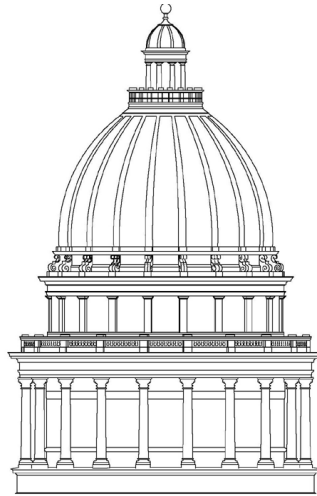


REPORT TO THE
UTAH LEGISLATURE

Number 2010-16



**A Performance Audit of
Utah Medicaid Provider Cost Control**

December 2010

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah



STATE OF UTAH

Office of the Legislative Auditor General

315 HOUSE BUILDING • PO BOX 145315 • SALT LAKE CITY, UT 84114-5315
(801) 538-1033 • FAX (801) 538-1063

Audit Subcommittee of the Legislative Management Committee

President Michael G. Waddoups, Co-Chair • Speaker David Clark, Co-Chair
Senator Patricia W. Jones • Representative David Litvack

JOHN M. SCHAFF, CIA
AUDITOR GENERAL

December 2010

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of Utah Medicaid Provider Cost Control** (Report #2010-16). 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,

A handwritten signature in black ink that reads "John M. Schaff". The signature is stylized with a large, sweeping initial "J" and a distinct "S" at the end.

John M. Schaff, CIA
Auditor General

JMS:KRM/lm

Digest of A Performance Audit of Utah Medicaid Provider Cost Control

In August 2009, Report #2009-12, *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program* outlined control weaknesses in Utah's Medicaid program. The report listed control deficiencies that limited the state's ability to reduce fraud, waste, and abuse, estimating that significant cost savings could be obtained by improving controls. However, the Executive Director of the Department of Health (DOH or department) and Utah's Medicaid director questioned whether fraud, waste, and abuse in Utah was comparable to other states.

Addressing DOH comments, the Audit Subcommittee directed our office to provide additional information on the occurrence of fraud, waste, and abuse in Utah's Medicaid program. Due to time constraints, this audit presents the results of limited work, but shows clear evidence that fraud, waste, and abuse is occurring in Utah and the department should be diligent in achieving the targets established in the August 2009 report. A contractor has been selected to do a full review. Their findings should be available in 2011.

Improper Medical Upcoding Is Occurring in Utah. As part of our audit work we reviewed Medical billing practices on what is known as evaluation and management (E&M) codes by physician offices. To determine if Utah Medicaid has a problem with upcoding (overcharging) on these E&M codes we selected two providers. We found that substantial upcoding is occurring in Utah. For the first provider we reviewed, a DOH owned and operated health clinic, we found that 99 percent of claims could not be substantiated at the level billed. All 99 percent were upcoded, many at a high level. DOH management members, as non-paid volunteers at the clinic, also submitted upcoded claims. DOH management acknowledges that the clinics upcoding is a problem and demonstrates the lack of coding training in a facility that clearly should be a leader and example in this field. For the second provider we reviewed, a private clinic, we found that 88 percent of claims could not be substantiated at the level billed. Also, at the same time Program Integrity reviewed an individual physician for upcoding and found that 97 percent of his/her claims were in error. This has not been a major audit area by Program Integrity; more emphasis is needed on upcoding (overcharging).

Recent Fraud, Waste, and Abuse Cases Confirm Trends in Utah. In light of comments made by DOH management that Medicaid fraud, waste, and abuse is not as prevalent in Utah, we reviewed current cases of those engaged in combating fraud, waste, and abuse. These cases show that millions have

Chapter II: Medicaid Fraud, Waste, and Abuse Is a Concern in Utah

Chapter III: Utah Medicaid's Own Payment System and Policies Have Allowed Fraud, Waste, and Abuse

been recovered; with better controls recommended in our August 2009 report, we believe much more can be recovered.

Utah Medicaid System Problems Contribute to Waste and Abuse. Previous legislative audits identified some Utah Medicaid internal system problems that contributed to program waste and abuse. We identified more instances in this report that make us believe that the likelihood of significant collections exists and justifies Program Integrity and Internal Audit conducting a full risk analysis of these concerns.

Policy Concerns Have Contributed to Waste in Utah's Medicaid Program. Previous audits identified that Utah's Medicaid program is hindered by loosely structured policies and procedures. This review again found additional areas where policies could be improved, which include: first, pharmacy costs need to be reviewed to ensure Utah Medicaid is getting the best possible price. Second, Medicaid policy allows for more than two teeth cleanings per year as long as they are done by different providers. This is more generous than other Utah insurance benefits.

Chapter IV: Inspector General Would Provide Greater Control and Independence of Medicaid Audit Functions

Medicaid's Substantial Budget Requires Increased Oversight. At \$1.7 billion, Utah Medicaid's budget is larger than that of any other single Utah state entity, and it is increasing. In addition, caseloads are at an all time high, and anticipated to continue to increase due to the requirements of federal health care reform. It is vital to minimize and retrieve misspent Medicaid funds in order to ensure that these funds are being spent effectively. An Office of the Inspector General could provide increased oversight for these funds.

Internal Audit and Program Integrity Need Increased Independence. The Office of Internal Audit and Program Integrity's (OIAPI) selection of audit scope, budget, and appeals process continues to lack independence. The current structure continues to have the auditee, Medicaid and other divisions, with some oversight over the audit and integrity functions. OIAPI's current operations demonstrate impairments that would not be allowed by the established standards of state and federal OIG offices. We believe these standards to be important to functional independence.

OIG Could Increase Utah Medicaid Cost Savings. Other states report that they have been able to increase fraud, waste, and abuse cost avoidance and recovery savings by implementing an OIG model. One state that tracked recoveries pre- and post-OIG reported increased cost recoveries of 322 percent and cost avoidance at 420 percent for the year following the introduction of its OIG program. A 322 percent increase in cost recovery would translate to about \$12.6 million in cost recovery savings for Utah. Cost avoidance savings could also significantly increase.

REPORT TO THE UTAH LEGISLATURE

Report No. 2010-16

A Performance Audit of Utah Medicaid Provider Cost Control

December 2010

Audit Performed By:

Audit Manager	Tim Osterstock
Audit Supervisor	Kade Minchey
Audit Staff	Leah Blevins Benjamin Buys David Gibson Tad Purser, DOH Internal Auditor

Table of Contents

	Page
Digest	- i -
Chapter I	
Introduction.....	- 1 -
Fraud, Waste, and Abuse Is a Serious Problem in the Medicaid Program.....	- 2 -
DOH Has Recently Released RFPs to Help Prevent and Recover Fraud, Waste, and Abuse	- 5 -
An OIG Could Increase the Independence of Medicaid Audit/Program Integrity Functions	- 7 -
Audit Scope and Objectives.....	- 8 -
Chapter II	
Medicaid Fraud, Waste, and Abuse Is a Concern in Utah	- 9 -
Improper Medical Upcoding Is Occurring in Utah.....	- 9 -
CMS Information Found Utah to Be Comparable to Other States	- 18 -
Recent Fraud, Waste, and Abuse Cases Confirm Trends in Utah	- 20 -
Recommendations	- 23 -
Chapter III	
Utah Medicaid's Own Payment System and Policies Have Allowed Fraud, Waste and Abuse	- 25 -

Utah Medicaid System Problems Contribute to Waste and Abuse.....	- 25 -
---	--------

Policy Concerns Have Contributed to Waste in Utah’s Medicaid Program.....	- 29 -
--	--------

Recommendations	- 36 -
-----------------------	--------

Chapter IV

Inspector General Would Provide Greater Control and Independence of Medicaid Audit Functions	- 37 -
--	--------

Medicaid’s Substantial Budget Requires Increased Oversight	- 38 -
---	--------

Lack of Medicaid Controls Illustrate Need for an OIG	- 41 -
---	--------

Internal Audit and Program Integrity Need Increased Independence	- 42 -
---	--------

OIG Could Increase Utah Medicaid Cost Savings.....	- 49 -
---	--------

OIG Structure Should Be Established on Sound Practices.....	- 52 -
--	--------

Recommendations	- 57 -
-----------------------	--------

Appendices.....	- 59 -
-----------------	--------

Agency Response	- - 65 - -
-----------------------	------------

Chapter I

Introduction

In August 2009, Report #2009-12, *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program* outlined control weaknesses in Utah's Medicaid program. The report listed control deficiencies that limited the state's ability to reduce fraud, waste, and abuse, estimating that significant cost savings could be obtained by improving controls. However, the Executive Director of the Department of Health (DOH or department) and Utah's Medicaid director questioned whether fraud, waste, and abuse in Utah was comparable to other states.

