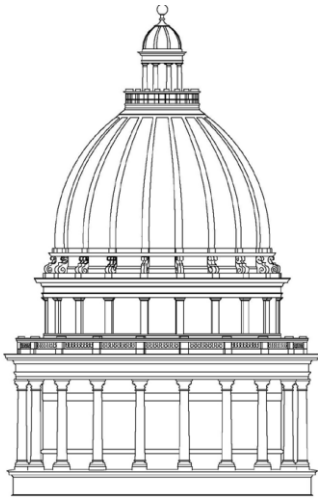
REPORT TO THE

UTAH LEGISLATURE

Number 2018-03



A Performance Audit of the Utah Office of the Inspector General of Medicaid Services

February 2018

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah

STATE OF UTAH

Office of the Legislative Auditor General

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Audit Subcommittee of the Legislative Management Committee
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JOHN M. SCHAFF, CIA
AUDITOR GENERAL

February 2018

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of the Utah Office of the Inspector General of Medicaid Services** (Report #2018-03). A digest is found on the blue pages located at the front of the report. The objectives and scope of the audit are explained in the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

John M. Schaff, CIA
Auditor General

JMS/lm

Digest of a Performance Audit of the Utah Office of the Inspector General of Medicaid Services

The Office of the Inspector General of Medicaid Services (OIG) was created in 2011 after two legislative audits found significant operational weaknesses and weak control of fraud, waste, and abuse (program integrity) in the Medicaid program. We recommended the Legislature create an inspector general's office to independently oversee Medicaid funds. The Legislature acted on that recommendation in the 2011 General Session. Since then, the office has had two inspector generals, with the current inspector general in office since 2015. OIG operations consist of three main activities: program integrity, performance audit, and special investigations. The OIG also devotes resources to provider education. While the OIG has neglected independent oversight of Accountable Care Organizations (ACOs), the OIG does coordinate with ACO program integrity units.

Chapter II Office of Inspector General Has Neglected Oversight of Accountable Care Organizations

OIG Activities Have Not Proportionately Addressed ACO Risk. While the OIG collaborates with ACOs, it has not been independently overseeing ACOs to the extent we would expect. The OIG's program integrity and performance audit functions should be doing more to ensure ACOs are effectively managing Medicaid funds. Program integrity and performance audit are two distinct units and functions within the OIG. The OIG told us that its oversight of ACOs has been impeded by pushback from Department of Health (DOH) and the ACOs, but the OIG has not provided us much documentation to support that claim. In fact, the OIG's statutory subpoena authority to compel cooperation has not been used.

OIG Should Set ACO Recovery Targets and Report on Their Recoveries. In 2017, the Center for Medicare and Medicaid Services' (CMS) encouraged the OIG to improve its ACO oversight. Among other things, CMS found that ACOs were not conducting sufficient investigations for programs of their size. In addition, CMS found that the ACOs were not identifying and recovering overpayments at the level CMS would expect. Based on CMS conservative estimates, we calculated an overpayment recovery target of $22.7 million over three years or $9.3 million in 2015. That is in addition to the $4 to $8 million in potential savings projected in the *In-Depth Budget Review of the Utah Department of Health* (2018-02) companion audit released on the same day as this audit.

Chapter III
OIG Processes and Accountability Need Improvement

OIG Should Improve Audit Planning, Reporting, and Practices. We believe the OIG can bolster declining recoveries and strengthen its audit and investigation practices by making improvements in several areas. Our concerns are as follows: OIG cost avoidance methodology lacks a substantive and repeatable methodology. OIG audit planning lacks a formal process or overall risk assessment. The OIG is not fully tracking its activities to know whether it is addressing the risks identified by potential audit planning. The OIG is not completing enough performance audits, with a 67 percent completion rate for audits started and staffed. In our opinion, this shows a weakness in OIG practices.

Legislature Should Consider Ways to Bolster OIG Accountability and Productivity. We believe with the concerns identified in this report, the Legislature should consider ways to bolster the OIG's accountability and productivity, and we discuss some accountability options. We also believe the Audit Subcommittee should consider prioritizing a legislative in-depth follow up audit after one year to assess the OIG's progress.

REPORT TO THE
UTAH LEGISLATURE

Report No. 2018-03

A Performance Audit of the Utah Office of the Inspector General of Medicaid Services

February 2018

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Chapter I
Introduction

The Office of the Inspector General of Medicaid Services (OIG) was created in 2011 after two legislative audits found significant operational weaknesses and weak control of fraud, waste, and abuse (program integrity) in the Medicaid program. We recommended the Legislature create an inspector general's office to independently oversee Medicaid funds. The Legislature acted on that recommendation in the 2011 General Session. Since then, the office has had two inspector generals, with the current inspector general in office since 2015. OIG operations consist of three main activities: program integrity, performance audit, and special investigations. The OIG also devotes resources to provider education. While the OIG has neglected independent oversight of Accountable Care Organizations (ACOs), the OIG does coordinate with ACO program integrity units.

The OIG has neglected oversight of 38 percent of Medicaid, totaling almost $1 billion in 2017.

The OIG has been unable to provide evidence of independent oversight of ACOs which is over 38 percent (nearly $1 billion) of Utah Medicaid patient expenditures. In our professional opinion, OIG management must strengthen its oversight of Medicaid by improving its cost avoidance measures, conducting better audit planning and risk assessment, and completing more performance audits.

OIG Organizational Structure Composed of Four Teams

The Office is organized into teams who can work independently of each other on specific projects or work collaboratively on projects that require a more multi-functional team approach. The teams are as follows:

The OIG is organized into four teams that handle medical reviews, investigations of waste and abuse, and auditing of Medicaid policies and processes.

- **Program Integrity/PERM Team (PI)**: Primarily responsible to focus on post payment medical reviews to ensure payments were billed and paid appropriately.
- **Special Investigations and Inspections Unit (SIIU)**: Conducts preliminary investigations of suspected fraud, as well as full investigations into the causes and effects of waste and

abuse. Additionally, performs on-sight inspections of providers to ensure Medicaid clients are receiving adequate care.

