UTAH OFFICE OF INSPECTOR GENERAL – MEDICAID SERVICES

2018 ANNUAL REPORT

10/31/2018

Inspector General – Medicaid Services

The Utah Office of Inspector General of Medicaid Services was established on July 1, 2011. The primary goal of the Office is to eliminate fraud, waste, and abuse from the Utah Medicaid Program.

Utah Office of
Inspector General

Gene D. Cottrell,
Inspector General

October 31, 2018

To: Governor Gary R. Herbert, President Wayne L. Niederhauser, Speaker Gregory H. Hughes, and the Executive Appropriations Committee

Subject: 2018 Annual Report of the Utah Office of Inspector General of Medicaid Services (UOIG)

Please find attached the Utah Office of Inspector General's 2018 Annual Report to the Governor and the Executive Appropriations Committee, in compliance with *Utah Code 63A-13-502.* This report outlines activities and results of the Office for state fiscal year 2018.

The Utah Legislature created the UOIG to serve as an independent oversight agency for the Utah Medicaid Program and all Medicaid related spending. The Office serves two roles, first as part of the federally directed Program Integrity function for the State, which duties are primarily outlined in *42 CFR 455 and 456*. The responsibilities of this role are established through a Memorandum of Understanding with the Utah Department of Health's Division of Medicaid and Health Financing. UDOH is the designated "Single State Agency" responsible for administration of all Medicaid funds as outlined in the State Plan. The second role is the oversight responsibility outlined in *Utah Code 63A-13-502*. The code outlines the duties and responsibilities of the Inspector General and the Office and clearly establishes the authority by which the Office conducts audits and investigations of the Medicaid Program.

During 2018 the Office developed cost avoidance methodology as a key performance indicator. Traditionally the key performance indicator used by stakeholders to determine the Office's effectiveness was recovery amounts. However, recoveries are simply tools employed by the Office to change billing behaviors. Recovery amounts, alone, do not capture the effect of policy changes recommend by the OIG or the effect of training on a provider. This new methodology, which is explained in the body of this report captures the value of those, and other, activities the Office undertakes. In essence, this new methodology captures the sentinel effect as it is driven by sentinel events, which include audits, investigations, inspections, reviews and training. The Centers for Medicare and Medicaid (CMS) contacted the Office to discuss our use of this methodology as a way of showing the value of units, such as the UOIG, throughout the United States.

Looking ahead to 2019, UOIG will continue working closely with key stake holders including DOH, DHS, DWS and other local, state and federal entities to ensure all state and federal dollars are being spent appropriately to provide necessary treatment and services to Utah Medicaid recipients. Building positive relationships with all key stakeholders remains a central theme in this Office.

It is my pleasure to continuing serving the Citizens of the great State of Utah as we ensure their Medicaid tax dollars are applied in the most effective manner and that the medical needs of the neediest amongst them are met. I am available to meet with any of their elected representatives to discuss items contained in this report and to answer questions regarding our ongoing efforts to identify fraud, waste and abuse within the Medicaid Program.

Sincerely,

Gene D. Cottrell, Inspector General

Cc: Justin Harding, Governor's Chief of Staff
Michael Mower, Governor's Deputy Chief of Staff
Wayne L. Niederhauser, President of the Senate
Gregory H. Hughes, Speaker of the House
Member of the Executive Appropriations Committee
Dr. Joseph Miner, Executive Director, Utah Department of Health

Table of Contents

2018 Annual Report to the Governor of Utah and the Legislative Executive Appropriations Committee

Background

The Utah Office of the Inspector General of Medicaid Services (UOIG or Office) serves as the Utah citizens' watchdog in ensuring their taxpayer dollars are used efficiently in one of the biggest tax expenditures in the State of Utah, Medicaid.

The Utah State Legislature created the Utah Office of the Inspector General for Medicaid Services during the 2011 Legislative Session as an independent oversight agency responsible for oversight of the State Medicaid Program. To create the Office the Legislature removed the Internal Audit Section from the Utah Department of Health (UDOH) and the Bureau of Program Integrity from the Division of Medicaid and Health Financing (DMHF). They then used those resources to create the independent office. The Office began operations in July 2011, with Lee Wyckoff as the first Inspector General. At that time, the Office was housed under the Governor's Office of Management and Budget, however, was later moved under the Department of Administrative Services (DAS) to achieve even more independence.

The relationship between DAS and the UOIG is administrative only. DAS personnel assist in areas such as finance, budgeting and other minor administrative tasks. However, the Executive Director and their staff do not direct the work of the Office in any way.

The Office's first four years of operations were tumultuous. The Office failed to establish clear processes and procedures. The roles of managers were unclear which resulted in a 105% personnel turnover within a two-year period, between 2013 and 2014.

In January 2015, the current Inspector General, Gene Cottrell, was asked to serve as an Interim Manager of the Office while the search for a new Inspector General took place. He immediately set about the daunting task of changing the Office culture while at the same time, documenting processes and procedures within the Office. Mr. Cottrell was appointed as the second Inspector General in December 2015, which allowed the Office to continue the path to improvement. The cultural shift resulted in a completely new management team, which was finally in place in late-2016, with clearly defined roles and responsibilities.

The Inspector General understood the critical need for continual training of the Office's 28 employees. Medicaid programs are complex and those who seek to fraud taxpayers use increasingly complex and ever evolving techniques to divert Medicaid funds for their own gain. Office staff must be aware of emerging trends and lessons learned throughout the entire spectrum of Medicaid services. The Inspector General leveraged the Medicaid Integrity Institute (MII) to keep his employees current on emerging trends and to develop skills they needed to accomplish the Office's mission. The MII is a Centers for Medicare and Medicaid (CMS) run institute on the campus of the University of South Carolina that trains Program Integrity personnel in various skills. Presenters at the MII are chosen from among all of the States' programs and allows states to share trends they are observing within their states and initiatives they undertake to address them. CMS covers all expenses associated with attendance at the MII and is of tremendous value to the States.