Addressing DOH comments, the Audit Subcommittee directed our office to provide additional information on the occurrence of fraud, waste, and abuse in Utah's Medicaid program. Due to time constraints, this audit presents the results of limited work, but shows clear evidence that fraud, waste, and abuse is occurring in Utah and the department should be diligent in achieving the targets established in the August 2009 report. A contractor has been selected to do a full review. Their findings should be available in 2011.

Chapter II provides information on fraud, waste, and abuse occurring in the provider community including: upcoding (overcharging) issues at various health clinics, CMS algorithms comparing Utah fraud, waste, and abuse rates to other states, and other cases discovered by both the department and OLAG indicating fraud, waste, and abuse.

Chapter III demonstrates how Utah Medicaid's own payment system and policies have been insufficient to prevent fraud, waste, and abuse, leading to the loss of valuable program dollars.

Chapter IV discusses the option of creating an Office of Inspector General (OIG) that can be equipped with much needed independence and other tools that can bring clear, independent, unfiltered analysis of Medicaid providers and the Medicaid program.

This report was requested to provide information on the occurrence of fraud, waste, and abuse in Utah Medicaid.

Fraud, Waste, and Abuse Is a Serious Problem in the Medicaid Program

Inappropriate payments or provider fraud, waste, and abuse are serious concerns nationwide. Recently, the federal government said that Medicaid fraud, waste, and abuse are serious problems that must be controlled. These have been defined as:

- **Fraud:** Intentional deception or misrepresentation to obtain an unauthorized benefit.
- **Waste:** Overutilization of resources, typically driven by policy, institutional constructs, and episodic behavior, including any form of inappropriate payment.
- **Abuse:** Actions inconsistent with sound fiscal, business or medical practices that result in unnecessary costs.

Substantial efforts to control these problems are underway on a federal level.

Our August 2009 report detailed system and control weaknesses in cost avoidance and recovery for fraud, waste, and abuse that annually cost the state millions of dollars. There is no exact measurement of Medicaid fraud, waste, and abuse nationally, or in Utah. While national estimates are in the 5 to 10 percent range of total provider payments, we suggested three percent as a target for Utah recovery collections. Executive management at the Department of Health took exception to that value. This value is supported by pre-pay vendors that conducted Utah specific analyses. Their RFPs set potential savings between 2.59 and 3.67 percent.

Medicaid Fraud, Waste, and Abuse Is a National Concern

The federal government, realizing that substantial payment errors can exist in its programs, has recently taken steps to measure the percent of payment errors. The government's study can be found at www.paymentaccuracy.gov. From this process, the federal government created a list of 14 high-error programs. The national Medicaid program ranked number two on this list. Figure 1.1 shows the federal government's estimates of inappropriate payments for the last two federal fiscal years. Note that the definition we have used of fraud,

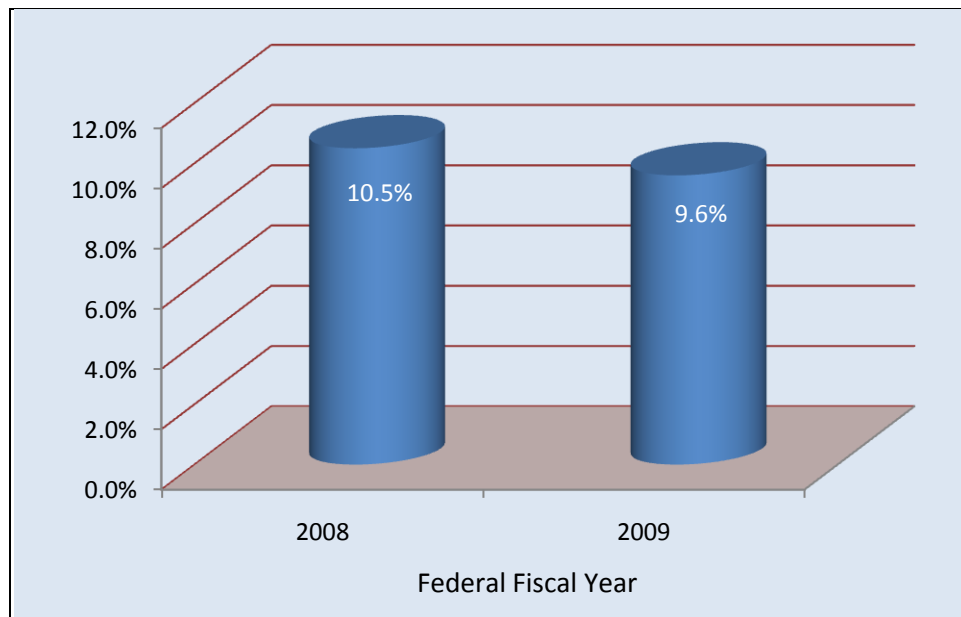
In 2009, we suggested three percent as a target for fraud, waste, and abuse collections.

Medicaid ranked second on a federal list of high error programs.

waste, and abuse includes all payments that have been made in error and are inappropriate.

Figure 1.1 Federal Estimate of Inappropriate Payments in Medicaid.

The following shows what the federal government is estimating as a national average for inappropriate Medicaid payments (fraud, waste, and abuse) nationwide.



Source: www.paymentaccuracy.gov

With the estimated current national average for inappropriate Medicaid payments at about 10 percent, we believe that our estimate of three percent for Utah Medicaid remains a viable target for savings.

National leaders are discussing the pervasiveness of fraud, waste, and abuse in Medicaid and Medicare; their comments include:

- Acting Deputy Attorney General Gary G. Grindler, summer 2010: “The combined spending on Medicare and Medicaid has more than doubled over the past decade and it's projected to exceed \$800 billion this year. Fraud has also increased; external estimates project the fraud accounts for three to ten percent of total spending. That's between \$27 and \$80 billion.”
- Daniel R. Levinson, HHS Inspector General, September 22, 2010: “OIG's work has also demonstrated that Medicare and

National leaders are expressing concern with the prevalence of fraud, waste, and abuse.

Medicaid pay too much for certain services and products and that aligning payments with market costs could produce substantial savings.”

It is well documented that fraud, waste, and abuse in Medicaid are national concerns; our work has shown that it is a problem in Utah as well.

Fraud, Waste, and Abuse In Utah Medicaid Is a Concern

In August 2009 our report stated, “about \$20 million in additional program dollars could be saved by increasing efforts to 3 percent from the current 1.72 percent. At 5 percent, an additional \$52 million could be recovered.”

Our estimate of 3 percent was based on national data and appeared to be conservative. However, this estimate was questioned by management in the Department of Health. During the Legislative Audit Subcommittee meeting on August 18, 2009, the Executive Director of the Department of Health questioned the ability to recover funds lost to fraud, waste, and abuse.

The Executive Director of DOH said to the Legislative Audit Subcommittee:

The recommendations we will look at carefully and we will implement them whenever we can. . . . I do not think for a minute that if we recover every inappropriately covered Medicaid service, we would find anything close to \$20 million in Utah. . . . the Utah medical community has a higher ethical standard. . . I don’t think there is as much of it there as has been implied.

Accordingly, the audit subcommittee asked that we conduct an in-depth review of the occurrences of fraud, waste, and abuse in Utah’s Medicaid program. We began this work in the summer of 2010 and this report releases the information we have gathered since that date.

It is important to note that exact measurements of fraud, waste, and abuse are unknown. States and the federal government are engaged in a myriad of solutions to combat this problem. Savings

Officials at DOH questioned the ability to recover fraud, waste, and abuse funds.

The exact measure of fraud, waste, and abuse is unknown.

from fraud, waste, and abuse should be achieved through a combination of cost avoidance and cost recovery efforts.

DOH Has Recently Released RFPs to Help Prevent and Recover Fraud, Waste, and Abuse

The DOH has released three requests for proposals (RFPs) dealing with expanding its cost avoidance and cost recovery efforts. We are encouraged by these efforts. However, the DOH must ensure that they structure their vendor contracts appropriately and allow the vendors access to all provider claims, otherwise these contracts will have limited success.

To paraphrase one state OIG director, a state can have the best systems and staff possible to recover fraud, waste, and abuse; but to be truly successful management over the Medicaid program must also be supportive if goals are to be reached.

Medicaid management, along with program integrity, must be diligent, informed, and accepting of efforts to combat fraud, waste, and abuse. Otherwise, the state will languish behind in collections while inappropriate payments continue with little challenge through Medicaid's payment system. Independent oversight can better ensure that inappropriate payments do not occur and that the Legislature is better informed. Chapter IV discusses the need for independent oversight in more detail.