- **Audit Team**: Responsible for conducting evaluations and performance audits of Medicaid policies and processes where the potential for risk exists, which includes all Medicaid services.

- **Mission Support Team**: Comprised of specialists who are used to support the above three teams. The specialists include: Policy and Training Coordinator, Data Scientist, Program Specialist, and Office Specialist.

OIG Funded Through State and Federal Funds

The OIG receives state funding which then acts as seed money for a federal match, because they house the Program Integrity function. Figure 1.1 shows the funding sources for 2017.

Figure 1.1 OIG's 2017 Funding Is from State and Federal Sources. About 61 percent of OIG's funding comes from the federal government.

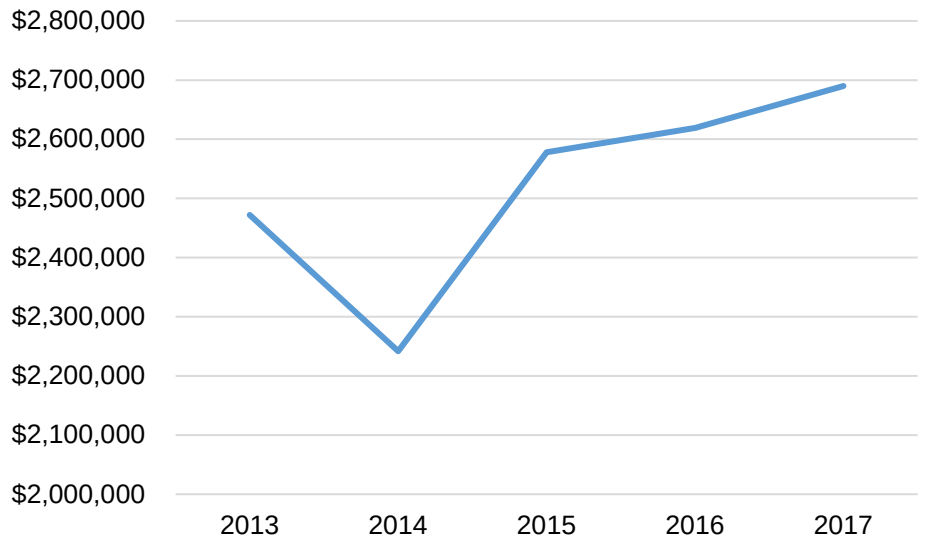
Fiscal Year 2017 OIG Funding Sources	
Source	Amount
State	$1,122,500
State (Pass Thru)	1,400
Federal	2,325,200
Carry Forward Balance	386,700
Total	**$3,835,800**

Source: OIG 2017 Annual Report

Over half of the $3.8 million OIG budget is federally funded, approximately $2.3 million.

As the Figure shows, a majority of OIG's funding comes from the Federal government, approximately $2.3 million of their $3.8 million total budget. Figure 1.2 shows the expenditures of the OIG from the past five years.

Figure 1.2 OIG's Expenses Have Grown Slightly Since FY 2013. Expenses have increased since FY 2014.



Source: OIG Annual Reports

Expenditures have increased from $2.4 million in 2013 to $2.7 million in 2017, a 9 percent increase.

OIG's expenditures have increased from about $2.4 million in fiscal year 2013 to $2.7 million in fiscal year 2017, approximately a 9 percent increase. The reason for the decline in expenditures in fiscal year 2014 is no new staff were hired and no training expenses were incurred. This performance audit is a companion piece to the ***In-Depth Budget Review of the Department of Health (2018-02)***, which is being concurrently released with this audit.

Audit Scope and Objectives

This audit was initiated as part of the in-depth budget review process required by ***Utah Code*** *36-12-15.1*. This is the fourth audit to be released relating to the in-depth budget review of the Department of Health. This audit reviews specifically how the OIG can improve its oversight over Medicaid funds. The first audit released in the budget review series was, *A Performance Audit of the Beaver Valley Hospital's Medicaid Upper Payment Limit Program* (2017-10) released in October 2017. The second audit, *A Performance Audit of the Division of Family Health and Preparedness* (2017-13) was released in November 2017. The third audit, *An In-Depth Budget Review of the Utah Department of Health* (2018-02), is a companion audit to this one, and was released together on the same day.

The scope of this audit was to review the following objectives:

- Oversight OIG provided to ACOs
- OIG oversight processes and accountability

Chapter II
Office of Inspector General Has Neglected Oversight of Accountable Care Organizations

The Office of the Inspector General of Medicaid Services (OIG) has been unable to provide evidence of independent oversight of over 38 percent (nearly $1 billion) of Utah Medicaid patient expenditures. The OIG is statutorily designated to provide independent oversight over Medicaid. Thirty-eight percent of Medicaid expenditures in fiscal year 2017 were managed by Accountable Care Organizations (ACOs). While ACOs have their own claims review functions, they lack the independence the OIG possesses. Further, as demonstrated in our ***In-Depth Budget Review of the Department of Health (2018-02)***, significant saving opportunities exist in the ACOs (as much as $4 to $8 million annually).

By statute, the OIG provides independent oversight over all Medicaid.

The OIG should also set recovery targets for Medicaid overpayments and report on ACOs' progress in reaching them. We estimated a target of $22.7 million in possible ACO recoveries between 2013 and 2015. During that period, the three largest ACOs combined actually recovered $265,000.

OIG Activities Have Not Proportionately Addressed ACO Risk

While the OIG collaborates with ACOs, it has not been independently overseeing ACOs to the extent we would expect. The OIG's program integrity and performance audit functions should be doing more to ensure ACOs are effectively managing Medicaid funds. Program integrity and performance audit are two distinct units and functions within the OIG. The OIG told us that its oversight of ACOs has been impeded by pushback from the Department of Health (DOH) and the ACOs, but the OIG has not provided us much documentation to support that claim.

ACOs' $1 Billion in Expenditures Need Independent Oversight

ACOs managed 38 percent of Medicaid expenditures in 2017.