Three auditing agencies conducted audits of the Utah Medicaid program, starting in 2014, that significantly influenced the Inspector General's Strategic Plan including office structure and how the IG interacts with stakeholders. The findings of those audits, and their impacts on the Office, are discussed throughout this report but include:

1. Office of the Utah State Auditor, Report No. 14-09, *Department of Health Single Audit Management Letter for the Year Ended June 30, 2014*
2. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Program Integrity, *Utah Focused Program Integrity Review, Final Report Jun 2017*
3. Office of the Legislative Auditor General, State of Utah, Report No. 2018-03, *A Performance Audit of the Utah Office of the Inspector General of Medicaid Services*

The Inspector General also met with the Governor's Staff, the Speaker of the House of Representatives, and the President of the Senate while developing the strategy the Office is currently following.

The Inspector General's Goal

Eliminate fraud, waste and abuse within the Medicaid Program

Mission Statement

The Utah Office of Inspector General of Medicaid Services, on behalf of the Utah Taxpayer, will comprehensively review Medicaid policies, programs, contracts and services in order to identify root problems contributing to fraud, waste, and abuse within the system and will make recommendations for improvement to key stakeholders.

Standards

The UOIG applies the professional standards outlined in the Association of Inspector's General manual, Principles and Standards for Offices of Inspector General, commonly referred to as the Green Book. The Green Book establishes standards of conduct and quality standards for all activities the Office undertakes. The Green Book also recommends Offices of Inspectors General incorporate quality standards found in Government Auditing Standards, commonly referred to as the Yellow Book, issued by the Comptroller General of the United States. The Office is also applying those standards to its oversight work. Incorporation of these standards complies with Utah Code 63A-13-202(1)(q).

The Two Roles of the Office

The UOIG fulfills two significant roles for the State Medicaid Program, Program Integrity and oversight. These two roles are frequently divergent, and it is difficult to draw the distinction between the two. However, during 2018 the Inspector General took measures to define the roles and this section of the report is included to help key stake holders understand those activities.

Medicaid Program Integrity

What is Medicaid Program Integrity?

It is difficult to accurately define what Program Integrity is since agencies have differing definitions. Loosely defined Medicaid Program Integrity are those activities undertaken by the Single State Agency to eliminate fraud, waste, and abuse within the Medicaid Program. The Single State Agency is the State Agency designated by the State to administer the entire Medicaid program in accordance with 42 CFR§431.10. Utah designated the Utah Department of Health as the Single State Agency in the Utah

Medicaid State Plan. UDOH further delegates that responsibility to the Division of Medicaid and Health Financing (Division or DMHF).

Strong Medicaid Program Integrity is key to controlling Medicaid spending. DMHF frequently relies on post payment activities to catch fraud, waste, and abuse. However, effective controls such as contracts and policy are also critical to a successful program.

Generally speaking the responsibility for Program Integrity falls to every employee involved at every level of the Medicaid Program in the State of Utah. The Division contracts with other state agencies to perform parts of the Medicaid Program. For example, The Department of Workforce Services conducts recipient enrollment activities and the Utah Department of Human Services oversees many Medicaid waiver programs that address the needs of specific segments of the Medicaid population. Each of these agencies' shoulders part of the Program Integrity responsibility. Additionally, managed care organizations contracted with the Single State Agency have Program Integrity responsibility. These organizations should ensure their employees are aware of their duty as public servants to report suspected fraud, waste, and abuse rather those elements exist within the provider community or within their own programs. Employees should feel comfortable reporting fraud, waste, and abuse without fear of reprisal from their agencies.

42 CFR§455 is the federal statute for Medicaid Program Integrity if readers are interested in learning more.

What is the UOIG's Program Integrity role?

When the Utah State Legislature created the Office in 2011 it dissolved the Bureau of Program Integrity within the Division of Medicaid and Health Financing and used those resources to create the independent Office. The Division was left without a means of conducting formalized Program Integrity. The Utah Code (63A-13) attempts to define limited Program Integrity functions as responsibilities of the Office, however, DMHF, as the Single State Agency, has ultimate authority over those responsibilities. In 2012 the Office entered into a Memorandum of Understanding (MOU) with DOH in an attempt to clearly define what responsibilities the Office would perform on behalf of DMHF.

For the first four years, the Office attempted to perform the MOU completely independent of DMHF input. However, in 2014 the Utah State Auditor issued a report with a finding that the Single State Agency did not have proper oversight of the Program Integrity functions performed by the Office. The report created a significant independence question for the current Inspector General when he assumed duties as the Interim Manager on January 1, 2015. The question became how to balance delegated Program Integrity responsibilities with oversight responsibilities.

The Inspector General met separately with the President of the Senate and the Speaker of the House after the 2015 Legislative Session to discuss these and other concerns. After those meetings it was clear to the Inspector General that there were, in fact, two very distinct opinions, one held by Medicaid and one held by Legislators, about what the Office's role was. In order to succeed at both the Inspector General set about splitting the Office into two sections.

Responsibility for the Office's Program Integrity Role falls to the Program Integrity section which is managed by the Program Integrity Manager, Andrew Hill. This section, in cooperation with the Investigations Section, managed by John Slade, receives complaints of fraud, waste, and abuse, conducts

post payment reviews, conducts preliminary investigations and initiates recoveries of inappropriately billed claims. This section interacts directly with Medicaid and other agencies in fulfilling their Program Integrity responsibilities. Through their work this section helps the Office identify policy and contracts that may not provide adequate control of Medicaid expenditures. The Program Integrity section also interacts with providers in answering provider questions.

During 2018 the Office entered into a new MOU with the Department of Health that focuses on the delegated tasks the Office performs on DMHF's behalf. A copy of the new MOU is included at Appendix B. The new MOU better defines what tasks the OIG performs and how they are reported in response to the 2014 Utah State Audit. The Inspector General insured this current MOU avoids the pitfalls of the previous MOU that attempted to limit the Office's oversight duties and responsibilities.

Medicaid Oversight

What is Medicaid oversight?

CMS considers activities conducted by offices similar to the UOIG as additional measures, above the Program Integrity minimum requirements. They recognize states may take additional steps to provide oversight of the Medicaid programs they administer. Many states created independent offices to provide oversight of their Medicaid programs, but none are structured the same. The Arkansas Medicaid Inspector General's Office is the most similar to Utah in both size and responsibility.