Pre-pay Contract Should Be Operational In December 2010

The Department of Health awarded a contract for additional pre-payment editing services to Bloodhound Incorporated in April 2010. Estimates of cost avoidance savings from companies responding to the RFP averaged around \$25 million for a two-year period (\$12.5 million annually). One responder to the RFP estimated the percentage of savings that could be achieved at 3.67 percent of analyzed claims, while another responder estimated savings at 2.59 percent of analyzed claims.

Fraud, waste, and abuse vendors must have access to all provider claims.

Independent oversight can better ensure that inappropriate payments do not occur.

Reponses to a pre-payment RFP ranged from 2.59 to 3.67 percent recovery estimates.

There have been concerns voiced about the structure and breadth of the contract that DOH put together for the vendor. For example, Utah Medicaid decided to do a fixed price contract for years two and three of this contract. Using a fixed price contract is a questionable decision as it obligates Medicaid funds earlier and appears to deviate from an industry practice of contingency-based contracts. We asked the Medicaid director why a fixed price was established and his response was that in the first year they wanted to ensure that they received the fullest value of the contract up front in the first year, and putting a contingency contract in the first year followed by fixed contracts the remaining years was a way to achieve this. We encourage DOH management to continue to be supportive of the work of the vendor and strive where appropriate to uphold their findings.

Cost Recovery Contract Has Been Awarded and Should Be Recovering Funds by 2011

The department worked cooperatively with our office in their issuance of an RFP for a cost recovery contract. The contract was recently awarded for the two previous years and should shortly be operational. Some programs were excluded from the scope of this RFP. Also, in the review of the bidders' preliminary findings, we became concerned that Medicaid policies prevent cost recovery of some claims. This issue is discussed in Chapter III. For this project to be successful, DOH and Medicaid management should ensure that the vendor has full opportunity and access to recover funds.

FADS RFP Should Be Operational in Fall 2011

Another RFP for an on-going recovery audit/Fraud and Abuse Detection System (FADS) has been released and proposals will soon be in the review stage. The intent of the RFP is to obtain the analytical tool (FADS) we recommended in our August 2009 report. It also has the option to contract out the medical review and recovery portion of Program Integrity.

This RFP originally had the future contractor reporting to Utah Medicaid with oversight coming from that entity. This would have further diminished independence of the cost recovery effort. The reporting oversight line was changed after we questioned the intended

A cost recovery contract was recently awarded.

structure. This RFP should be operational in September 2011 and will also require management's support to be successful.

We believe that these RFPs should be allowed to carry forward with oversight by an independent OIG, if one is created, or by the department's Office of Internal Audit and Program Integrity (OIAPI) if an OIG is not created. With the advent of these contracts, further audit work or follow-up by our office targeting fraud, waste, and abuse, may not be necessary for a year or more.

An OIG Could Increase the Independence of Medicaid Audit/Program Integrity Functions

Other states have established an Office of the Inspector General (OIG) in an attempt to increase the independence of their program integrity and auditing, as well as increase cost savings from fraud, waste, and abuse. While the basic structure of these offices may differ, they are all expected to increase the public trust in government operations. With nearly \$2 billion in Medicaid funds being expended in Utah each year, independent, focused oversight is essential. An OIG could bring that independent oversight to the use of Medicaid funds. The Association of Inspectors General (Association) states that:

The public expects OIGs to hold government officials accountable for efficient, cost-effective government operations and to prevent, detect, identify, expose and eliminate fraud, waste, corruption, illegal acts and abuse.

In order to create and maintain this public trust, an OIG needs independence from the agency it audits or oversees. Currently, the internal audit and program integrity group at the Department of Health does not have the necessary independence.

In order to gain this independence, we recommend in Chapter IV that the Legislature consider the creation of a Utah OIG. The Association recommends that:

The OIG be established by statute or, if necessary, by executive order. The statute should establish the OIG's mandate, authority,

Because of Medicaid's nearly \$2 billion budget, independent oversight is vital.

We question the independence of DOH's internal audit and program integrity function.

An OIG could greatly increase Utah's cost savings.

and powers; provide for confidentiality of records and proceedings; identify qualifications for the inspector general and staff; protect the office's independence; and provide protection to whistleblowers.

In creating such an office with increased independence, Utah could greatly increase Medicaid cost savings. After the creation of its OIG, Texas increased savings three to four times what they had been.

Audit Scope and Objectives

We were asked to audit the Division of Medicaid and Health Financing (DMHF) and providers of Medicaid services to uncover instances of fraud, waste, and abuse in the Utah Medicaid program. As part of this audit, a DOH internal auditor worked with us. He was extremely helpful in gathering and assimilating data, and was an excellent resource in understanding the complexities of Utah Medicaid and the department.

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

- Examine and detect cases of fraud, waste, and abuse occurring in the Utah Medicaid program.
- Determine internal system and policy control weaknesses in the Medicaid program that can allow for fraud, waste, and abuse.
- Review options that would ensure oversight of Utah's Medicaid program is independent and fully capable of avoiding and recovering fraud, waste, and abuse monies.

Chapter II

Medicaid Fraud, Waste, and Abuse Is a Concern in Utah

As directed by the Legislative Audit Subcommittee, we identified and performed limited work geared at illustrating possible cases of fraud, waste, and abuse by Medicaid providers. Our work in this area was centered primarily on three areas, which were:

- First, a test proposed to us by the Texas OIG to review selected providers for possible upcoding (overcharging), which is the billing of medical service codes with higher reimbursement levels than justified.
- Second, work with the federal Center for Medicare and Medicaid Services (CMS) to compare Utah's rate of potential overpayments and risk to that of surrounding states.
- Third, review cases the Utah Office of Internal Audit and Program Integrity (OIAPI or Program Integrity) and other authorities uncovered. The intent of this work was to develop a better understanding of the spectrum of fraud, waste, and abuse in Utah.

When our August 2009 report was released, the Department of Health (DOH) questioned the degree to which higher recoveries in Utah were possible. They are now reacting to the Legislature's concerns. The department has awarded a contract to a payment recovery contractor and recently released another Request For Proposal (RFP) to continue with recovery activities. To ensure that these efforts are successful, we believe independent oversight of these contractors is necessary. In Chapter IV, we recommend that the Legislature create an independent inspector general to oversee all cost avoidance and cost recovery efforts. In the absence of an OIG, Internal Audit and Program Integrity should serve as an oversight mechanism.

Improper Medical Upcoding Is Occurring in Utah

As part of our audit work, we reviewed medical provider billing practices on what is known as evaluation and management (E&M)

Our tests confirm that fraud, waste, and abuse is a concern in Utah and should be controlled.

We reviewed some clinics with the most aberrant billings toward higher reimbursement codes for possible upcoding.

The clinic with the highest billing pattern skewed toward higher dollars codes (upcoding) was a clinic owned and operated by the DOH.

codes. This test was provided by the Texas Office of Inspector General (OIG) over Medicaid. The Texas OIG said that this upcoding (overcharging) can be common in Medicaid due to the lower reimbursement amounts that are common in Medicaid programs.

To determine if Utah Medicaid has a problem with upcoding of E&M codes, we selected two providers based on the test that Texas suggested we run. These two providers had the highest submission of claims with the most expensive E&M code (the 99215 code). Results of a third provider, an individual physician independently selected by Program Integrity in response to a CMS Fraud Alert, concurred with our findings from the two tests we ran. Summarizing the findings for each of these provider reviews:

- Provider 1: Salt Lake Health Clinic of Utah. This is a DOH-owned and -operated health clinic. The independent review found that 99 percent of the sampled 99214 and 99215 claims could not be substantiated at the level billed.
- Provider 2: A private health clinic located in the Salt Lake valley. A review by Program Integrity nurses found that 88 percent of claims could not be substantiated at the level billed.
- Provider 3: Claims submitted by an individual physician at a different private health clinic were reviewed by the Program Integrity nurses. The nurses found that 97 percent of his/her claims were incorrectly billed.

Based on these three reviews, over 96 percent of sampled claims did not have documentation to substantiate the level at which they were billed. As discussed below, providers have financial incentive to upcode (overcharge) claims, and the process of upcoding is very simple. This is clearly a problem in Utah Medicaid and warrants increased scrutiny of the expensive E&M codes by Program Integrity.

Higher Reimbursement Is a Motive for Upcoding

Claims are billed at one of five E&M code levels from 99211 to 99215. The 99215 code is supposed to represent the most intensive care and receives the highest reimbursement amount. For a claim to justify a 99215 coding, the documentation must demonstrate that at least two of the following three criteria were met:

Only the most complex codes should be billed at the 99215 level.

- A comprehensive history
- A comprehensive examination
- Medical decision making of high complexity

There are significant differences in the amount of reimbursement among the E&M codes, as shown in Figure 2.1. This rate difference may create an incentive for clinics to upcode claims.