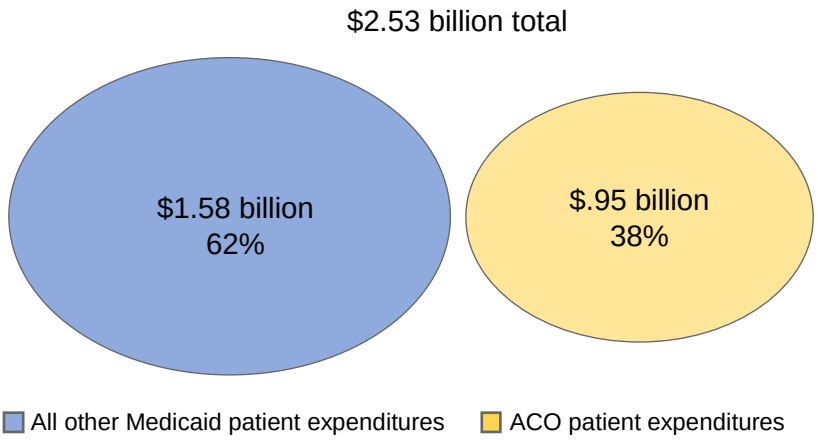
ACOs managed almost $1 billion, or 38 percent, of Medicaid recipient expenditures in 2017. Such expenditures represent a large risk that has not been appropriately addressed by the OIG, which is statutorily designated as Utah's independent Medicaid oversight entity.

The OIG is responsible to monitor Medicaid's use of federal and state funds.

The OIG was established as an independent agency on which the state could rely for oversight over the entire Medicaid program. Among the OIG's responsibilities are the requirements to inspect and monitor the use and expenditure of federal and state funds, and the provision of health benefits and other services. The OIG must also monitor the implementation of, and compliance with, state and federal requirements. The OIG's statutorily established responsibilities are in no way diminished by Medicaid's agreements with its ACOs or with the OIG. The OIG bears the responsibility to independently review Medicaid funds and services, including those services related to ACOs.

Figure 2.1 illustrates the amount of Medicaid recipient dollars managed by ACOs.

Figure 2.1 ACOs Were Responsible for 38 Percent of Utah's Medicaid Recipient Expenditures in fiscal year 2017. The OIG's focus on the larger portion of Medicaid expenditures neglects needed independent oversight of ACO recipient expenditures.



Source: Department of Health.

The nearly $1 billion in ACO managed expenditures represents a significant risk to the Medicaid program. Risk is defined by the

Institute of Internal Auditors as "the possibility of an event occurring that will have an impact on the achievement of objectives. Risk is measured in terms of impact and likelihood."

In 2012, the OIG recognized the risk of integrating ACOs into Medicaid and conducted an audit of the ACO implementation process. Unfortunately, based on OIG records there have been no audits completed on ACOs since 2012. In sharing its reasons for conducting the audit, the OIG stated:

In 2012, the OIG recognized the potential impact and risk of using ACOs.

> ***This project was selected for review because of the inherent risk and impact of an implementation of this magnitude.***

In terms of potential impact, the OIG recognized that ACO management of Medicaid recipients constituted an inherent risk to the Medicaid program.

Medicaid contracts with ACOs to provide medical services to Medicaid recipients. Recipients living in Utah's most populated counties must choose an ACO, whereas recipients living in other counties can choose an ACO or Medicaid's Fee for Service Network, which is directly managed by Medicaid. Each ACO is responsible to provide enrolled Medicaid recipients with most medical services covered by Medicaid. Medicaid typically pays a monthly fee for each Medicaid member enrolled in an ACO.

ACOs resemble insurance plans in that recipients enrolled in an ACO must receive all services through a provider in that ACO's network. ACOs then pay the providers for services rendered to their recipients. Recipients enrolled in the Fee for Service Network may use any Utah Medicaid provider, after which the provider is paid by Medicaid directly.

ACOs conduct their own analyses and investigations into potential fraud, waste, and abuse among providers and Medicaid recipients, but lack administrative independence. Some ACOs are affiliated with their providers, and because all ACOs are administering Medicaid programs, they lack independence. We did not audit the ACOs' internal program integrity efforts and offer no opinion on their performance. Our focus and concern is with the OIG's independent oversight of ACO program integrity reviews.

OIG Cannot Identify the Extent of Its ACO Program Integrity Oversight

The OIG has not proportionately reviewed ACO Medicaid claims. In fact, the OIG has not identified the amount of ACO independent program integrity reviews the office has completed even though ACOs manage 38 percent of all Medicaid recipient expenditures. Additionally, the OIG has not attempted to independently review ACO program integrity reviews to identify their programs' sufficiency or effectiveness.

The OIG's program integrity unit cannot identify how much work it has done on ACO claims.

The OIG's program integrity unit has the responsibility of testing Medicaid claims to ensure that providers are appropriately billing Medicaid. Previously, this testing was performed by the state's Medicaid program, but due to the lack of Medicaid's independence, our office recommended an OIG be established to perform that and other Medicaid oversight activities.

The OIG reports it has not proportionately tested ACO Medicaid claims. Instead, the OIG reports that it has focused much of its program integrity efforts on Medicaid's Fee for Service recipients. Fee for Service is Medicaid's category for recipients who are directly managed by Medicaid, instead of being managed through an ACO. The OIG reports that because ACO data is so different from Fee for Service claims data, they have difficulty data mining ACO data.

When asked, the OIG reported that it does not regularly review reports on ACO recoveries. We are concerned that the OIG, with responsibility to oversee all Medicaid spending, does not regularly identify the extent of ACOs' efforts to mitigate fraud, waste, and abuse among their own providers. Additionally, the OIG appears not to be conducting independent checks on ACO claims reviews.

The OIG has not independently reviewed ACO program integrity activities.

The OIG reports it has not independently reviewed ACO program integrity processes and reviews. ACOs have their own investigative units which perform program integrity reviews. While we can see that internal ACO oversight might lessen the risk for overpayment in those claims, they still present a risk because of the ACOs' lack of independence. For that reason, we would expect the OIG to be independently reviewing ACO claims reviews to determine if the investigations are adequately identifying overpayments.