Utah Code 63A-13-202 outlines the Office's duties and responsibilities related to oversight of the Utah Medicaid program. Specifically 63A-13-202(1)(b) states:

> (1) The inspector general of Medicaid services shall:
> (b) inspect and monitor the following in relation to the state Medicaid program:
> (i) the use and expenditure of federal and state funds;
> (ii) the provision of health benefits and other services;
> (iii) implementation of, and compliance with, state and federal requirements; and
> (iv) records and recordkeeping procedures.

Additional oversight responsibilities are found at 63A-13-202(1)(h) and (i). Those paragraphs say:

> (1) The inspector general of Medicaid services shall:
> (h) audit, inspect, and evaluate the functioning of the division for the purpose of making recommendations to the Legislature and the department to ensure that the state Medicaid program is managed:
> (i) in the most efficient and cost-effective manner possible; and
> (ii) in a manner that promotes adequate provider and health care professional participation and the provision of appropriate health benefits and services;
> (i) 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.

The Inspector General used these two paragraphs of the law to develop the Office's oversight strategy.

How does the UOIG accomplish oversight?

The UOIG accomplishes Medicaid oversight through evaluations and performance audits conducted by the Audit Section, managed by Neil Erickson. The audit section is also capable of conducting finance audits as needed.

Evaluations focus on specific segments of the Medicaid program such as subordinate programs, policies, or contracts. They provide information to the reader and are useful in helping staff understand how a program works. Evaluations do not usually generate findings. If the auditor determines there is a finding during the course of an evaluation, the internal audit committee may transition the evaluation into an audit.

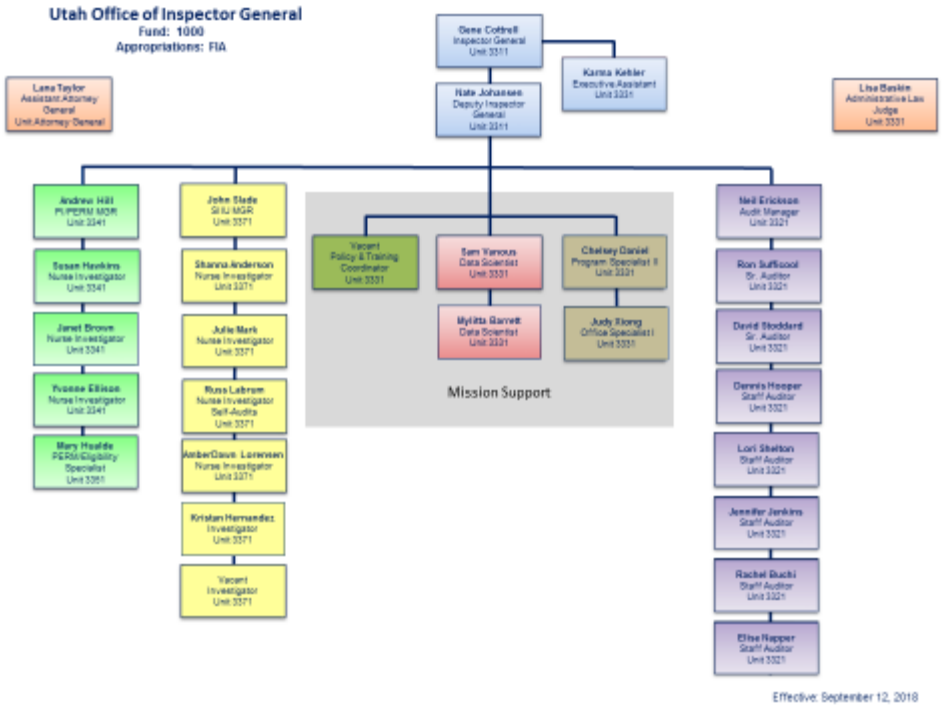
Audits focus on any part of the Medicaid program where the Inspector General determines there is potential risk for fraud, waste or abuse. UOIG Audits include other state agencies outside of the Single State Agency due to the contractual relationship within the state Medicaid program. For example, the Office may conduct recipient eligibility audits that include elements of the Department of Workforce Services (DWS) or waiver program audits, which include elements of the Department of Human Services (DHS). Additionally, the Inspector General may conduct audits of contracted private entities that perform Medicaid work on behalf of the Single State Agency. Contracted agencies include managed care organizations (MCO) such as the Affordable Care Organizations (ACO), Prepaid Mental Health Plans (PMHP), and Dental Managed Care Organizations. Audits conducted by the UOIG auditors may also include individual providers and group practices since they sign provider agreements when they enroll; essentially enter into a contract with the State.

During 2018, the Inspector General worked with the Audit Manager to develop and document processes by which, the Office conducts audits. The Inspector General refined the process so they follow the principles and standards of Government auditing outlined in the GAO Yellow Book. The Office now uses a risk-based, objective oriented audit process. This means the Office identifies risks within an area they intend to audit and then develop the audit objectives prior to the start of the audit. If the auditor discovers another objective needs added after the start of the audit brings the potential objective before the internal audit committee who decides to add the objective or push it into a future audit. This process keeps the audit focused which increases audit efficiency.

The Inspector General intends to continue building on these processes during SFY 2019. UOIG Audits cover the full spectrum of Medicaid services and in order to use available resources efficiently the Audit Team is improving processes with the goal to complete more audits each year.

Organization of the Office

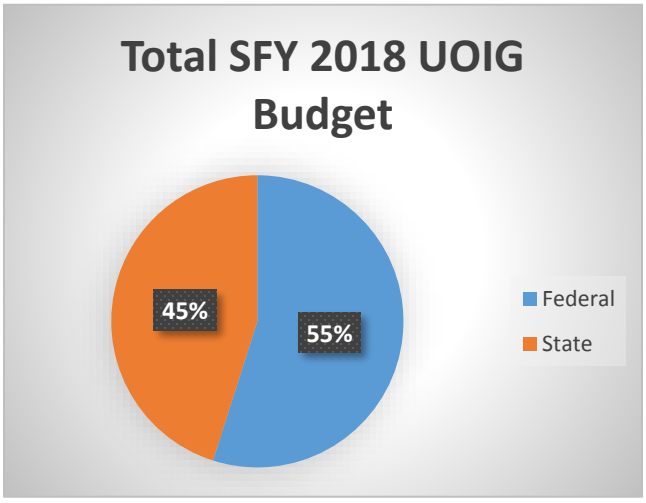
The two roles of the UOIG, discussed in the previous section, influenced how the Inspector General organized the Office. The Office is comprised of four sections, which are the Program Integrity Section (PI), the Special Investigations Unit (SIU), the Audit Section and the Mission Support Section. The PI and SIU perform the tasks outlined in the MOU with the Single State Agency and report their results to DMHF's Program Integrity Committee. The Audit Section performs the independent oversight work and issues their reports to both the Single State Agency and the Legislature. The Mission Support Section is comprised of specialists who support the other sections in accomplishing their missions. The Office employs the services of one full time attorney from the Utah Attorney General's Office and a part-time Administrative Law Judge (ALJ).