Figure 2.1 Reimbursement Rates of E&M Codes Increase Significantly. E&M codes range in reimbursement from \$16.12 to \$89.71.

Code	Utah Medicaid Reimbursement Rates	Complexity
99211	\$16.12	Least Complex
99212	28.86	↓
99213	39.33	
99214	61.68	
99215	\$89.71	Most Complex

Upcoding by one level can increase reimbursement by 36 to 79 percent.

E&M reimbursement rates increase from 36 to 79 percent for every level that a claim is upcoded; upcoding two levels more than doubles reimbursement. Providers can significantly increase claim reimbursements by upcoding.

Upcoding Has Occurred at DOH-Owned Health Clinic

The clinic with the billing pattern most skewed toward higher dollar codes was the Salt Lake Health Clinic of Utah, which is owned and operated by the Department of Health. To ensure the claims were examined by a qualified, independent firm, we partnered with the Centers for Medicare and Medicaid Services (CMS or federal Medicaid) and together had the claims reviewed by their private, medical review contractor, Health Management Systems (HMS). The department also recently selected HMS to conduct the state's recovery audit work.

A random sample of claims by full-time practitioners found that 99 percent of the sampled 99214 and 99215 claims were incorrectly billed. Another random sample of DOH management members

volunteering at the clinic found that 88 percent of the highest level codes were incorrectly billed.

When we asked the department about this clinic, one of the responses we got back was that federal and state appropriations will cover any deficit the clinic runs, so billing patterns are not as critical for this clinic. The clinic is currently running a deficit. We believe that upcoding is wrong no matter the circumstances. Further, if the department were to accept upcoding at its own health clinics, they would either have to allow it at all other private clinics or be inconsistent in the application of the rules, enforcing the rules for other clinics but not themselves.

A CMS official we spoke with said that upcoding should never be tolerated. This official said that, in the past, government clinics have not received the same scrutiny as other clinics, and this inattention needs to be corrected. The DOH run health clinics have also not been scrutinized in the past by Program Integrity. It was reported to us that, in the past, Program Integrity had been discouraged from reviewing the DOH clinics. The current executive director of DOH told us that he has never discouraged oversight of the clinics. He believes this perception occurred before his tenure at the department. Nevertheless, this perception existed among staff during the course of our audit.

Additionally, the practice of upcoding can hide other deficiencies by not showing the true cost return of the provider.

The DOH Salt Lake Clinic billed 99215 codes more often than any other Medicaid provider.

Our Methodology Was to Sample Claims Submitted at the Highest Reimbursed Code (99215). To run the test proposed to us by the Texas OIG, we determined which clinics had most frequently billed the 99215 code in calendar year 2009. The DOH Salt Lake Health Clinic came up as the highest biller of the 99215 code to the Utah Medicaid program. The Salt Lake Health Clinic had 718 of the 99215 codes billed to the Utah Medicaid program. This represents 5.6 percent of Utah Medicaid's 99215 codes and is 179 more than the second highest provider. Figure 2.2 shows the ten clinics who submitted the most 99215 claims in calendar year 2009.

Figure 2.2 Top 10 Providers Billing 99215 Code. During 2009, the DOH Salt Lake Clinic billed 718 of the 99215 code, 179 more than the next highest provider. For all providers submitting E&M claims in 2009, the average number of 99215 claims was 5.7.

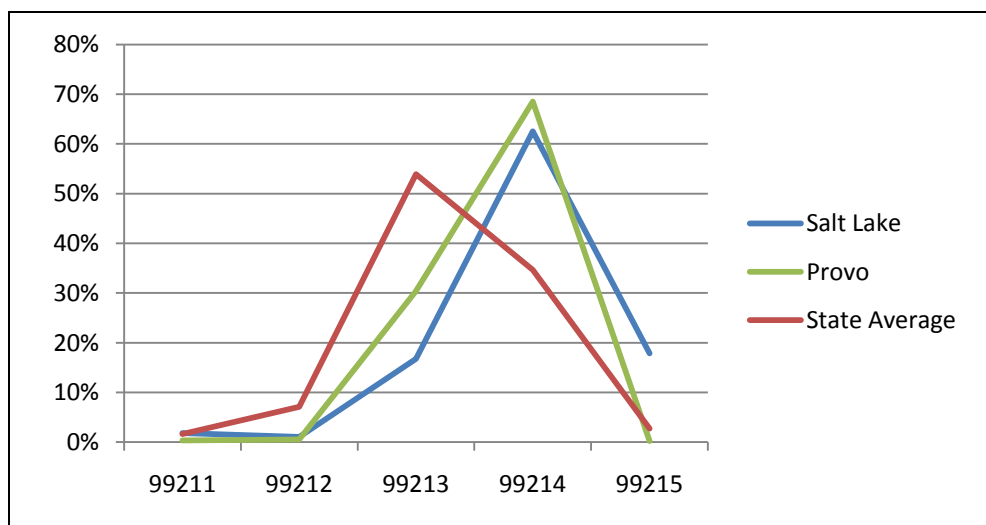
Provider 1 (DOH Salt Lake Clinic)	718
Provider 2 (Private Health Clinic)*	539
Provider 3	333
Provider 4	329
Provider 5	274
Provider 6	267
Provider 7	253
Provider 8	252
Provider 9	238
Provider 10	213

* Also reviewed as part of our audit.

Next, we compared the clinic's billing pattern to the state average, as well as to the other two DOH health clinics located in Ogden and Provo. While Ogden's billing patterns closely resembled the state average, both Salt Lake and Provo skewed toward the high-end codes, as seen in Figure 2.3. Although Provo billed very few 99215 codes, and therefore was not selected in our review, the high number of 99214 codes warrants further investigation by Program Integrity staff and/or the DOH fraud, waste, and abuse recovery contractors.

The high number of 99214 codes at the Provo Clinic warrants further investigation.

Figure 2.3 Salt Lake Clinic Frequently Bills 99215 Codes. For Calendar Year 2009, the DOH Salt Lake Clinic billed a 99215 code 18 percent of the time, compared to the state average of three percent. The Salt Lake and Provo clinics were both well above average on billing the 99214 codes.



The DOH Salt Lake Clinic billed 99215 over six times more frequently than the state average.

DOH management members who volunteered at the clinic also upcoded claims.

99 percent of sampled claims were incorrectly coded.

Figure 2.3 shows that both Salt Lake and Provo clinics billed the high-end 99214 code much more frequently than the state average, and Salt Lake billed 99215 over six times as often as the state average. In order to determine if the high billing patterns were caused by highly complex patients or upcoding, we sent 95 of the 2,518 claims coded as 99214 and 72 of the 718 coded as 99215 to be reviewed.

DOH management members, as non-paid volunteers at the clinic, also submitted upcoded claims. We conducted a separate sample of 42 claims by these management members, as part of normal audit protocols, to determine the extent that upcoding, or inappropriate billings, occurred in the management levels of the department. DOH management acknowledges that the clinic’s upcoding is a problem and demonstrates the lack of coding training in a facility that clearly should be a leader and example in this field.

To identify upcoding we conducted two statistically valid samples; first, a sample of 99214 and 99215 claims for the entire clinic, exclusive of DOH management providers. Second, a sample of the 99214 claims submitted by DOH management members, along with all ten of the 99215 claims they submitted. Figure 2.4 identifies clinic upcoding.

Figure 2.4 Most Sampled Claims from SL Clinic Were Upcoded. An independent review of claims showed that only 0.8 percent of claims were correctly coded.

	Clinic Sample	
Correctly Coded	1	0.8%
Upcoded One Level	14	11.2
Upcoded Two Levels	59	47.2
Upcoded Three Levels	32	25.6
Not Medically Necessary/ Insufficient Documentation	11	8.8
Non-E&M Code*	8	6.4
Total	125	100%

* Non-E&M Codes paid less than billed codes for these claims.

The results of this review clearly show that upcoding has occurred at the DOH owned and operated Salt Lake Health clinic. DOH has stated that they are committed to improving training. We recommend that DOH continue to facilitate training state-wide, especially on the E&M and other codes, to help promote cost avoidance.

The upcoding at the clinic does have a budgetary impact. For the clinic sample, the 99214 claims were overbilled an average of \$32.82 per claim and the 99215 claims were overbilled an average of \$54.77. If this finding held true across all claims, the 2,518 claims coded 99214 and 718 claims coded 99215 billed by the clinic in 2009, the clinic could have overbilled in excess of \$118,000, not including any overbilling that occurred on 99213 and 99212 claims. Medicaid is the primary payer of these claims, but not the sole payer, consequently the overbilled amount represents gross overpayment for all payers.