OIG Has Completed Only One ACO Performance Audit

The OIG should be conducting periodic efficiency and effectiveness performance audits of ACO operations. The OIG has a performance audit unit which is equipped to address broad issues of program compliance, efficiency, and effectiveness. Of the 74 performance audits initiated by the OIG, only 7 addressed ACOs. Of those, only one was completed. Figure 2.2 shows the OIG performance audits addressing ACOs.

Figure 2.2 The OIG Has Not Completed a Performance Audit of ACOs in Over Five Years. Of the OIG's ACO audits, only the ACO Implementation Project Management audit in 2012 was completed.

Audit	Date	Completed
ACO Implementation Project Management*	**10/15/2012**	**Yes**
Medicaid Administrative Expense Payable Controls	6/18/2013	No
ACO Network Adequacy	5/23/2016	No
Medicaid Third-Party Liability (TPL) Recovery Process	10/25/2016	No
Encounter Data Quality Assurance	9/20/2017	In-process
MCO Recipient Enrollment	11/30/2017	In-process
EQRO Validation	12/12/2017	In-process

** The actual title of the audit was MCO Implementation Project Management.*
Source: OIG

Figure 2.2 shows that the OIG only completed one ACO audit since it began in 2012 (three others are in-process). In the five years since 2012, the OIG has not completed any other ACO audits. In fact, that audit was completed before ACOs took effect in 2013. Of the incomplete audits we reviewed, we did not find sufficient support for their termination. We discuss our concerns with incomplete performance audits in Chapter III.

The OIG has not completed an audit of ACOs since 2012 (before ACOs were fully implemented).

The OIG's 2012 audit on ACO Implementation Project Management was the kind of audit we would hope to see from the OIG. The audit addressed the contracts being written to govern relationships between Medicaid and the ACOs along with other managed care entities. The audit raised concerns about contract processes, contract oversight provisions, and Medicaid non-cooperation with the audit. Another audit we would expect to see is

an analysis similar to the one shown in our ***In-Depth Budget Review of the Department of Health (2018-02)***. Finally, we would hope to see from the OIG something like the Center for Medicare and Medicaid Services' (CMS) audit that will be discussed later in this chapter.

In general, we would expect to see the OIG doing performance audits on the efficiency and effectiveness of the ACOs. Performance audits can not only address compliance and fraud/waste/abuse issues, but also broader issues of program effectiveness and operational efficiency, like the efficiency audit we discussed in Chapter II of our ***In-Depth Budget Review of the Department of Health (2018-02)***. The OIG is particularly lacking in ACO audits of these kinds.

OIG Claims Pushback from ACOs But Has Not Exercised Its Authority

The OIG has been unable to provide sufficient evidence of pushback from Medicaid or the ACOs.

The OIG has reported to us that they have experienced pushback from Medicaid and ACOs when the OIG has attempted to review them. When we asked for evidence or documentation of the pushback, we were given very little. Regardless, the OIG has authority to compel cooperation from Medicaid and the ACOs, but has never exercised that authority. The OIG claims it has not used the authority both because it lacks enforceability and because the OIG wanted to maintain positive relations with Medicaid and the ACOs.

We did document a 2012 example when the OIG audited contracts between Medicaid and the ACOs. The OIG reported that it asked repeatedly for information regarding the contracts but was insufficiently answered. Also, the OIG reported that some recommendations made to Medicaid regarding the contracts were not addressed. In that case, the OIG reported its findings of Medicaid noncooperation in the OIG's 2012 audit of the contracts.

Lack of cooperation from Medicaid, at least in the case of the OIG's audit of ACO contracts, is concerning. For such a reason, the OIG was given the authority to compel cooperation from Medicaid and those with whom Medicaid contracts. While voluntary cooperation is important, the OIG has the ability to demand what it needs to perform its oversight responsibilities.

The OIG's Statutory Subpoena Authority to Compel Cooperation Has Not Been Used. The OIG reported to us that they did not remember ever issuing a subpoena for access to information or

people. The OIG's subpoena authority in matters related to Medicaid is codified in state statute. ***Utah Code*** 63A-13-401 grants the OIG power to issue subpoenas. It states:

> (1) The inspector general has the power to issue a subpoena to obtain a record or interview a person …
>
> (2) A person who fails to comply with a subpoena issued by the inspector general…
>
> (a) is in contempt of the inspector general; and
>
> (b) …the attorney general shall:
>
> (i) file a motion for an order to compel obedience to the subpoena.…

This statute gives the OIG the authority to compel Medicaid and its contractors to provide data or access to persons. The statute also allows the court to hold noncompliant persons in contempt of the inspector general and to impose penalties.

In light of OIG claims of non-cooperation, we were surprised to find that the OIG has never issued a subpoena. Although our office has resorted to issuing subpoenas for information, no agency has continued to refuse access to that information. Our office has not needed to seek recourse for non-compliance. We can only assume that such would also be the case for the OIG if the office felt the need to issue a subpoena.

The OIG reports it has never issued a subpoena.

One reason shared by the OIG for issuing no subpoenas was that a subpoena could potentially strain important relationships between the OIG and Medicaid. While such could be the case, those relationships must be balanced by the need to protect taxpayer dollars from Medicaid fraud, waste, and abuse, and the OIG is tasked with that role. The OIG was established by the Legislature in 2011 for that purpose.

OIG Should Set ACO Recovery Targets and Report on Their Recoveries

In 2017, CMS encouraged the OIG to improve its ACO oversight. Among other things, CMS found that ACOs were not conducting

sufficient investigations for programs of their size. In addition, CMS found that the ACOs were not identifying and recovering overpayments at the level CMS would expect. Figure 2.3 shows three years of the ACOs' investigations and overpayments records as reported to CMS. Based on CMS conservative estimates, we calculated an overpayment recovery target of $22.7 million over three years. For example, we estimate that three ACOs could have recovered $9.3 million in 2015.

Figure 2.3 CMS Reports that ACOs Are Not Identifying Expected Overpayments. Using 1 percent as a conservative target recovery, we estimate that the three ACOs listed could have potentially recovered as much as $22.7 million from 2013 to 2015.

