



OFFICE OF INSPECTOR GENERAL OF MEDICAID SERVICES

EXECUTIVE OFFICES & CRIMINAL JUSTICE APPROPRIATIONS SUBCOMMITTEE
STAFF: ZACKERY KING

ISSUE BRIEF

SUMMARY

This issue brief provides information on two building block requests and an update to the Legislature on the implementation of HB 84 *Office of Inspector General of Medicaid Services* passed during the 2011 General Session. This brief is for informational purposes only and requires no Legislative action.

DISCUSSION AND ANALYSIS

HB 84 Office of Inspector General of Medicaid Services

HB 84 *Office of Inspector General of Medicaid Services* (<http://le.utah.gov/~2011/bills/hbillenr/hb0084.pdf>) creates within the Governor's Office of Planning and Budget the Office of Inspector General of Medicaid Services and mandates certain activities which are discussed here below:

- 1. Creation of New Inspector General Office** - the office is tasked with identifying, preventing, and reducing fraud, waste, and abuse within the Medicaid program. The office receives all of the Department of Health's FY 2011 Medicaid program integrity funding as well as an additional \$819,100 total funds (\$300,000 General Fund) from the Department of Health. The Inspector General indicates that it has used the extra funds to pay for space rental, continuing software contracts, and the development of a data mining function.
- 2. Inspector General Position** – the inspector general serves two year terms by appointment of the Governor with the consent of the Senate. The Inspector General received the Senate's consent in July 2011.
- 3. Annual Report** – the Inspector General must provide an annual report to the Legislature by October 1 of each year and must present the report by November 30th each year to the Executive Appropriations Committee. Members of the Executive Appropriations Committee received the report via email by October 2011. The Social Services Appropriations Subcommittee heard the report presented at its October 20, 2011 meeting. The report covers the activities and results of the office's activities as well as suggested measures the Governor and the Legislature could take to reduce fraud, waste, and abuse in the Medicaid program. The report is Appendix A. Below are some of the highlights from the report:
 - a. "Mr. Auston Johnson, Utah State Auditor, agreed that an audit would be prudent in order to evaluate whether cash balances, cash collections, write off's, separation of duties controls, ROI and other key financial information for our office is accurately stated and materially correct. The primary concern relates to a weakness in internal control that has existed for many years. Cash collections have been housed within the office, and one person had access to checks, accounts receivable, and the medical review notes that identify money for collection." (page 1)
 - b. "The office released three performance audits during FY2011. The audit identified \$1 million in Medicaid costs that were recoverable during fiscal year 2011, and an additional \$3.9 million in future cost avoidance. Audits cited concerns such as inappropriate billings, unsubstantiated provider costs, and unaccounted for vaccines." (page 3)
 - c. "Audits conducted by the Program Integrity function of the Office of Inspector General of Medicaid Services recovered approximately \$10.1 million dollars in one-time state and federal Medicaid funds during fiscal year 2011." (page 4)
 - d. "Based on estimated collections for fiscal year 2011, and compared to estimated cost, the unit produced an ROI of 691 percent on collections. For every dollar the State spends on program integrity efforts, the unit returns \$6.91." (When you include the federal dollars) (page 5)
- 4. Fraud Reporting** – the Legislation requires health care professionals as well as State of Utah and local government employees to report any suspected Medicaid fraud. The Legislation provides the option for the report to be anonymous. The Inspector General reports opening 20 cases from hotline calls and internet submissions through November 2011.

5. Holding Medicaid Payments – the Inspector General may hold provider payments long enough to determine if they constitute fraud and/or abuse. The Inspector General has exercised this authority once through November 2011.

138,000 Building Block Request

This \$138,000 request would fund three new full-time equivalent positions to expand the Fraud, Waste, and Abuse Program. The state receives a federal match to assist in funding these positions and the OIG has estimated \$151,000 of federal matching funds for this request. The requested funding and federal matching funds exceed the estimated salary and benefits costs by \$34,000. The \$34,000 has been identified for the funding of existing personnel costs.