Funding the Office

Sources of UOIG Funding

The Utah Office of Inspector General is funded the same as the State Medicaid Program, due to the Program Integrity responsibilities the Office performs.



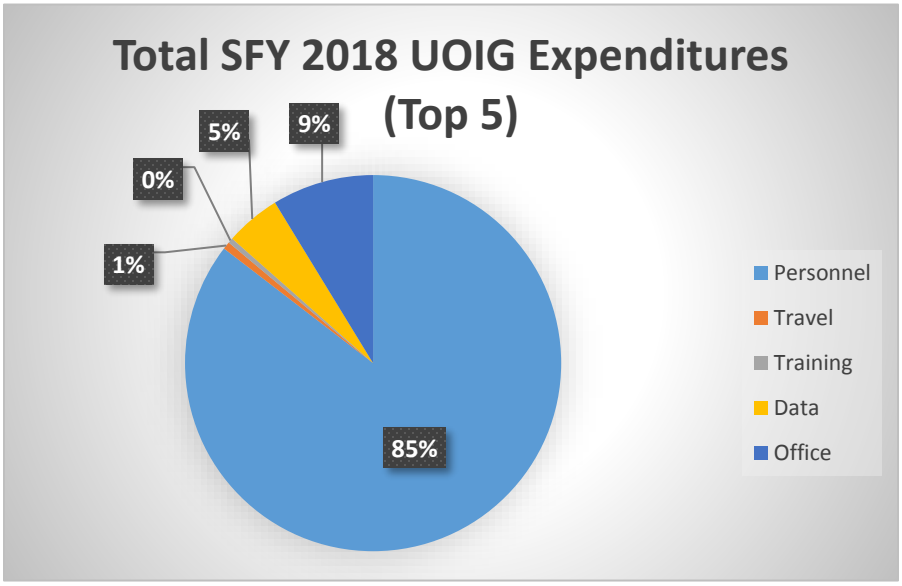
Therefore, the Office receives a portion of funding from the State and a portion from the federal government. The federal percent received by the Office is based on Federal Medical Assistance Percentages (FMAP), which results in most UOIG positions funded at 50/50 state/federal match and medical professionals paid at 25/75 state/federal match. In SFY 2018 the total allocated budget for the Office was $2,969,994 and the FMAP for the Office resulted in the UOIG receiving $1.33 million (45.09%) from state funds and $1.6 million (54.91%) from federal funds.

UOIG Expenditures

The five UOIG expenditure categories in SFY 2018 were personnel, travel (in state and out of state), training, data, and Office operations.

Personnel

Personnel expenditures include all expenditures associated with the retention of employees including payroll, insurance, taxes, etc. The personnel expenditure, as with any office, is the largest at 85% of the total budget or $2,537,235.



Travel (in and out of state)

The expenditure category of travel includes any travel related expenses associated with the work of the Office. In state travel includes statewide travel expenses to conduct on-site provider visits and training. Out of state travel expenses include travel to and from national level Program Integrity related conferences. Travel expenses in SFY 2018 were 1% of the budge or $19,232.

Training

Training associated expenditures include registration fees for conferences and other training events. Training is critical for maintaining certification of Office employees. In SFY 2018 the Office spent less than 1% of its budget on training or $13,102.

Data

Data expenditures include maintenance of computer systems, purchase of software licenses, case management software contracts, data storage and services performed for the Office by the Department of Technology Services (DTS). In SFY 2018 the Office spent 5% of its budget on data or $141,041.

Office Operations

The Office Operations expenditure category captures all other expenditures including office supplies, attorney fees, paper shredding, etc. In SFY 2018 the Office spent 9% of its budget on Office Operations or $259,385.

SFY 2020 Budget Concerns

The UOIG's Program Integrity work will continue to increase with Medicaid expansion and as the Office increases reviews conducted within Managed Care and Waiver programs. The OIG currently employs seven full time Registered Nurses who are funded at the higher 75/25 FMAP. RNs are critical for medical record review and play a critical part of the UOIG's work. During the 2019 Legislative Session the Inspector General requests an increase in budget to allow for an additional two nurses.

Additionally, the Inspector General noted an increasing demand for experienced nurses. The type of investigative medical record review conducted by the Office requires nurses with exceptional clinical experience and medical decision-making skills, which are currently in high demand throughout the healthcare systems. The Inspector General will work with DHRM to determine the feasibility of reclassifying the Office's nurse positions to the next higher level. This reclassification will allow the

Office to retain its current, experienced nurses while attracting new talent in a more competitive manner. If the reclassification is feasible, it will require an additional small increase in budget.

UOIG Performance Indicators

During SFY 2017 CMS and State Program Integrity Units throughout the country held numerous discussions regarding performance indicators. Specifically the discussion centered on how to quantify the work performed by units such as the UOIG. The Inspector General participated in many of the discussions and concluded that Utah uses the incorrect measures to indicate the performance of his Office. The stated goal of the Office is to "eliminate fraud, waste and abuse within the Medicaid program", which encompasses all facets of the Medicaid program. The previous Inspector General focused on tax dollars recovered as the primary performance indicator, which created an unrealistic expectation among key stakeholders.

Recovery Amounts Alone Do Not Demonstrate True ROI

The first Inspector General elected to use recovery amounts as the primary performance indicator presented to key stakeholders. He calculated simple ROI based on the recovery amount for any given year; a practice the Office continued through 2017. In 2017, the new Inspector General recognized a number of problems with using recovery amounts as a performance indicator.