FFY	Dollars Managed	Investi-gations	Over-payments Identified	Over-payments Recovered	Target Recoveries
University of Utah Health Plan					
2013	$165,651,678	N/A	N/A	N/A	$1,656,517
2014	230,200,362	28	$292,639	$145,877	2,302,004
2015	283,293,854	25	86,997	54,095	2,832,939
Molina					
2013	181,895,300	11	121,213	65,000	1,818,953
2014	221,141,221	10	1,308,854	0	2,211,412
2015	249,878,674	8	12,952	0	2,498,787
SelectHealth					
2013	167,111,345	15	0	0	1,671,113
2014	371,583,281	9	0	0	3,715,833
2015	399,945,850	20	0	0	3,999,459
Total	**$2,270,701,565**	**126**	**$1,822,655**	**$264,972**	**$22,707,016**

** This analysis does not list Healthy Utah because CMS did not include it in its report.*
*** This analysis compares investigations and overpayments identified and recovered for federal fiscal years 2013-2015 with dollars managed and target recoveries for state fiscal years 2013-2015*
Sources: CMS, Department of Health

Using a conservative CMS estimate, ACOs could have recovered $22.7 million between 2013 and 2015.

CMS reported that both investigations and overpayments were low. The report states:

> The above tables demonstrate that Utah's ACOs recover overpayments in small percentages. These low figures are likely the result in how the ACOs define and investigate credible allegations of fraud and the low number of fraud investigations being conducted by each ACO.

We believe CMS's conclusion could be characterized as a significant understatement. We spoke with CMS staff who suggested an ACO overpayment recovery rate of at least between 1 to 10 percent. Accordingly, for this analysis, we chose 1 percent as our analysis target, which was the most conservative rate based on CMS's estimated range. That target estimates almost $23 million in recoveries for three ACOs over three years. Actual ACO recoveries, as shown in Figure 2.3, fell far below that target. In fact, actual recoveries were $265,000 or about one hundredth of one percent (0.01 percent).

Actual ACO recoveries between 2013 and 2015 were only 0.01 percent, well below our conservative 1 percent target.

We understand the occurrence of fraud, waste, and abuse varies from system to system and state to state. Our 1 percent target was based on our discussions with CMS. We would hope that the OIG would have its own targets based on more rigorous methodologies or improved analytical systems. Because the OIG is the statutorily established oversight entity for Medicaid spending, we believe the OIG should be the expert on what recovery levels should be in the state of Utah. The OIG should be identifying such targets annually and reporting on whether ACO recoveries approach those targets.

Recommendations

1. We recommend that the Office of the Inspector General track future program integrity claims reviews, conduct independent reviews of ACO claims, and independently review a sample of ACOs' program integrity reviews.

2. We recommend that the Office of the Inspector General establish annual recovery targets for Medicaid expenditures, including for Accountable Care Organizations.

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Chapter III
OIG Processes and Accountability Need Improvement

While we primarily focused on the Office of the Inspector General of Medicaid Services' (OIG) work with Accountable Care Organizations (ACOs) due to our analysis in our ***In-Depth Budget Review of the Department of Health (2018-02)***, we did review some of the OIG's recovery areas, past audits, and its audit planning and risk assessment process. In our professional opinion, OIG management must strengthen its oversight of Medicaid by improving OIG cost avoidance measures, conducting better audit planning and risk assessment, and completing more performance audits. We also believe that the OIG should be working with the Department of Health (DOH) to develop the kinds of insights that were reported in our DOH report.

We believe the concerns identified in this report justify a change to the OIG's reporting mechanisms. We recommend the Legislature consider implementing one of three structural changes to the OIG to enhance accountability and productivity. We also believe the Audit Subcommittee should consider prioritizing a legislative in-depth follow up audit after one year to assess the OIG's progress.

OIG Should Improve Audit Planning, Reporting, and Practices

Declining recoveries can be bolstered by improving OIG practices.

Diminishing recoveries in fraud, waste, and abuse may soon threaten the OIG's financial return on investment. We believe the OIG can bolster declining recoveries and strengthen its audit and investigation practices by making improvements in several areas. Our concerns are as follows:

- OIG cost avoidance methodology lacks a substantive and repeatable methodology.
- OIG audit planning lacks a formal process or overall risk assessment. The OIG is not fully tracking its activities to know whether it is addressing the risks identified by potential audit planning.

- The OIG is not completing enough performance audits, with a 67 percent completion rate for audits started and staffed. In our opinion, this shows a weakness in OIG practices.

OIG Recoveries Have Declined Since 2013

The OIG was established by statute in 2011. Since the first year of operations, recoveries have declined. Figure 3.1 shows OIG recoveries and expenses as reported in the OIG's annual reports.

Figure 3.1 OIG Recoveries Decreased from $12 million in 2013 to $6 million in 2017. The OIG's annual reports show that recoveries have steadily decreased over the past five years.

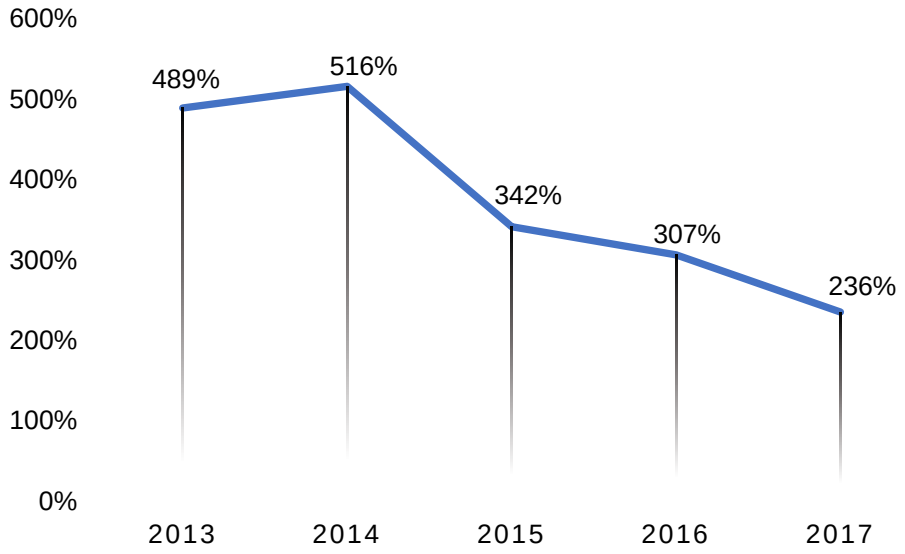
OIG reports show recoveries have steadily declined since 2013.