Despite this upcoding, the Salt Lake clinic still ran at an operating deficit of \$90,000 for fiscal year 2009. This may be, in large part, because Medicaid office visit reimbursement rates are lower than those of private insurance carriers. Since these clinics are set up specifically to improve access to care for Medicaid recipients, the majority of clients at the clinic use Medicaid as their primary insurer.

In order to determine whether these billing patterns were unique to Medicaid, we looked at the clinic's billing to the Public Employees Health Program (PEHP) and found similar billing patterns. Both 99214 and 99215 codes were billed more frequently than the state Medicaid average. Although we do not have good comparison data for private insurance and the PEHP claims were not reviewed for correct coding, it does appear that the Salt Lake clinic may upcode in an attempt to cover cost.

Some Claims at the Salt Lake Clinic Have Also Been Billed Higher than Doctors Indicated. In addition to the overbilling that has taken place at this clinic, we found inconsistencies between the paperwork and the claim that was submitted for payment. In most cases, the physician indicates each claim's billing code. However, 14 sampled claims were left blank by the physician. We asked the billing clerk how this omission is handled and she said she asks the physician at what level to bill the claim. There was no documentation showing the physician's expectation for the claim's billing.

More concerning were 20 sampled claims (12 percent) where the physician marked one code level, but the claim was submitted at one code level higher. While HMS found that most of these 20 claims would still have been considered upcoded even if they had been billed

Based on our sample, overbillings by the DOH Salt Lake Clinic were in excess of \$120,000.

The DOH Salt Lake Clinic billed PEHP similarly to Medicaid.

Twenty claims were submitted for a higher reimbursement than the doctor indicated on the claim.

at the level indicated by the physician, coding changes clearly contributed to the overall upcoding that has occurred at this clinic.

Code changing is a concerning activity as upcoding may have happened without the physician's knowledge. The only way of determining whether upcoding is occurring is by physically inspecting the claim. Clearly, in these reviewed claims, an overpayment has occurred.

In the Past, Program Integrity Was Discouraged from Reviewing Health Clinics. Some Program Integrity staff stated that they were instructed not to review department-owned and -operated health clinics. While current executive management have stated that they do not agree with this oversight exclusion and never ordered it, this perception is, nevertheless, present among some staff and may have come from a previous administration. It is unclear why the department would not want these clinics reviewed, perhaps because shortfalls were covered by state and federal appropriations.

As already noted, the Department's Salt Lake clinic has a high percentage of Medicaid beneficiaries, which contributes to operating deficits. Despite these deficits, the clinic is not exempt from following correct coding and claim submittal guidelines. Nor does the clinic's state-run status give reason to bar Program Integrity staff from reviewing the clinic's claims. As part of the Department of Health, we believe the clinic's operation should be seen as a positive model for other providers.

Management May Have Incentivized Physicians at the Salt Lake Health Clinic to Bill Higher Codes. From our discussions with two members of the health clinic's management, it appears that there has been an incentive to reduce the clinic's deficit. The clinic manager calculated the amount each provider needed to bill in order to break even and encouraged staff to code claims as high as correctly possible. These break-even amounts were carefully tracked. The clinic also employs a number of volunteers, including the two DOH management members discussed earlier. These employees do not have an individual incentive to overbill, but the revenue they generate contributes directly to the clinic's overall profitability.

Program Integrity staff reported they were instructed not to review DOH clinics.

DOH Clinic providers were encouraged to bill high amounts through performance reviews.

Also, performance reviews of two of the clinic's service providers commented on the issue of higher billings under "Areas for Improvement."

Upcoding Also Occurred at A Private Health Clinic

With Program Integrity staff, we conducted a joint review of the private clinic with the second highest billing pattern for higher level E&M codes (shown in Figure 2.2) and found a similar pattern of overbilling. Specifically, we found that 88 percent of claims were incorrectly coded. In a sample of 16 claims that were billed at the highest level (99215), only two could be supported at that level. Nine of the 16 claims supported a mid-tier level (99213), two supported the second highest level (99214), and three were denied for medical necessity or incorrect coding reasons.

It appears reviews of this area of fraud, waste, and abuse could be expanded upon. When Program Integrity has the advantage of using the analytical tool that we recommended in the first report, more can be done in this area to deter inappropriate claims and recover overpayments.

Other Reviews Have Identified Upcoding Problems

A third provider reviewed for upcoding on E&M codes was selected by Program Integrity. Program Integrity began this review after receiving a CMS fraud alert. The alert was about service providers who abuse electronic billing software by copying and pasting old claim information into new claims, which prompts the software to recommend a higher-level billing code than appropriate.

Program Integrity staff followed similar methodology we used in selecting providers to review. They looked at the individual providers who most commonly billed 99215 codes over an 18 month period, and then looked at billing patterns to determine which providers appeared to be upcoding. Then, records were obtained and reviewed for a selected provider. Program Integrity reviewed 137 claims and found that 133 (96 percent) were upcoded.

A review of a private clinic showed that 88 percent of 99215 claims were incorrectly coded.

A review conducted by Program Integrity found 96 percent of claims incorrectly coded.

Program Integrity staff and/or the recovery contractor soon to begin work in Utah should continue to review potential upcoding of the E&M codes. If statewide upcoding of E&M codes was similar to what we found, Utah Medicaid could be paying several hundred thousand dollars annually in improper payments just in the area of E&M codes.

CMS Information Found Utah to Be Comparable to Other States

DOH management responded to our August 2009 report by saying that they felt Utah's providers were uniquely honest compared to the rest of the country. While we believe Utah does have many excellent providers, it appears Utah's fraud, waste, and abuse rates are still comparable to other states.

To compare Utah's level of fraud, waste, and abuse with surrounding states, we partnered with both CMS's Medicaid Integrity Group (MIG) and Utah's Program Integrity group. CMS was very helpful and provided an avenue to compare Utah with surrounding states using specific computerized analytical tests, or algorithms. These tests, when run in Utah, found that overall, Utah appears similar to other states and that benchmarks used in other states can also be used as targets for Utah.

The MIG initially applied 16 of its algorithms to Utah's claim documentation and found that about \$1.3 million in potential recoveries existed. The MIG has at least another 34 algorithms that can be run and is willing to work with Utah to create more Utah specific tests. As part of our audit we facilitated getting the CMS "cleaner" pharmacy data and CMS is now in the process of updating the information and running more algorithms.

CMS Tests Found Opportunities for Cost Savings in Utah's Medicaid Program

While the 16 CMS algorithms do not allow a one-for-one recovery, they do show areas of concern in Utah's Medicaid program. One such identified area of concern is Utah's pharmacy program.

We partnered with the CMS Medicaid Integrity Group to compare Utah's level of fraud, waste, and abuse to other states' levels.

CMS ran 16 algorithms that showed about \$1.3 million in potential recoveries.

Figure 2.5 shows the relative rank of Utah compared to surrounding states. In some areas, Utah has high risk and in other areas, low risk. This test shows that overall, Utah is about average when compared to other states.

Figure 2.5 CMS Algorithms. CMS algorithms illustrate that in many areas, Utah’s risk for fraud, waste, and abuse risk is average. Utah may have higher risk in its pharmacy program.

Summary of Algorithms
Pharmacy Issues: 6 Algorithms Tested 4 out of the 6 Algorithms Utah had the highest potential for recovery
Unbundling Issues: 4 Algorithms Tested All 4 Occurrences Utah had the lowest potential recovery.
Duplicate Payments/ Payments After Death: 6 Algorithms Tested 3 out of the 6 algorithms Utah has the highest potential recovery. The other 3 algorithms Utah has the lowest or near lowest risk potential recovery

Four of six algorithms run on pharmacy claims showed Utah had the highest risk rates of surrounding states.

CMS notes that direct dollar-for-dollar comparisons of the above algorithms would be difficult to make due to several variables such as different population sizes, time period fluctuations, and different state policies. Accordingly, we analyzed the data to assess Utah’s position relative to its surrounding states, and note that there are still limitations to that analysis. While limited, the results of the MIG algorithms do highlight areas needing improvement.

It Appears Utah Medicaid Is Paying Duplicate Pharmacy Claims. CMS’s algorithm found several duplicate pharmacy claims. The CMS algorithm was based on limited data, but nonetheless, found that there were instances where multiple claims had been paid to the same pharmacy for a single pharmacy service. The CMS algorithms found that a potential \$21,334 in duplicate pharmacy claims may have been paid to 138 unique billing providers.

CMS algorithms identified over \$20,000 in duplicate pharmacy claims, caused by an unidentified problem that has not been corrected.

Utah Program Integrity staff investigated these duplicate billings and found that Utah Medicaid staff could not explain why the duplicate payments were occurring. Utah Program Integrity is in the process of finalizing recoveries in this area. It is likely that duplicate pharmacy billings could still be occurring. The Utah Medicaid program should determine why these duplicate billings are occurring and ensure that they are stopped and controlled.