First, different definitions of what recoveries are exist between various stakeholders. For example, analysts at the Legislative Fiscal Analysts (LFA) Office focus on cash recovered since that amount factors into their analysis. However, of the three techniques used by the Office to collect overpayments, cash collection is arguably the least desirable due to complex accounting processes required of the Single State Agency. The Single State Agency's preferred method of recovery is to have the provider rebill the claim correctly which provides for much cleaner accounting.

The second problem with using recovery amounts as the performance indicator is that it fails to capture the value of other activities associated with the work of the Office. For example, an audit may identify policy or contract issues (waste) during a performance audit and make recommendations to the Single State Agency for improvement. If the Single State Agency accepts and implements those recommendations there is not a recovery amount, but there is still value added by an improvement to the program.

The most commonly used activities include audits, evaluations, investigations, reviews, directed self-audits, and training. Any of these may generate recovery amounts, but many of them do not. The Office refers to these activities as Sentinel Events. These events drive the sentinel effect.

What is the Sentinel Effect

The Sentinel Effect is a theory that productivity and outcomes may be improved through a process of observation and measurement. In April 2015, the Speaker of the House met with the Inspector General and discussed the Office's operations. The Inspector General was the Interim Manager at that time and voiced his concerns regarding declining recovery amounts. The Inspector General understood that recoveries would decline and the Speaker agreed but observed the mere activity of observing providers' billing activity would have a positive effect on the Medicaid program. He went on to compare the effect of the Office's work to the effect a patrol officer, on the side of the road in Draper, has on speeders. His mere presence slows them down. The Inspector General came away from that meeting determined to incorporate the idea of Sentinel Effect into the Office's strategy moving forward.

Cost Avoidance Methodology

During SFY 2018, the UOIG management team and their data scientist developed a cost avoidance methodology that captures changes in provider billing behavior as well as impacts of less tangible Office activities like audit recommendations and training. CMS showed interest in the UOIG's methodology as they struggled to capture additional value beyond the simple ROI calculation they adopted.

The Inspector General defines cost avoidance, as any action the Office takes that will reduce Medicaid costs in the future.

The cost avoidance methodology establishes a baseline to determine the changes that occur after a sentinel event. The UOIG calculates the baseline by first, determining how much the procedure or policy is costing the Medicaid program over a specified period, usually no more than 36 months. The Office then takes some action (sentinel event) and monitors the baselines for changes in trends. The Office then calculates the difference between pre and post event to calculate cost avoidance.

The Office usually observes trends over an equal amount of time pre and post event and forecasts cost avoidance no more than three years into the future. During the post event period, the Office monitors the trend lines for changes. This step is necessary since new policy or new providers can cause the previous behavior to resurface.

The following example illustrates the UOIG's cost avoidance methodology:

Providers use Bilirubin Lights as in-home treatment for jaundice, most often in newborns. When the UOIG reviewed policy that outlined the use of Bilirubin lights they discovered providers left the lights in homes longer than necessary and billed for that additional time. The Office conducted three reviews of bilirubin lights and recovered approximately $70,000 dollars. Prior to the UOIG's review there were 12,400 claims submitted over a three-year period to Medicaid, equaling $652,288. After the review, the claims dropped to 1478 over the subsequent three years and cost the state $240,704. The Office's action resulted in a behavioral shift of $411,584 and resulted in annual savings to the Medicaid program of $137,194 or $411,584 projected over three years. The Office continues to monitor bilirubin lights and the behavioral change remains consistent. However, if there was a spike in claims submitted for the lights the Office could conduct an audit to determine the cause.

Cost Avoidance Outcomes

The Office fully implemented the cost avoidance methodology in January 2018 and the outcome is $14,072,782 in cost avoidance for SFY 2018. There are already $14,009,053 in cost avoidance projected for SFY 2019. The sentinel effect saves the taxpayers' dollars.

Cost avoidance return on investment (ROI) for SFY 2018 is 474% or $1 spent for every $4.74 that Medicaid avoided spending due to action by the UOIG.

UOIG Recoveries, Restitution Payments and MFCU Pass Through

OIG Recoveries

The Office continues to recover inappropriately paid tax dollars and receive court-ordered restitution payments as part of its Program Integrity responsibilities. The Office categorizes recoveries into three methods, cash recoveries, rebilled claims and credit adjustments (offsets). Cash recoveries are the least

desirable method due to the complexity of Medicaid accounting. Medicaid prefers the rebilling of claims because it creates a better audit trail and presents a more accurate accounting picture.

The Office initiates all recoveries through a Findings Report and a Notice of Recovery Letter that it issues to the provider. During SFY 2018 the Office issued 698 recovery letters which encompassed 7,019 total transaction control numbers (TCN) reviewed by the Office.

If the claim is still within the timely filing window, the Office generally directs the provider to rebill the claim correctly. The recovery amount is the difference between the initial payment and the rebilled payment. For example, if a provider billed $1,000 for a procedure, but the Office determines a coding error exists and the correct payment should be $750, the recovery amount is $250. Coding errors like this example are frequently systemic and may result in large recoveries.

When a provider fails to respond to a Notice of Recovery or fails to provide requested medical records the Office may initiate an offset against future claims by that provider. In the case where the Office initiates an offset, the UOIG notifies the Division who then conducts the Offset and notifies the OIG when it is complete.

Finally, the provider may choose to submit a check as cash payment if they agree with the Office's findings.

Recovery Results

In SFY 2018, the Office recovered $1,423,963 through cash collection, $1,327,266 through rebilled claims, and $743,315 through offsets. The Office recovered a total of $3,494,545. This recovery amount is consistent with the Inspector General's 2015 estimate, as discussed with the Speaker of the House, that cash collections would average between three and five million dollars annually. This recovery amount is also comparable to other state recovery amounts where the population and Medicaid enrollment are similar to Utah.

Total UOIG SFY 2018 ROI

The Inspector General uses simple calculation method (recovery amount/expenditures)x100 to determine return on investment. The recovery return on investment for SFY 2018 is 117% or $1 spent for every $1.17 recovered and the cost avoidance ROI is 474% or $1 spent for every $4.74 that Medicaid avoided spending due to action by the UOIG. Therefore, the combined total ROI for SFY 2018 is 591%.