	2013	2014	2015	2016	2017
Recoveries	$12,100,385	$11,570,604	$8,809,157	$8,031,309	$6,336,431
Expenses	$2,472,266	$2,241,697	$2,577,847	$2,619,030	$2,689,993

Source: OIG annual reports

Figure 3.1 shows that OIG recoveries have been declining since the first year of OIG operations. The sharpest decline in recoveries happened in 2015 when recoveries dropped 24 percent. The next sharpest decline was in 2017 with a 21 percent decrease in recoveries. Figure 3.2 shows that the OIG's return on investment (ROI) has been decreasing since 2014.

Figure 3.2 OIG Return on Investment Is Declining. Return on investment decreased from 489 percent to 236 percent.



Source: Calculations based on OIG Annual Reports

OIG return on investment has decreased from 489 percent to 236 percent.

In 2017, the OIG reported a record low ROI at 236 percent. The OIG reports the declines are due to a "sentinel effect" or a change in provider behavior resulting from the OIG's active oversight over Medicaid expenditures. At the same time, the OIG has neglected oversight over ACOs which, as stated earlier, are responsible for 38 percent ($1 billion) of Medicaid expenditures. While we believe that an OIG sentinel effect is within reason, we question its effect in areas where the OIG is conspicuously absent. In any case, such an effect should be consistently measured and documented.

OIG Cost Avoidance Lacks Validity but Could Be Improved Through Increased ACO Recoveries

The OIG reported to us that they use no formal method for calculating cost avoidance, but rather develop an estimate. Cost avoidance operates under the premise of the sentinel effect discussed earlier that the existence of oversight and training prevents fraud, waste, and abuse from happening. The OIG reports that cost avoidance has increased from $5.2 million in 2016 to $10 million in 2017. However, the difficulty with reporting a cost avoidance measure for the OIG is that the office uses no consistent methodology to measure it. Understandably, cost avoidance calculations are difficult, but it is not acceptable to include an estimate in the OIG's annual report that lacks a consistent, legitimate methodology. If such an

The OIG's cost avoidance measure is not based on a consistent methodology.

estimate is reported, the OIG should make clear that the estimate is not based on consistent and quantifiable measurement.

One quantifiable measure the OIG could use for cost avoidance is ACO recoveries that have been independently identified by the OIG. As discussed in Chapter II, ACO recoveries were questioned by a 2017 Center for Medicare and Medicaid Services' (CMS) report. The report drew attention to a lack of ACO recoveries between 2013 to 2015. ACOs were not identifying overpayments to their providers at the level CMS expected to find. In fact, surprisingly, the ACO with the most Medicaid expenditures reported that it had found no overpayments between 2013 and 2015.

ACO overpayments occur when a provider inappropriately bills an ACO for more than is allowed for a specific procedure. Left unidentified, an ACO may lose the money it overpaid, but over time the overpayment will be calculated into the overall cost to ACOs. Those costs will then be considered by Medicaid and future rates set to ensure that ACOs will continue to be sustainable. In effect, unidentified overpayments increase costs to Medicaid through the annual rate setting process.

If the OIG can independently identify ACO overpayments, the office can reduce future Medicaid costs. Overpayments can also be more easily quantified, giving the OIG a supportable methodology for at least one cost avoidance measure.

OIG Should Conduct Better Audit Planning

The OIG lacks an annual risk-based audit planning process.

The OIG should develop a risk-based audit plan to annually determine the priorities of the office. The OIG currently has no formal process for determining the direction of the office in addressing Medicaid risk. The OIG told us that it does use reported trends in fraud, waste, and abuse, but those responses to trends are not formalized in annual audit planning. Adopting a risk-based planning process could increase the effectiveness of the OIG's audit functions by ensuring audits of high-risk areas are conducted before audits of low-risk areas. In addition, by adopting risk-based planning, the OIG would be following audit best practices.

Utah Code 63I-5-401, part of the Internal Audit Act, requires that audit plans "…be based on the findings of periodic risk assessments."

The OIG reports it has neither performed these risk assessments nor incorporated them into audit planning. As a result, the OIG is not developing annual audit plans based on relative risk and could be potentially missing areas of high risk like ACOs.

Audit planning would require the OIG to have reliable information on what audit activities are already taking place. The OIG reports that Fee for Service program integrity efforts constitute a large part of the OIG's program integrity efforts, but the OIG does not distinguish between the program integrity reviews it does of Fee for Service claims and ACO claims. Without that level of understanding, risk-based audit planning will likely be flawed.

Developing an annual audit plan based on risk begins with auditors gaining an understanding of the organization and all areas or processes that can be audited. This process should take place "…at least annually to reflect the most current strategies and direction of the organization". This information could then be used to create an audit plan by combining OIG and Medicaid management input with a risk assessment of possible audit areas. Adopting this risk-based planning approach could help the OIG to better allocate limited audit resources.

Because of limited time and resources, we could review only a few key areas in our audit. Our report has identified key Medicaid areas that have been neglected by the OIG. An audit planning process based on identifying the relative risk of potential audit areas would enable the OIG to maximize the impact of audit resources.

OIG Should Complete More Performance Audits

OIG performance audits are often cancelled and may lack appropriate justification for their cancellation. Performance audits are a tool for addressing not just fraud, waste, and abuse, but also efficiency and effectiveness. Effectiveness audits of Medicaid (and its contractors) can provide great value because they can affect broader issues of governance and oversight.

According to OIG records, only 67 percent of performance audits have been completed. At times, a performance audit may not be completed because something has happened to address the scope of the audit. Another reason an audit may not be completed is because something in the scope becomes involved in litigation.

Only 67 percent of OIG performance audits were completed.