CMS algorithms found over \$16,000 in pharmacy services and over \$72,000 in long-term care services after death.

Pharmacy Services after Death Should Be More Closely Controlled. The CMS algorithms identified potential pharmacy services where the prescription fill date is after the recipient's date of death. The potential for collection is \$16,190. At the time of this review, Utah Medicaid had some controls in place for date of death after discharge from a hospital and some other general date of death controls, but nothing specific for pharmacy. During the collaborative work on potential cost recoveries, CMS and the Program Integrity group developed a new control to identify pharmacy services provided after death, though we have not audited the control.

Long-Term Care Services after Death Should Be Further Reviewed. The CMS algorithm found a potential overpayment of \$72,175 for long-term care services provided after death. Utah Program Integrity staff validated some of these dates with vital statistics, though they did find some discrepancies. Utah Medicaid should review its payment methodology systems to ensure that these types of after-death payments are eliminated.

Recent Fraud, Waste, and Abuse Cases Confirm Trends in Utah

In addition to identifying examples of Utah Medicaid fraud, waste, and abuse using CMS's algorithms, current findings of the Utah and Federal Medicaid Program Integrity units and Utah's Medicaid Fraud Control Unit (MFCU) in the Attorney General's office also demonstrate examples of Utah Medicaid fraud, waste, and abuse.

Again, in light of comments made by DOH management that Medicaid fraud, waste, and abuse was not as prevalent in Utah, these cases clearly show that Utah Medicaid does have a current problem with fraud, waste, and abuse. Our August 2009 report said that even at a three-percent level of fraud, waste, and abuse, tens of millions of dollars can be wasted each year. As illustrated in this report, more must be done in Utah's Medicaid program to combat fraud, waste, and abuse and recover these funds. A contractor recently selected by the department will begin work soon on recovery activities.

Program Integrity Recently Uncovered Suspected Fraud at a Women's Clinic

Program Integrity discovered a case in which a clinic was allegedly coaching low-income women to use fake Social Security numbers to register for Baby Your Baby, a prenatal care program. Baby Your Baby is a Medicaid program intended as a stopgap measure for pregnant women waiting for their Medicaid eligibility to be processed.

The allegation includes the clinic billing Medicaid for care that was not medically necessary and performed by an unlicensed person. This care included ultrasounds performed too early in pregnancies to be useful and unclear ultrasounds. Program Integrity discovered this case when the clinic billed Medicaid for more ultrasounds than any other clinic in Utah. They also determined that the clinic filed a high number of claims for the prenatal program, but only a small number of those claims were Medicaid-eligible. MFCU is continuing the investigation for possible criminal charges.

Program Integrity Discovered Medicaid Paid for Medically Unnecessary Hospital Days

As part of the hospital utilization review, Program Integrity discovered that a hospital had billed Medicaid for a patient who stayed in the hospital for 34 days while only ten were medically necessary. Medicaid initially paid the full \$99,000 bill, but a Program Integrity review determined only four days were Medicaid-pay eligible and that the hospital needed to reimburse Medicaid about \$75,000. A settlement conference resulted in a negotiated reimbursement of \$56,000. This is a fairly typical recovery example as many Program Integrity cases involve hospital stays rejected for being medically unnecessary. Program Integrity then requires the provider to return the Medicaid money for the medically unnecessary days.

Program Integrity found a clinic was using fake social security numbers to register patients for prenatal care.

In one case, Program Integrity recovered \$56,000 from a provider who billed a stay beyond the allowed days-of-service.

In 2009-10, Utah recovered about \$25 million in two separate cases against drug companies.

MFCU Recovered \$24 Million From a Drug Company

In a 2010 lawsuit, the Utah Attorney General's Office, with the assistance of the department, successfully recovered over \$24 million from a drug company for off-label promotion. This occurs when a company claims that drugs should be prescribed for uses outside those approved by the FDA. This drug was approved for depression and was advertised by the pharmaceutical company for other uses, including dementia. Four million dollars of the recoveries went to legal fees, and the remaining \$20 million was returned to the general fund.

MFCU Recovered \$1 Million From a Drug Company

In a 26-state global settlement, a drug company settled with the Utah MFCU for \$1,005,000. This company, primarily the manufacturer of airway and allergy medications, allegedly inflated the reported drug prices used by Medicaid to determine reimbursement amounts to pharmacies. They then marketed the spread between the reported and actual prices to convince pharmacies that its products were more profitable than competing products. The case began in 2007 and was closed in September 2009. This kind of fraud, referred to as average wholesale price civil litigation, is being pursued for a number of other drug companies.

A Care Facility Paid Over \$365,000 for Patient Neglect

MFCU recovered \$365,525 from a Utah residential care facility when a disabled man died due to neglect. The 6'2" man, who weighed 200 pounds one year prior to his death, weighed 110 pounds when admitted to the hospital after passing out. A doctor determined that malnutrition prevented him from recovering from a necessary surgery, and the patient died a month later. The Department of Human Services Division of Services for People with Disabilities and DOH's Long Term Care Bureau assisted with the investigation. The settlement covered Medicaid restitution and investigation costs.

Recommendations

1. We recommend that the Department of Health, as required in *Utah Code*, regularly report to the Legislature regarding the progress that is being made in avoiding and recovering fraud, waste, and abuse in Utah Medicaid.
2. We recommend that Department of Health continue to facilitate state-wide Medicaid provider training of frequently used or potentially abused codes to help promote cost avoidance.

This Page Left Blank Intentionally

Chapter III

Utah Medicaid's Own Payment System and Policies Have Allowed Fraud, Waste, and Abuse

Utah Medicaid's identification and fund recovery system is hindered by system design problems and insufficient policies and procedures. The Legislature directed us to specifically review for possible recoveries of inappropriately paid claims. This chapter provides some examples of two internal Utah Medicaid issues that can unintentionally allow waste and abuse to occur in the program, which are:

- Utah Medicaid internal payment system problems and concerns
- Utah Medicaid policy and practices concerns

This chapter gives some examples of system problems that could be a much larger concern. Since these system problems can be corrected and internally controlled, leading to program savings, the Office of Internal Audit and Program Integrity (OIAPI), or, as discussed in the next chapter, an Office of Inspector General (if one is created) should continually audit for internal weaknesses. OIAPI should make their findings available to the Legislature on an annual basis and present the Legislature with a status report on corrective actions.

Utah Medicaid System Problems Contribute to Waste and Abuse

Previous legislative audits identified some Utah Medicaid internal system problems that contributed to program waste and abuse. We were directed by the Legislature to further look at the program and identify whether additional problems exist within the Utah Medicaid program. However, a comprehensive identification of internal problems or the magnitude of additional problems does not currently exist. Such an endeavor is better suited to the use of an audit recovery tool, as recommended in our previous audit. Currently, Utah Medicaid does not have this capability.

Medicaid payment system and policy weaknesses are contributing factors of fraud, waste, and abuse.

We identified additional system problems that contribute to fraud, waste, and abuse.

Various entities have identified instances with a likelihood of significant collections. We believe OIAPI should conduct a full risk analysis of these instances. Some of the system problems we encountered during this audit include:

- Payments over five years for transportation of unborn infants. This problem was identified twice before.
- For seven years, Utah Medicaid has paid duplicate claims in its managed care program. The full scope of this problem is still being investigated internally.
- Utah Medicaid has been paying for similar procedures separately that should be combined or bundled together as a single procedure.
- For over four years, Medicaid management has not prioritized correcting a system weakness that would allow Program Integrity to detect resubmission of claims that they previously identified and recovered as fraud, waste, or abuse.

Utah Medicaid should ensure that these problems, along with any others identified by future internal audits, are corrected.

Utah Medicaid Has Been Paying for the Transportation of Unborn Babies

Program Integrity found that for at least the past five years, Utah Medicaid has reimbursed one medical transportation company for transporting unborn infants, as well as the pregnant mothers. These payments occurred under a capitated payment contract whereby the provider is paid a set amount for every person eligible for the service, regardless of whether the service was used. The error occurred because unborn babies were being placed by the department on the list of eligible recipients. Two other businesses provided this same service, but were not paid separately for unborn babies likely because they are not paid on a capitated contract. The error totaled about \$187,000 over a five-year period.

Compounding the severity of this problem, it appears this is the third time in about seven years that this problem has been identified for this provider. Reportedly, the programming system had not been fixed after the first two occurrences, allowing the problem to continue. Further, Utah Medicaid could not produce evidence of repayment from the prior two occurrences.

Utah Medicaid has been paying to transport unborn infants.