Position Breakdown (estimated costs for the positions):

- 2 Program Specialist IIs: Focus on the Department of Workforce Services and eligibility issues in the state
 - Salaries, Benefits, and support costs - \$80,500 per person
 - These positions are matched 50% State and 50% Federal
 - Total State Cost \$80,500
- 1 Nurse Investigator: Focus primarily on outside providers.
 - Salaries, Benefits, and support costs - \$80,500 per person
 - These positions are matched 30% State and 70% Federal
 - Total State Cost \$23,500

Background

The Centers for Medicare and Medicaid (CMS) are requiring an increase in audit output by 40 percent beginning in FY 2013. CMS has developed the Payment Error Rate Measurement (PERM) Program in response to a Federal law passed in 2002, the Improper Payments Information Act (IPIA). The Improper Payments Elimination and Recovery Act of 2010 (IPERA) is an amendment to IPIA. PERM carries out the mandates from these two acts and Medicaid and CHIP have been identified as programs at risk for “significant improper payments.” The OIG has anticipated a doubling of its workload in FY 2013 due to Medicaid audits increasing, and from PERM beginning its oversight of the CHIP program.

The 40 percent mandate results from an increased estimated error rate for Medicaid eligibility in Utah. The increased error rate impacts the number of sample cases Utah is directed, by CMS, to audit in a measurement cycle. In PERM, statistical analysis is used to determine error rates for three different areas of Medicaid payments: Fee-for-Service (FFS), Managed Care, and Eligibility. All 50 states are tested in each of these three areas for erroneous payments. Following a three year measurement period, states are chosen for auditing in cycles, an auditing cycle lasts approximately 26 months. Following this audit, error rates are determined and the U.S. Department of Health and Human Services produces a report for each respective state with results and analysis of the findings. FY 2010 is Utah’s most recent PERM findings report. In this report, Utah’s Medicaid Eligibility component estimated error rate is 4.5 percent, up from the 2007 estimated error rate of 1 percent.

CMS has provided preliminary sample sizes for auditing in FY 2013; the overall sample size for Utah is 3,540, a 2,219 case increase from FY 2010. The preliminary sample size for Eligibility active cases in FY 2013 is 1,476, a case increase of 972 from FY 2010; Eligibility negative cases for FY 2013 is 756, a 559 case increase from FY 2010. An important note with these numbers is they are preliminary and are due to change at the beginning of the FY 2013 cycle. This is the case with PERM in each cycle, the estimates are volatile and are due to change (increase or decrease depending on error rates and CMS estimates) with the beginning of each new three-year cycle.

OFFICE OF THE INSPECTOR GENERAL OF MEDICAID SERVICES ANNUAL REPORT



10/1/2011

Inspector General of Medicaid Services

The Office of the Inspector General of Medicaid Services was established on July 1, 2011. It was created to monitor and evaluate the Medicaid program in the state of Utah.

October 01, 2011

TO: Senator Allen M. Christensen, Representative David Clark, Representative Bradley Last, and the Social Services Appropriations Subcommittee

SUBJECT: 2011 Annual Report for the Office of Inspector General of Medicaid Services

Attached is our 2011 annual report to the Social Services Appropriations Subcommittee, in compliance with **Utah Code 63J-4a-202**. This report shows the results from the Department of Health's Office of Internal Audit and the Office of Inspector General for fiscal year 2011.

I am available to meet with members of the subcommittee to discuss any item contained in this report and to answer any questions regarding the ongoing efforts of this office during our transition period.

Sincerely,

Lee Wyckoff, CPA, CIA
Inspector General of Medicaid Services

cc: President Michael Waddoups
Speaker Rebecca Lockhart
David Patton, Ph.D
Michael Hales
Robert Rolfs, M.D.
Russ Frandsen
Stephen Jardine
Clifford Strachan

Table of Contents

INTRODUCTION	1
CURRENT STATE / EXECUTIVE SUMMARY.....	1
ROLE AND RESPONSIBILITIES	2
STAFF.....	2
OIG IMPACT	3
AUDIT ACCOMPLISHMENTS	3
Audit Plan	4
Follow-Up Reviews	4
PROGRAM INTEGRITY ACCOMPLISHMENTS	4
Performance Measures.....	5
Return on Investment	5
Area of Focus.....	5
CONTRACT MANAGEMENT	6

INTRODUCTION

CURRENT STATE / EXECUTIVE SUMMARY

The Office of the Inspector General (OIG) was created through legislation during the last general session and became an independent office on July 1, 2011. As the new Inspector General, I joined this office on August 8th, 2011. Since that time, I have been evaluating our responsibilities, the team, and our existing capabilities.

Earlier this week, we reorganized the office to better position us for long term success. This reorganization served to align our staffing with our key deliverables and responsibilities. Key changes include:

- reducing the number of managers,
- evaluating who on the team, or in some cases, outside the team, has the best skill set to manage,
- recruiting an Administrative Law Judge (part time) to preside over our hearings / appeals, and
- creating a small data analysis group (two people) that will allow us to more efficiently utilize our higher cost personnel, specifically doctors and nurse investigators.