The OIG should be completing more performance audits.

However, in our professional opinion, an audit completion rate of 67 percent suggests that some audits lack appropriate planning or that some audits are being terminated prematurely. The few audits related to ACOs that were not completed either lacked documented reasons for their termination, or the reasons stated for the termination, in our opinion, lacked credibility. We believe the OIG should be completing more performance audits. The OIG should also document compelling reasons for terminating any audit. In all, our audit of OIG's ACO practices has shown that the OIG must improve its oversight of ACOs through its performance audit and program integrity activities.

Legislature Should Consider Ways to Bolster OIG Accountability and Productivity

We believe with the concerns identified in this report, the Legislature should consider ways to bolster the OIG's accountability and productivity, and we discuss some accountability options below. We also believe the Audit Subcommittee should consider prioritizing a legislative in-depth follow up audit after one year to assess the OIG's progress.

In December of 2010 we released an audit titled, *A Performance Audit of Utah Medicaid Provider Cost Control.* This audit recommended the creation of the Office of the Inspector General and gave 13 suggestions for powers and authorities to establish with the OIG. These suggestions were implemented by the Legislature when the OIG was created. One suggestion not specifically mentioned in the 2010 audit was an accountability component to ensure the duties of the office were being performed. To address that accountability component, we recommend that the Legislature consider one of the following options to increase OIG accountability:

- Require a more formalized reporting relationship to the Executive Appropriations Committee, with committee hearings on OIG progress, cost reductions achieved, and performance metrics

- Establish an oversight board which meets with the OIG quarterly to review operations, examine audit results, and provide direction

- Relocate the OIG to within Office of the State Auditor.

State Statute Already Requires Annual Reporting to the Executive Appropriations Committee. Currently, statute only requires the OIG to send annual electronic reports to the Executive Appropriations Committee, but that requirement could be strengthened to include a requirement for committee hearings on the OIG's performance reports. The OIG could report on its cost reductions achieved and its performance metrics with the committee reviewing the information and asking questions during legislative committee hearings. Of the options we provide here, regular hearings to the Executive Appropriations Committee would require the least amount of change.

Reports to the Executive Appropriations Committee could be supplemented with committee hearings.

Massachusetts Uses an Inspector General Council Composed of State Officials or Designees to Advise the Inspector General. The Massachusetts Inspector General is required to meet at least quarterly with the council and may consult with or request assistance from the council. State officials appoint council members who are required to have experience relating to law, business, or accounting. We believe a similar oversight board in Utah would strengthen accountability. The board could be composed of appointments from the Governor, the President of the Senate, the Speaker of the House, the State Auditor, and the Attorney General, on the condition that appointments have related business, accounting, and/or Medicaid experience.

An oversight board could meet quarterly to review OIG metrics and provide direction.

The OIG Could Be Placed within the Office of the State Auditor. While none of the states we reviewed placed the inspector general with their state auditors, it was an option our Legislature considered during the 2013 General Session. Ultimately, the inspector general was moved to where it currently resides within the Department of Administrative Services, but it has no reporting requirements to that department. If moved to the state auditor, the Legislature could require the inspector general to report to the state auditor.

The Legislature could reconsider placing the OIG within the state auditor's office.

Whatever the Legislature decides, we recommend an in-depth follow up audit of the OIG in a year to measure its progress in meeting the recommendations of this report.

Recommendations

1. We recommend that the Office of the Inspector General base cost avoidance and any other annual report measures on quantifiable and repeatable methodologies.

2. We recommend that the Office of the Inspector General conduct formal, annual audit planning and risk assessment to identify best uses of audit resources.

3. We recommend that the Office of the Inspector General, in conjunction with the Department of Health, conduct efficiency reviews of Accountable Care Organizations similar to the analysis in Chapter II of our in-depth budget review.

4. We recommend that the Office of the Inspector General complete all its performance audits or properly document valid reasons for terminating any audit after it has begun, particularly ACO audits.

5. We recommend that the Office of the Inspector General obtain audit methodology and program review training from a professional audit organization or other qualified organization.

6. We recommend that the Audit Subcommittee consider prioritizing a legislative in-depth follow up audit after one year to measure the OIG's progress in implementing the audit recommendations.

7. We recommend that the Legislature consider one the following options to strengthen the accountability and productivity of the Office of the Inspector General:

    - Require a more formalized reporting relationship to the Executive Appropriations Committee, with committee hearings on OIG progress, cost reductions achieved, and performance metrics

    - Establish an oversight board which meets with the OIG quarterly to review operations, examine audit results, and provide direction

    - Relocate the OIG to within Office of the State Auditor.

Agency Response

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Utah Office of
Inspector General

Gene Cottrell
Inspector General

February 21, 2018

Mr. John M. Schaff, CIA
Auditor General
State of Utah-Office of the Legislative Auditor General
W315 Utah State Capitol Complex
SLC, UT 84114-5315

Re: Report No. 2018-03

Dear Mr. Schaff,

We are grateful for this opportunity to respond to this audit. Our Office is in the midst of a significant transformation and see this audit as an opportunity to guide the transformational decisions we continue to make. Projects started within the past two years since I was appointed Inspector General, coupled with the recommendations provided in this audit, will guide us as we seek to fulfill our primary mission of protecting taxpayer funds while ensuring a quality Medicaid program.

Please find our response to the findings of Legislative Audit No. 2018-03 herein.

Chapter 2

1. We recommend that the Office of Inspector General track future program integrity claims reviews, conduct independent reviews of ACO claims, and independently review a sample of ACOs' program integrity reviews.
   We agree with this finding. We will begin tracking ACO program integrity reviews. Currently we review ACO claims as part of other projects within the Office. As such, the claims reviewed are rolled up into a total numbers of claims reviewed metric. We will begin treating ACO claims reviews as a distinct and separate reportable activity. Additionally, the Office is developing an ACO reporting tool that we expect to begin using in May 2018. This tool will require ACOs to report back specific information in a format determined by the OIG. That information will help identify areas of risk and will guide the Office in oversite activities related to the ACOs, including audits, inspections and claims reviews.