In 2005, a Utah Medicaid employee reported that payments to this company for transporting unborn children were actually not a programming error. The employee stated that Medicaid management specifically instructed that this company be exempt, and thus the system made the inappropriate payments. It is unclear why this exemption would have been allowed, but the exemption seems probable due to the continuing nature of the problem over several years. A former Utah Medicaid management member, in addressing why this problem had been allowed and detected several times over the years, said he believed the problem had been fixed.

What is clear is that Utah Medicaid repeatedly paid claims for transportation of unborn babies for one transportation provider. Program Integrity should continue to follow up for the next several years to ensure this problem does not reoccur.

Duplicate Managed Care Payments Have Occurred

Utah Medicaid has been paying duplicate payments to managed care providers for about seven years. Utah Medicaid discovered the problem as part of the federally required upper payment limit test. Utah Medicaid is now in the process of seeking the return of these funds. These tests are not yet complete, so exact figures are unknown. Estimates range between \$3 and \$8 million for the seven-year period. The exact amount will not be known until internal validation work is completed. Once a collection is made, Utah Medicaid should report it, and all others, to Program Integrity for tracking and reporting.

Duplicate payments were allowed by Medicaid's payment system due to initial insufficient claims editing. When managed care went from capitated to cost-plus in fiscal year 2003, Utah Medicaid did not initially have an adequate system to receive claims, adjudicate them, and remit payment. The inadequate system resulted in claims processing with relatively no editing. Thus, claims were often paid at face value with little or no review. Reportedly, one of the managed care organizations also had inadequate claims editing software on their end.

Improvements have been made that now allow for better editing of these managed claims. However, as with other identified system

Program Integrity should follow up to ensure payments for transporting unborn infants stop.

Utah Medicaid has paid millions in duplicate payments to providers enrolled in managed care.

problems, Utah Medicaid must continue to be diligent to ensure that duplicate payments do not continue.

Medicaid System Is Not Paying Bundled Services Correctly

It appears that the Utah Medicaid payment system is paying for unbundled service claims when, by rule, the claims should be bundled as a single, less costly claim. An algorithm (computer-based mathematical test) run by CMS, which was provided at our request, found that in some situations, Utah Medicaid is inappropriately paying more for services that should be packaged, or bundled, in a single claim. Coding rules allow that some services can be billed separately and receive separate reimbursements, but other services should be combined and paid together.

Utah Program Integrity staff brought this problem to the attention of staff in the Utah Medicaid Bureau of Operations and was told that the current system cannot adequately catch this problem and they are hoping the new pre-pay vendor will catch and collect any overpayments. It did not appear from the staffs' response that they planned to collect past overpayments, though Utah Medicaid management reports that they are looking into the matter. We recommend that Utah Medicaid determine the extent of the problem and seek collection for any overpayments. These overpayments should be reported to Program Integrity.

Four-Year Old Program Integrity Improvement Request Is Still Outstanding

When a payment system error is detected, Utah Medicaid operations identify the error and place it on the system's discrepancy list. Operations staff then prioritize the listed discrepancies for correction. One item that was added to this list in 2006, a needed system enhancement for program integrity, is still outstanding. The enhancement is intended to detect resubmitted claims that were previously recovered due to fraud, waste, and abuse. In other words, this system enhancement would detect whether a provider resubmitted an identical claim to one that Program Integrity previously recovered.

We found that this issue of rebilling an incorrect claim has happened on at least one significant occasion. In this case, Program

It appears Utah Medicaid payment system is paying for unbundled claims inappropriately.

A system enhancement to detect fraud, waste, and abuse is still incomplete after four years.

Integrity recovered about \$75,000. Shortly after being alerted that the claim payment was being recovered, the provider resubmitted the claim and was again paid in full. Program Integrity happened by chance to detect the second payment. Program Integrity again recovered the funds, and the provider then took the case to a hearing. The hearing officer decided that a partial payment would be allowed. However, when the claim was again submitted, it was paid in full a third time, requiring a manual adjustment to reduce the payment to the amount set at the hearing.

We asked Utah Medicaid operations staff why the full request for a system enhancement has not yet been completed after four years. Their response was that projects like this receive a programming priority and this request has not been deemed a high priority, even though Program Integrity has repeatedly requested the enhancement. Utah Medicaid should evaluate the cost benefit of including this programming. In addition, this issue is growing in importance with the RFPs that are being issued by the DOH to have vendors recover inappropriate claims on a contingency basis. If a provider resubmitted a claim after a Medicaid recovery contractor recovered the funds, then Utah Medicaid could end up paying the contractor contingency fee on top of still paying the claim.

We believe this system enhancement to automatically stop duplicate payments from Program Integrity recoveries should be completed. Additionally, Program Integrity and the Medicaid Fraud Control Unit (MFCU) in the Attorney General's office should review these claims for potential fraud. Once a provider learns that a claim is not valid, resubmission of the claim for payment may pass the threshold of abuse and qualify as fraud. Such cases should be investigated.

Policy Concerns Have Contributed to Waste in Utah's Medicaid Program

Previous audits identified that efficient operation of Utah's Medicaid program is hindered by loosely structured policies and procedures. This review found additional areas where policies could be improved and we suspect that there may be more. From our

Utah Medicaid staff said that the fraud, waste, and abuse system enhancement was not deemed a priority, even though Program Integrity repeatedly requested it.

We again identified areas where policies need to be refined.

review, policy inadequacies that should be reviewed and corrected include:

- Pharmacy costs and policies to ensure Utah Medicaid is getting the best possible price
- Teeth cleaning policy that allows for three or more teeth cleanings per year as long as they are done by different providers. This is more generous than other Utah insurance benefits.

We believe that the OIAPI should continually review Medicaid policy for weaknesses and make their findings available to the Legislature for review.

Utah Medicaid Should Review Its Pharmacy Costs To Ensure It Obtains the Best Possible Price

Utah Medicaid may be able to increase pharmacy program savings. Although Utah's pharmacy program is an optional Medicaid service with an annual cost of about \$134 million (see Appendix A), elimination of the service is not a realistic option. However, maintaining service levels while reducing pharmacy program costs should be explored.

Some other states have instituted aggressive maximum-allowed-costs (MAC) policies that drive pharmacy costs to the lowest possible price. Utah Medicaid reports that, in the last few years, a number of new MAC prices have been instituted. However, it appears that Utah Medicaid can do more to lower the drug prices of its pharmacy program.

Time constraints did not allow us to conduct a comprehensive review of Utah Medicaid's pharmacy program; consequently, we cannot positively quantify the full dollar savings possible. However, it appears savings could be substantial. To illustrate areas where Utah Medicaid program pharmacy prices appear to be high, we provide three examples, as follows:

- In some instances, Utah Medicaid prices are higher than prices set by Utah's Public Employees Health Plan (PEHP)
- Utah Medicaid Average Generic Drug Price and MAC policies do not appear to be as aggressive as some other states' policies

Utah Medicaid can do more to lower the price for its pharmacy program.

- Utah Medicaid should review prices charged by some pharmacies as a measure of its pricing structure.

To determine full cost savings potential and review other cost saving options for the Utah Medicaid program, we recommend that DOH's OIAPI conduct further audits and reviews.

In Some Instances, Utah Medicaid Pharmacy Rates Are Higher than PEHP's. As a government payer, we believe Utah Medicaid should strive for the best available price in its pharmacy program. We compared a small sample of some Utah Medicaid drug prices to PEHP's prices. Our sample was taken from drugs that had relatively high cost and utilization. We looked at 39 drugs and found that Utah Medicaid paid more than PEHP 13 times (33 percent of selected drugs). Figure 3.1 shows the results of our limited test. To protect the proprietary nature of drug pricing, we show only the percent difference per drug.

Figure 3.1 Some PEHP Drug Prices Are Lower Than Utah Medicaid's. This figure shows that Utah Medicaid pays more for some drugs than PEHP's negotiated prices.

Drug	Percent Utah Medicaid Higher Than PEHP
Drug A	64%
Drug B	51
Drug C	47
Drug D	40
Drug E	39
Drug F	39
Drug G	35
Drug H	26
Drug I	26
Drug J	25
Drug K	17
Drug L	12
Drug M	10%

Utah Medicaid pays more than PEHP does for some of its drugs.

We estimate that it could be costing Utah Medicaid tens of thousands a month for having their prices on the above drugs over PEHP's pricing level.

To ensure that the most accurate comparisons were made, every effort was made to ensure pricing periods were similar, rebate

information was included, and other pricing factors were considered. However, comparing two programs with unique policies and practices did not allow for a perfect comparison. Nevertheless, we believe the information does show that Utah Medicaid can seek lower prices for some of its drugs.

Also, to account for differences in dispensing fees and co-pay amounts, prices shown above are net prices (but before dispensing fees and co-pays are factored in). However, we did include any rebate information from both entities. Thus, the prices shown here should be an accurate reflection of price that the payer is making for the drugs.