Restitution Payments

Restitution payments are payments made to the Medicaid program because of a court decision, usually resulting from MFCU actions. The UOIG receives restitution payments and processes them but they do not contribute to the Office's overall ROI. In SFY 2018, the total amount of restitution payments processed by the Office was $12,457.

MFCU Global Settlement Pass Through

The Office also receives payments that result from global settlements resulting from legal action taken by the Medicaid Fraud Control Unit (MFCU). These actions are generally cases involving global action taken against pharmaceutical companies. These collected amounts belong to MFCU and do not factor into the Office's ROI. The Office passed through $1,519,715 from MFCU to Medicaid during SFY 2018.

Program Integrity Activities

During SFY 2018, the UOIG entered into a new MOU with the Department of Health, as the Single State Agency responsible for the administration of the Utah Medicaid program.

The Program Integrity Section also started reviewing claims submitted to the ACOs to ensure physicians bill the ACOs appropriately. The Section pulls a monthly encounter data sample for review, much like they do fee-for-service. However, it is important to note that when reviews identify billing errors in these sample claims the Office notifies the ACO, of the improper payment, and they perform the recovery action. Currently, there is not a way for the Office to recovery funds from the ACOs, because of contract language between the state and the ACO.

Some of the Program Integrity activities performed by the Office during SFY 2018 are listed below.

Capitation Payments vs Fee for Service Claims

Beginning in 2013, the Utah Legislature implemented a major change to the Medicaid system. Prior to that time, providers billed Medicaid on a fee-for-service (FFS) basis. Stakeholder deemed this payment method to be inefficient, so Utah Medicaid switched to a capitated healthcare system. Approximately 90% of all Utah Medicaid recipients are enrolled in managed care, but according to Medicaid, about 46.3% of the total Medicaid spend goes toward managed care. Managed Care includes medical care through the Accountable Care Organizations (ACO), mental health care through the Prepaid Mental Health Plans (PMHPs), or dental care through the Dental Maintenance Organizations (DMOs).

Accountable Care Organizations (ACOs) exists to provide general healthcare needs to the recipients. Overall, these ACOs receive a specific amount of money each month for each recipient, known as a capitated rate. These payments are supposed to cover all the necessary care the recipient requires, and the amount varies based on the health needs of each recipient.

In theory, a recipient belonging to an ACO should not have any FFS claims, or if so rarely. However, due to “carve-outs” many procedures are still billed FFS to Medicaid or to another type of managed care plan, such as the PMHPs or the DMOs.

Over the past several years, the UOIG identified payments that providers billed FFS rather than to the ACO, who received a capitated payment for the Medicaid recipient. If providers do not bill the appropriate payer, ACO or Medicaid, the taxpayer pays twice, once through the capitated rate and once through the FFS payment. During all of SFY 2018, the Office investigated a case where patients presented at emergency care facilities for mental health care. The emergency care facility billed FFS rather than billing the PMHP, where it was more appropriate to bill. This case was exceptionally complex because many of recipients also needed emergency medical care due to self-harm, which resulted from their mental health condition. Ultimately, the UOIG settled this case with the ACO for $500,000 and a commitment not to bill an additional $300,000 of similar claims in the same manner. The settlement agreement occurred just after the close of the fiscal year, so the Inspector General excluded those recovery amounts from this fiscal year total. This case, however, demonstrates UOIG work performed in the managed care area.

In SFY 2018, the Office audited 92 (40%) Encounter Claims data pulls and 134 (60%) Fee-for-Service data pulls. Because of these data pulls, the Office reviewed, either through audit or investigation, 23,574,833 (88%) individual encounter claims and 3,185,859 (12%) fee-for-service claims.

During SFY 2019, the UOIG will continue to conduct both audits and investigations into this matter. It is important to note that current Medicaid contracts with managed care organizations do not allow for direct recovery of funds by the UOIG. Therefore, UOIG audits in the managed care area will identify problems and recommend that the Single State agency take steps to recovery any inappropriately paid funds and adjust the capitations, as necessary.

Laboratory Services

The Office also focused on laboratory services during SFY 2018, especially tests for controlled substances, toxins, and poisons. Program Integrity units across the nation reported increased misuse of laboratory services starting in 2016. The Office started monitoring laboratory compliance and investigating any anomalies it detects. Medicaid reimburses laboratories based on the kind and quantity of tests they perform. Some providers order very few tests, while other providers order many different tests for each recipient. Improper billings occur when providers order unnecessary labs, or when laboratories conduct labs not ordered. Labs can be quite expensive, due to the volume of tests billed to the program.

The Office compares labs with one another using a series of metrics to determine where potential waste occurs. When the Office identifies a lab where potential abuse is occurring it requests medical records and conducts a comparison of tests ordered by physicians and actual tests completed by the labs.

During SFY 2019, the Office will continue identifying suspect labs and will investigate those that they identify as outliers.

Controlled Substances

The Office reviewed controlled substance prescribing and Medicaid recipient overuse for many years prior to SFY 2018. However, the Inspector General struggled convincing State or Federal law enforcement to prosecute such cases. During SFY 2018, with National attention focusing on the problem of opioid addiction, the Office finally started seeing some success in controlled substance cases. The Office identified a number of providers prescribing very high levels of controlled substances and opened investigations into the reason for such high prescribing practices. In some cases, prescribing high amounts of controlled substance is appropriate, especially in certain types of pain management involving diseases like cancer. However, in other cases, high prescribing practices are not appropriate and the UOIG is working with State and Federal partners to identify and prosecute those offenders.

Changes in Utah Code over the past three years made many controlled substance related charges at the recipient level a misdemeanor rather than a felony. As a result, the Office found local law enforcement agencies unwilling to accept these types of cases. That may change during SFY 2019, because HHS OIG may broaden MFCU's authority to accept some types of recipient fraud including, potentially, frequent drug seeking cases. During 2018, the Office started developing several algorithms to help identify both recipient and provider activity.