During the transition period, most audit staff who were transitioned to the OIG left the office to pursue other opportunities. We have posted a number of positions for audit staff, and expect to have that function staffed, trained, and fully operational in early 2012.

In the process of evaluating our budget for the current fiscal year, reviewing past financial data, and examining our internal controls of cash collections and write-off's, we have a number of unanswered questions. On September 26, 2011, Ron Bigelow, Executive Director, Governor's Office of Planning and Budget, and I met with the Utah State Auditor, Auston Johnson to speak about the specifics. Mr. Johnson agreed that an audit would be prudent in order to evaluate whether cash balances, cash collections, write-off's, separation of duties controls, ROI and other key financial information for our office is accurately stated and materially correct. The primary concern relates to a weakness in internal control that has existed for many years. Cash collections have been housed within the office, and one person had access to checks, accounts receivable, and the medical review notes that identify money for collection. We have moved the cash collection process to the Governor's Office of Planning and Budget to remove access to those checks.

The numbers contained in this report are calculated using the historic methodology for calculation. They should be considered tentative numbers, and we will provide you with another, interim report that either confirms the numbers in this report as accurate, or restates them using a corrected methodology.

The final Memorandum of Understanding (MOU) with the Department of Health was executed on September 28, 2011, and provides the OIG office with the authority and ability to begin recovering funds. We have continued preparing recovery letters, and will be releasing them to providers soon. We have used this period, where we could not issue letters, to meet with certain provider groups and associations in an effort to communicate and build a relationship with those providers prior to having difficult, recovery discussions.

ROLE AND RESPONSIBILITIES

The mission of the Office of Inspector General of Medicaid Services Audit division is to:

- Ensure compliance with state and federal requirements as they pertain to Medicaid.
- Audit, inspect, and evaluate the functioning of the division to improve Medicaid operations.
- Advise the Department and Division of an action that should be taken to ensure the state Medicaid program is managed in the most efficient and cost-effective manner possible.
- Identify, prevent and reduce fraud, waste and abuse in the state Medicaid program.
- Recoup, reduce costs and avoid or minimize increased costs of the state Medicaid program.

See 63J-4a-202

STAFF

Inspector General	Lee Wyckoff, CPA, CIA
Audit Manager	Broc Christensen
Program Managers	Noleen Warrick Kylene Hilton
Audit Staff	Doug May, CIA
Program Integrity Staff	Cindy Carner, RN Kathy Cordova John Hylan, MD Connie Keuffel, RN Alexandra Meyer, Toni Shepard, RN John Slade George Smith, MD Brenda Strain Sally Valdez, RN Marian West, RN
Administrative Support	Ann Carrillo

OIG IMPACT**AUDIT ACCOMPLISHMENTS**

The office released three performance audits during FY2011. Audit identified \$1 million in Medicaid costs that were recoverable during fiscal year 2011, and an additional \$3.9 million in future cost avoidance. Audits cited concerns such as inappropriate billings, unsubstantiated provider costs, and unaccounted for vaccines. The following table shows the impact of audits during fiscal year 2011.

Complete Audits	Fiscal Year 2011	
	2011 Only	Prevented Waste Prospectively
Recoverable Funds	\$1 Million*	0
Cost Avoidance	0	\$3.9 Million**
Total	\$1 Million	\$3.9 Million

*See detailed explanation below.

**Amount based upon report 2011-04 stating that HOME is unable to reliably and sufficiently substantiate \$3.9 million in claims. \$717,160 has already been collected. The Medicaid Division is currently working with Centers for Medicare and Medicaid Services (CMS) to determine whether the remaining unsupported claims should be recovered or accepted.

Some key outcomes from these audits include:

- Performance audit on emergency room and ambulatory surgical center billing on October 25, 2010. This report contained recommendations to correct billing coding errors, reprocess inappropriate billings, and implement a policy to ensure timely implementation of billings changes. The Department of Health agreed to program changes to be implemented by October 1, 2010. It resulted in approximately \$900,000 in reprocessed, recoverable claims. Although we did not count prospective savings on this control enhancement, it is likely that the controls would have remained the same costing Medicaid an additional \$900,000 (9 months at \$100,000) for the remainder of the fiscal year 2011.
- Performance audit of the University of Utah's Healthy Outcomes Medical Excellence (HOME) was completed in December 2010. This audit report recommended that the HOME program substantiate \$3.9 million in costs in the format required by federal regulations and their contract with the Department of Health (DOH), or repay Medicaid and Health Financing (division) for the unsubstantiated costs. The audit report also recommends greater coordination between the division and HOME, an audit of HOME fiscal year 2010 costs, and adjustment of HOME prepayments to reflect documented costs. HOME is negotiating directly with CMS to determine the amount and timing of repayment

- Performance audit released in February 2011 on the Vaccines for Children (VFC) program in a particular group of clinics discovered \$134,950 in lost, missing or unaccounted for vaccines. The program reimbursed Medicaid for these costs.

