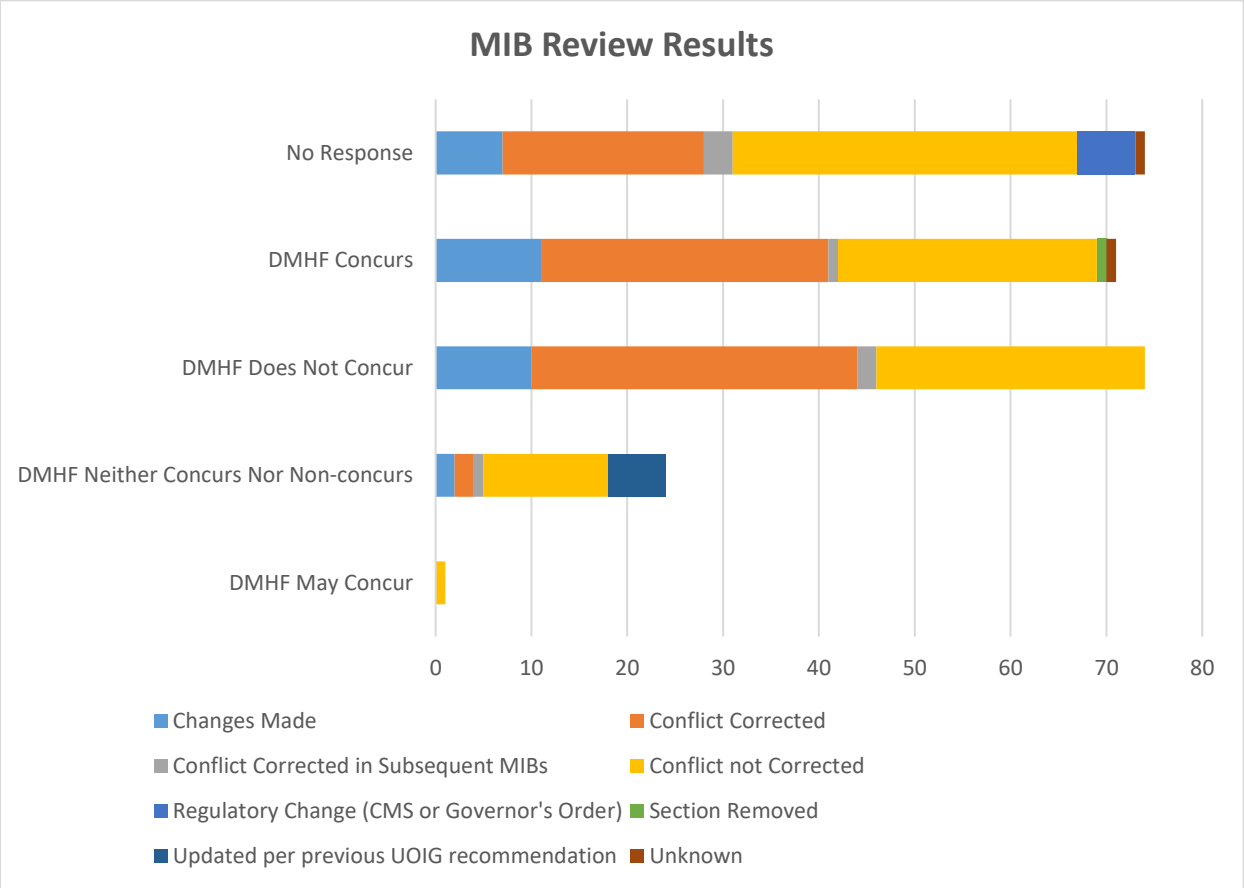


Figure 3. SFY 2020 MIB Review Results

Note: UOIG only makes recommendations; it is up to the Single State Agency to accept or decline those recommendations.