When the Office identifies a recipient, whom it believes is inappropriately seeking controlled substances it refers the recipient to Medicaid for placement on the restriction program. When Medicaid places a recipient on restriction the recipient is restricted to, what provider can prescribe controlled substances and what pharmacy can fill prescriptions. The action frequently changes the recipient's behavior since both the doctor and the pharmacy can track the recipient's controlled substance usage. However, there are ways to circumvent the controls by using cash. The Office is designing algorithms and metrics that

work in conjunction with the restriction program and focus on prescription patterns, rather than simply number of pills prescribed.

The CDC designed a Morphine Equivalents metric that the UOIG started incorporating into its controlled substance work during SFY 2018. The Morphine Equivalents metric allows investigators to place controlled substance on the same scale for comparison purposes, which was difficult in the past. For example, Fentanyl has a much more powerful effect than Oxycodone, so to compare their effects would provide inaccurate information. Using Morphine Equivalents, Fentanyl has a value of 7.2 and Oxycodone has a value of 1.5, which allows the investigator to compare the impacts of various opioids using a conversion factor for each prescription based on its strength. Investigators can then compare each recipient, or provider, against one another to determine if providers are prescribing excessively. When the Morphine Equivalents values reach a certain value, it becomes dangerous to the recipient (value varies). The Office then uses this data to identify providers or recipients that need additional investigation.

The UOIG will continue developing relationships with law enforcement agencies during SFY 2019, in order to strengthen its investigations. The UOIG hopes to be part of the larger solution combatting controlled substance abuse.

Medicaid Oversight Activities

The UOIG Audit section refined and documented audit procedures during SFY 2018. The revised procedures bring the oversight activities of the Office more into compliance with AIG Green Book Standards and GAO Yellow Book Standards. The overall audit process is now fair, unbiased, professional, and meaningful. The Inspector General designed the processes for more efficiency and expects to double the number of audits released during the next fiscal year.

During the past year, the Office also introduced evaluations as an additional oversight tool. The Inspector General introduced evaluations as a way to add clarity to the complex Medicaid programs. Evaluations differ from audits because they likely will not produce recommendations, but simply seek to clarify how a program works. The Inspector General feels this is an underutilized aspect of Office's capacity since Legislator's could request an independent evaluation by the Office when considering legislation affecting the Utah Medicaid program.

Evaluations

The Audit team conducted the following four evaluations during SFY 2018:

1. 2017-05 Ambulance Billing
2. 2017-07 Provider Preventable Conditions
3. 2018-05 Evaluation of PMHP/FFS Payment Split
4. 2018-08 PARRIS Report

The Office does not post evaluations on the UOIG website since they are clarifying in nature, but does release the reports to the requester of the report.

Audits

In SFY 2018, the Audit section completed four audits of the Medicaid Program. The four audits were:

1. 2016-02 HIPAA Compliance for BAA of the Utah DOH
2. 2017-07 Dental MCPs
3. 2017-13 Chiropractor Billing Practices
4. 2018-09 Deficit Reduction Act (DRA) Compliance

The Office releases audits of Medicaid on its public website unless they contain personal identifying information. When the Office conducts audits, the goal is to identify areas of potential risk within Medicaid programs and test the controls Medicaid has put in place to determine if those controls are effective in controlling the risk. Controls may include policy, contract oversight, or even edits within the claims software. This area of oversight is critical for identifying and mitigating waste within the Medicaid system.

During 2018, the Inspector General and the Audit Manager worked closely to improve the Office's audit process. The Inspector General estimates that the changes the Audit Manager implemented will result in doubling the number of released audits in 2019.

Appeals and Hearing

A Notice of Hearing Rights accompanies every action the Office undertakes. During SFY 2018, the Office received 424 requests for hearings. In many cases, the providers submit a request for hearing simply to give them additional time to review the Office's Notice of Recovery. This practice is evident by the number of cases closed in favor of the Office, which is 227 cases. Only 50 cases were closed in favor of the Provider and 96 cases resulted in a stipulated agreement between the two parties. There are 51 cases still open.

Concerns

The Office needs the ability to extrapolate. The Utah Office of Inspector General is one of the few Program Integrity Offices, in the country, that does not use extrapolation. State legislators restricted the Office's ability to use extrapolation as a tool, which decreased the Office's efficiency. They did not completely remove the Office's ability to extrapolate, but did seriously restrict it.

See Appendix A, for a white paper released by the Office that outlines how the Office could use extrapolation if the current restrictions are loosened.

Appendix A: Extrapolation White Paper

Extrapolation as a Means for Estimating Claim Error Rates and Recoveries

Introduction

The Utah Office of Inspector General (UOIG) relies on investigations, reviews, and audits to provide oversight to the Medicaid system. This is accomplished using a variety of techniques, including statistical extrapolation. Extrapolation is technique that is used to provide estimates from known values.

While the UOIG can currently use extrapolation, there are several criteria that need to be met first. While each criterion can be argued on its own merit, most appear to reasonable from an investigative standpoint. However, one criterion is very limiting and with more flexibility the UOIG recoveries would reflect the true impact of the UOIG.

In Utah Administration Code **R414-512-3,** it states "the value of the claims for the provider, in aggregate, exceeds $200,000 in reimbursement for a particular service code on an annual basis." This makes the use of extrapolation in Utah very limited.

Extrapolation is best used with providers that bill numerous low charge claims. For example, a dental claim may have $200.00 in allowed charges. This same dental claim may also have 10 different service codes (or more). Combined the service codes would not reach the criterion of $200,000 reimbursement. This would make all of the providers' claims ineligible for extrapolation.

Claims that have large allowed charges typically do not have the volume of billings to warrant extrapolation. In cases such as this the investigator/auditor may review all of the suspect claims. Extrapolation is key when both the volume of claims make reviewing every claim difficult, and when the return on investment is low per claim. To illustrate this, a past investigation will be discussed and explained, which will then be compared with extrapolated results. This may be an oversimplification, but it illustrates the value of extrapolation in obtaining improper payments.

Home Health Agency Review Investigation

Home Health Agency Provider's Billing Summary	
Date Range:	MAR 2011- AUG 2015
Number of TCNs	346
Number of Procedure Codes	12
Number of Procedures	960
Number of Billing Months	56
Number of Recipients	28
Sum Allowed Charges	$94,471.45

A Home Health Agency (HHA) provider was investigated by a nurse. This provider did not meet the extrapolation criteria ($94,471.45 in allowed charges total), even though there were 960

procedures billed. The volume of claims that were billed makes it difficult to review every claim, so instead a small random sample was used for initial investigation.