2. We recommend that the Office of the Inspector General establish annual recovery targets for Medicaid expenditures, including for Accountable Care Organizations.
   We agree with this finding. Historically the office has created estimated potential targets as reported to the LFA multiple times throughout a fiscal year. These estimates have been high level and have not been separated out by ACO/MCO/FFS. The Office will create a more formalized process for targets and include the ACOs as a separate piece in those targets.

Chapter 3

1. We recommend that the Office of Inspector General base cost avoidance and any other annual report measures on quantifiable and repeatable methodologies.

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We agree with this finding. We currently have a methodology in place, but we will refine the current method to ensure it is as accurate as possible and repeatable. All program integrity offices across the country are encountering this same problem and CMS is scheduling a symposium to discuss best practices. The purpose of that symposium is to establish a solid methodology for use in the Medicaid arena. We plan to attend that symposium and apply any lessons learned to our cost avoidance calculation methodology. In addition, in January 2018 the OIG management team began developing a comprehensive list of Performance Indicators (PI), from which, we will develop 8-10 Key Performance Indicators (KPI), including cost avoidance. Work is already underway on the development of a dashboard to visually display the Key Performance Indicators. The current plan is to add the dashboard to our website which will allow Legislators, and the public at large, added visibility of the Office's reportable metrics.

2. We recommend that the Office of the Inspector General conduct formal, annual audit planning and risk assessment to identify best uses of audit resources.
We agree with this finding. We recently created a committee comprised of the Inspector General, Deputy Inspector General, Audit Manager, Program Integrity Manager, and Special Investigations Manager. This committee will essentially serve as an audit and investigation committee. We are establishing protocols for this committee but plan to establish a regular reporting schedule for active audits and investigations. This team will also have responsibility for conducting the annual audit planning and risk assessment.

3. We recommend that the Office of the Inspector General, in conjunction with the Department of Health, conduct efficiency reviews of Accountable Care Organizations similar to Chapter II review.
We agree with this finding. We have two complex audits currently underway that will result in efficiency reviews of the eligibility and rate setting functions associated with the Affordable Care Organizations.

4. We recommend that the Office of the Inspector General complete all of its performance audits or properly document valid reason for terminating an audit after it has begun, particularly ACO audits.
We agree with this finding. The Inspector General directed the termination of a number of low risk audits and audits that had unclear criteria during the transition of Audit Managers. This decision was made with the understanding that from that point forward audits would be planned and executed through completion rather there was a negative or positive finding.

5. We recommend that the Office of the Inspector General obtain audit methodology and program review training from a professional audit organization or other qualified organization.
We agree with this finding and will continue to train, certify and recertify OIG employees. Over the past two years all of our qualified auditors have been certified through the Association of Inspector's General as Certified Inspector General-Auditors (CIG-A). Additionally, the Inspector General was certified as a Certified Inspector General (CIG) and a number of the Office's Investigators also received certification as Certified Inspector General-Investigators (CIG-I). Additionally, five personnel have certified as Certified Fraud Examiners (CFE). Prior to the transition to the new Inspector General no training and certification program existed in the Office. The new Inspector General saw training and certification as a key component that had to be completed before complex audits of the Affordable Care Organizations could effectively take place. We will continue this incredibly important initiative as we do both quality and quantity of Audits will improve.

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In addition to the training and certification initiatives already underway within the Office the Inspector General would appreciate a closer working relationship with the Office of Legislative Auditors. Such a linkage will do two things, first, it will provide further training opportunities to OIG staff. Secondly, and probably more importantly, it will help open more direct lines of communication between the OIG and Legislators.

6. We recommend that the Audit Subcommittee consider prioritizing a legislative in-depth follow up audit after one year
   We agree with this finding. A follow up audit by the Legislative Audit Group will be a helpful measure of the initiatives for improvement already underway within the Office. We are confident that the ongoing transformational measures implemented by this Office over the past two years will be near full implementation at that point and noticeable changes will be easily identifiable.

7. We recommend that the Legislature consider one of the following options to strengthen the accountability and productivity of the Office of Inspector General:

   a. Require a more formalized reporting relationship to the Executive Appropriations Committee, with committee hearings on OIG progress, cost reductions achieved, and performance metrics.
      We agree with this recommended course of action. The Office would welcome an improved reporting relationship with the Executive Appropriations Committee, something the Inspector General has sought for the past two years since his appointment.

   b. Establish an oversight board which meets with the OIG quarterly to review operations, examine audit results, and provide direction.
      We agree with this recommended course of action. The Office believes creation of an oversight board would greatly enhance the effectiveness of the Office. The Office recommends, if possible, that such an oversight board be comprised of at least one member from the Executive Branch. Many other states have a similar structure and report success with this approach.

   c. Relocate the OIG to within the Office of the State Auditor.
      We disagree with this recommended course of action. The Office fulfills both federally mandated Program Integrity responsibilities and state mandated oversight responsibilities. The Utah State Plan identifies the Utah Department of Health as the "Single State Agency" responsible for the administration of the Medicaid Program, in accordance with 42 CFR 431.10. In order to perform the Program Integrity role the OIG entered into a Memorandum of Understanding with the Division of Medicaid and Health Financing (DMHF) that identifies and delegates specific responsibilities to the Office. Over the past two years the Inspector General has worked hard to divide Program Integrity responsibilities from state oversight activities. The current relationship works since the Office is designated as an independent agency. Relocating the OIG within the Office of the State Auditor may cause a contractual relationship between the Office of the State Auditor and the Department of Health. Such a contractual relationship may hinder future audits of the Department of Health by the Office of the State Auditor.

The Utah Office of Inspector General remains committed to building on the many improvements made over the past two years. We look forward to improved communication with the Legislators of this great State and with the Office of Legislative Auditors. We are wholly committed to improving our processes as we continue

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Utah Office of
Inspector General

Gene Cottrell
Inspector General

our mission of ensuring the State has an efficient and cost effective Medicaid Program. Thank you again for the outstanding work of your team of professionals.

Sincerely,

Gene D. Cottrell
Inspector General
Utah Office of Inspector General of Medicaid Services

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