Audit Plan

There is a preliminary audit plan that was established prior to the inception of the Office of the Inspector General. That plan includes many high risk business processes. While we are in the process of building our audit function and enhancing our audit plan, we have chosen several high-risk audits to conduct (School Based Skills Development and Medical Policy Implementation). We plan to enhance the methodology for establishing potential audits and the associated risk. We will accomplish this through routine meetings with executive leadership at the Department of Health (DOH), and reaching out to communicate with other areas that overlap with DOH and Medicaid spending (Department of Workforce Services, Medicaid Fraud Control Unit, etc.). Audit staff will continue to collect and compile information throughout the audit plan execution so that the Inspector General can adjust the plan as needed.

Follow-Up Reviews

The Office of Internal Audit and Program Integrity issued a follow-up of the Legislative Auditors' report on *A Performance Audit of Fraud Waste and Abuse Controls in Utah's Medicaid Program*. This follow up report was issued in November of 2010 and stated that 14 of the Legislative Auditor's recommendations are fully implemented and the remaining 11 are in the process of being implemented.

PROGRAM INTEGRITY ACCOMPLISHMENTS

Audits conducted by the Program Integrity function of the Office of Inspector General of Medicaid Services recovered \$10.1 million dollars in one-time state and federal Medicaid funds during fiscal year 2011.

The program integrity unit has developed several performance measures to more objectively assess performance of the unit, individual employees, and other important functions of the department. Most have been measured for fiscal year 2011, but have been reviewed at irregular intervals and with a lack of consistency. Over the next year, we plan to increase the consistency of how we measure and monitor these metrics.

The following ratios have been identified as significant metrics.

- Federal reviews closed to total cases closed
- Reviews in functional areas to total cases opened
- Total hours and total PERM overtime hours to total amount of PERM hours
- Hours spent working cases to total recoveries
- State / federal recoveries to hours spent on recoveries

- Complete federal reviews to total dollars recovered
- Recoveries due to algorithms to total recoveries
- Cases greater than 12 months

Performance Measures

Two key performance measures are presented below:

Performance Measure	Est. FY 2011	FY 2011 Minimum Target
State Return on Investment (ROI)	691%	200%
Recoveries per FTE	\$652,000	\$450,000

Return on Investment

The main measurement is a return on investment (ROI) for the program integrity unit. Based on collections for fiscal year 2011, and compared to estimated cost, the unit produced an ROI of 691 percent on collections. For every dollar the State spends on program integrity efforts, the unit returns \$6.91.

The investigation of several providers resulted in the discovery of multi-million dollar overpayments. Two examples are a woman’s clinic (over \$1 million) and medical supply provider (over \$4 million). Program integrity has also developed more than 32 new algorithms that generate reports automatically to review for fraud, waste and abuse.

Area of Focus

We monitor the percentage of cases under medical review that are over one year old. The percentage of cases that are greater than one year old have increased dramatically (over 200%) in the last year. Most of this issue relates to the training of new staff, and an overall increase in our case inventory. We plan to closely manage the nurses’ workload and continue to use metrics to monitor their productivity. We also have added a nurse to our funded positions so that we have the flexibility to work the inventory more aggressively.

CONTRACT MANAGEMENT

In response to recommendations from the Office of Legislative Auditor and the Bangerter Commission Report, the Office of the Inspector General of Medicaid Services will:

- Monitor and manage the day to day activities of contractors (currently HMS), who reviews and recovers money on certain 2008 and 2009 Medicaid claims. The Affordable Care Act directs states to contract with a recovery audit contractor (RAC) by January 12, 2012. The RAC's will review submitted claims to identify overpayments and underpayments. These RAC's will operate on a contingency basis, keeping a percentage of what they are able to recover.
- There is a contract with Advanced Med and Thompson Reuters to utilize a software tool called Data Probe for identifying potential fraud, waste, and abuse in post payment Medicaid claims. Once aberrant practices are identified by the tool, results are turned over to the Inspector General for investigation. The contract will be free of charge for five years, during which time the Office of Inspector General will determine if it is meeting its needs for post payment claims review.