The focus of the investigation was to compare the documentation provided by the provider with their billings in the Medicaid system. This provider was found to have no documentation for a variety of billed services, or insufficient documentation at best. This was found for 11 of the 20 records reviewed.

In order for the UOIG to collect an improper payment, without extrapolation, each individual claim must be reviewed. This would mean 346 different claims. The expected improper payment was very small, in most cases around $30.00. The provider in this case no longer bills for Medicaid. In total less than $300.00 was recovered due to the review.

Extrapolation

Extrapolation would have been an ideal solution in this case. For extrapolation to be successful it relies on random samples being utilized. Random samples ensure that each claim has the same probability of being in the sample. While the sample must be random for extrapolation, the size of the sample must also be of sufficient size for any predictions to be made.

There are several statistical software packages that will provide random numbers, as well as provide the required number of claims needed to conduct extrapolation (SPSS, SAS, Excel, etc.) Using a sufficient random sample is critical in providing reliable estimates.

For example, in the case of the HHA provider, a random sample of 182 claims would be needed to provide a reliable estimate of provider behavior and recoveries. While this is much more than the original sample for investigation, it is still nearly half of what is required without the use of extrapolation.

Statistical techniques and software are required to extrapolate the findings of the investigator as well as the recovery amounts. To use extrapolation, it should be reproducible by providers under investigation. The software and methodology should be transparent and available to the providers. For this reason, RAT-STATS will be utilized.

RAT-STATS is a statistical package that was developed by the Office of Inspector General (US Department of Health and Human Services) in the 1970s. It has been an invaluable tool to estimate improper payments. The entire statistical package is transparent. All formulas are made available, as well as limitations and weakness of the methodology.

The UOIG would propose that extrapolation be done exclusively using RAT-STATS. Random numbers and sample size can be reproduced with certain information with most statistical software packages, The UOIG would be completely transparent and expect any provider to have the ability to reproduce the extrapolation results. For this reason, extrapolation should be done exclusively with RAT-STATS.

RAT-STATS provides several estimates useful in estimating improper payments. The main difference between these is their accuracy. These estimates are expressed in confidence intervals and confidence levels.

While both confidence intervals and levels sound similar they are very different. Confidence intervals provide a range of values in which the true value is expected to lie. There is a lower

limit and an upper limit. This is often seen in political polling. A result may be a given percentage +/- points. For example, a poll may indicate that 53% of citizens are in favor of recycling. This may be followed by a value of +/- points (4 pts.), which would indicate that the true value lies somewhere between 49% and 57% of the citizens are actually in favor of recycling.

Confidence levels are different in that they are expressed in percentages. If a confidences level is set by the researcher at 80%, that means 80% of the samples created with the same methodology would have near identical values and the confidence interval would contain the actual value being predicted.

RAT-STATS provides both an upper limit and lower limit for the confidence interval. It also provides three different sets of confidence limits. There is an 80%, 90%, and 95%. This allows for a variety of values to choose.

HHA Results if Extrapolated

It should be noted the original sample that this example is designed was very limited and in no way statistically valid or significant. It does provide an illustration at the two different processes and the necessary effort involved in doing both. The traditional method requires every claim to be reviewed, while extrapolation would reduce the effort of both the UOIG and providers (record requests costs, staff, delivery, etc.)

In the limited sample 11 out of 20 claims had recoveries. For extrapolation to be statistically valid 182 claims (9.1 times more claims than originally reviewed) would have to be randomly selected. This would satisfy a confidence interval of 95%. However, with extrapolation the recoveries may be worth the additional effort.

Confidence Level	Lower Limit	Upper Limit
80%	$11,554.00	$20,217.00
90%	$10,245.00	$21,526.00
95%	$9,058.00	$22,714.00

The HHA provider results indicate that at most there is a maximum of $22,714 and a minimum of $9,058 in recoveries. This range of values coincides with a confidence level of 95%. This occurs since the 95% confidence level needs to contain a wider range to ensure the actual values are captured.

This is also the reason that the OIG recommends that the 95% confidence interval be used with the lower limit for recoveries. This will be the most conservative and reliable value possible. It may not be the most accurate, but it will help offset the costs for the additional records supplied by the providers, while still providing the State of Utah recoveries due to improper payments. The original amount collected was under $300, the extrapolated amount is just over $9,000 (30 times more recoveries than the original investigation).

Extrapolation Methodology

Extrapolation is a statistical technique that has been used for quite some time at both the federal and state level. It relies on sound methodology and statistical techniques. This alone lends itself

to criteria. The UOIG office considers many different aspects when conducting audits, reviews, and investigations. The cost to the providers and potential recoveries are part of the process, but not the complete process.

Extrapolation would reduce the burden for providers when many low dollar claims are involved. It would also increase the efficiency of the UOIG by allowing more improper payments to be recovered with less financial stress to do so.

The UOIG would recommend using statistically valid random samples based on a 95% confidence level. RAT-STATS should be employed to conduct the extrapolation based on the random sample. The results for recoveries should be based on the 95% confidence level using the lower limit provided.

The random sample seed number and data universe should be given to the provider upon request so that the analysis can be repeated if necessary. The UOIG is transparent when possible with techniques, however in this case the provider will have access to everything needed to replicate the results to the last dollar. The RAT-STATS manuals contain all formulas and methodology used to obtain the results (if that level of detail is needed).

Summary

Statistical extrapolation is a tool that is used frequently by other OIGs. In Utah, the criteria to perform the technique is limiting, in particular the $200,000 limitation for one code by one provider for one year. With this criteria eliminated, or reduced the UOIG would be able to recover more improper payments efficiently. In order to conduct extrapolation the data must already meet statistical requirements (be of sufficient size and reliability), adding further requirements unnecessarily limits the UOIG's ability to extrapolate and collect improper payments. Extrapolation would only be done when the data and investigations warrant the analysis and it will be conducted using the most conservative Confidence Intervals and Levels.