Utah Medicaid should more closely review its price for drugs to determine if lower prices are available. The next section reviews options, such as contracting out pharmacy price review, for Utah Medicaid to achieve lower prices in its pharmacy program.

Utah Medicaid Average Generic Drug Cost May Be Unnecessarily High. Utah Medicaid may be able to achieve substantial cost savings by lowering the price it pays for generic drugs. A limited review shows that Utah Medicaid's average generic drug cost is higher than generic drug prices in some other states. Currently, Utah Medicaid reports an average generic prescription cost of about \$24. We were able to obtain Idaho's and Maine's average prescription costs and found they are both lower. While differences understandably occur between states, and differences in cost could be explained by a number of factors including case mix, we believe that Utah should examine its policies and practices to determine where it may be able to drive costs down.

For example, one company reports on its website that it lowered Maine's average cost per generic prescription 27 percent over six years. Figure 3.2 shows what this company reports its intervention has done to Maine's generic drug costs.

Utah Medicaid's average generic prescription cost is higher than some other states' costs.

Figure 3.2. Maine Medicaid Generic Prescription Costs Have Been Reduced. Reportedly, Maine has been able to lower its pharmacy costs 27 percent over six years.

Year	Average Cost Generic Prescription
2002	\$16.30
2003	14.76
2004	13.08
2005	12.73
2006	12.45
2007	\$11.82

The company managing Maine’s prescription program did not provide data beyond 2007, but Maine Medicaid staff reported that the average price is now about \$10 per generic prescription.

The possibility that Utah Medicaid pharmacy prices can be lowered and substantial cost savings achieved was also mentioned in a response to a letter that President Michael Waddoups and Speaker David Clark sent to stakeholders in the Utah Medicaid program. The legislative leaders asked for feedback on ways Utah’s Medicaid program could be improved. Complete findings from this survey are still being compiled. However, one comment dealt directly with lowering pharmacy costs through better MAC pricing. We spoke with this respondent, who sits on Utah Medicaid’s Pharmacy and Therapeutics committee and is knowledgeable in this field. The respondent provided us with the following response:

I serve on the Pharmacy and Therapeutics committee that was enacted by the Legislature a few years ago. It seems that the MAC (maximum allowable cost) list that the state uses to reimburse pharmacies for all medication in the absence of a specific contract has not been kept up to date. This means that if the price of a medication falls over several months as a generic becomes available, that the State continues to pay the high price of the past, not realizing that it is overpaying.

The division director for Medicaid, assures me that a new pharmacist has recently been hired who will have some time to spend on this, but it should never have been allowed to get this way in the first place. I have been told that Medicaid pharmacy staff is so short they just haven't had time to pay attention to this (And admittedly, it is not a straight forward thing, as there are

A member of Utah Medicaid’s Pharmacy and Therapeutics committee believes that Utah Medicaid can achieve lower costs.

If staff resources are insufficient to lower pharmacy costs, Utah Medicaid should review the costs/benefits of contracting out services to achieve cost savings.

In some instances Utah Medicaid is allowing pharmacies to bill them over eight times more than what other pharmacies are charging.

many medications to keep track of, and finding out the true cost of a medication is not always obvious), but it makes no financial sense for the state when they are paying out millions of dollars every month in medication costs to not have someone paying close attention that they aren't overpaying.

We agree. It does appear that cost savings are possible in Medicaid's pharmacy program. Due to time constraints related to the audit, we were not able to estimate the full amount of savings that might be possible with a more aggressive MAC policy. However, if staff resources are a concern, as stated above, Utah Medicaid should seek out companies, like the one managing Maine's program, to lower its costs.

Utah Medicaid, in conjunction with DOH internal auditors, should review options to lower its pharmacy costs, including contracting with an outside prescription management firm.

Utah Medicaid Should Review Prices Charged by Other Pharmacies as a Measure of Its Pricing Structure. Some pharmacies publish price lists for certain drugs. Utah Medicaid should use this information as another source to determine if it has an opportunity to lower its prices paid.

For example, several companies offer \$4 prescriptions that can be used as a general indicator of cost. We understand that some of these drugs are used as "loss-leaders" to bring business into their stores. However, we believe that the information can be useful. For example, we found that Utah Medicaid is allowing other pharmacies to bill them over eight times more for some of the drugs on the \$4 dollar prescription lists.

Along with assessing whether drug management firms may be able to lower costs in pharmacy, the DOH internal auditors should also conduct an analysis and determine what savings are possible with a more aggressive pharmacy pricing and delivery system.

Teeth-Cleaning Policy Allows for Near Limitless Cleanings if They Are Done by Different Providers

The current Medicaid dental policy for teeth cleaning allows Medicaid beneficiaries who qualify for dental care to have their teeth cleaned more than twice a year as long as they go to a different provider after the second cleaning. Theoretically, this policy allows for coverage of near limitless teeth cleanings.

This policy concern was brought to our attention during the RFP process to select a vendor to recover fraud, waste, and abuse for Utah Medicaid. The vendor submitted claims payments they believed could be recovered, one of them being teeth cleanings that occurred three or more times per year. However, Utah Medicaid had to deny those recoveries due to this loosely-written policy. We are concerned that similar poor policies may exist in other areas.

This particular dental policy is more generous than policies of other insurance companies in the state. Figure 3.3 shows that the three major insurance companies in Utah allow only two cleanings per year. In addition, Medicare does not cover any cleanings.

Figure 3.3 Medicaid Teeth-Cleaning Policy Needs to Be Reviewed.

The current policy allows for eligible Medicaid beneficiaries to have their teeth cleaned more than twice a year. Other entities in the state allow for only two cleanings per year.

Teeth Cleanings Allowed Per Year by Insurance Provider			
Utah Medicaid	PEHP	Blue Cross Blue Shield	IHC Select Health
Two times a calendar year per provider.	Twice a year	Twice a year	Twice a year

Data from 2005 to 2010 shows that there were 4,920 teeth-cleaning procedures reimbursed by Medicaid. Of those, 983 or 20 percent of the procedures would not have been approved if Medicaid's policies were similar to those of other entities in Figure 3.3. The average reimbursement cost for the 4,920 procedures was \$108, so over five years Medicaid would have saved about \$106,000 if the policy covered a total of two cleanings per year.

Current Utah Medicaid teeth-cleaning policy is more generous than policies of other insurance companies.

Over five years, Utah Medicaid could have saved about \$106,000 if its dental policies were similar to other insurance companies' policies.

Figure 3.4 Medicaid Policy Allows for More Than Two Teeth Cleanings in One Year. Some Medicaid recipients had their teeth cleaned four times in one year.

Patients with More than Two Visits per Year						
	2005	2006	2007	2008	2009	2010
Total						
Patient visits	13	34	246	242	290	158
	983					

We recommend that Utah Medicaid change its dental cleaning policy to be in line with other accepted insurance policy standards.

Recommendations

1. We recommend that Utah Medicaid report all collections, recoveries, and overpayments that they process to the office of Internal Audit and Program Integrity (OIAPI) for tracking and reporting.
2. We recommend that the Office of Internal Audit and Program Integrity (OIAPI) conduct an analysis on pharmacy maximum-allowed-costs (MAC) policies and practices to determine the potential cost savings if Medicaid changes policies and MAC prices.
3. We recommend that Utah Medicaid, in conjunction with the Office of Internal Audit and Program Integrity (OIAPI), review the cost and benefits of contracting with a firm to manage prescriptions costs.
4. We recommend that the Office of Internal Audit and Program Integrity (OIAPI) should continually audit for internal weaknesses, including payment and policy weaknesses. OIAPI should make any findings available to the Legislature on an annual basis and provide the Legislature a status report on corrective action that the Department of Health takes.
5. We recommend that Utah Medicaid change its dental cleaning policy to be in line with other accepted insurance policy standards.

Chapter IV

Inspector General Would Provide Greater Control and Independence of Medicaid Audit Functions

An Office of the Inspector General (OIG) for Utah's Medicaid program is needed to provide better oversight over Medicaid's growing \$1.7 billion program budget (\$1.9 billion with administrative funds), which is about 18 percent of the state's total budget. No other single state program is responsible for this level of funding. Further, previous reports by our office have shown that the Department of Health (DOH or department) has not always had strong controls to prevent fraud, waste, and abuse. As well, Chapter II of this audit describes abusive billings in the form of upcoding (overcharging) by a clinic owned and operated by the department at which DOH management members were involved, upcoding was also found at a private provider.

The structure of the DOH audit and Program Integrity functions has demonstrated past and continuing independence problems that lead us to question if the current structure is capable of providing adequate oversight to the over one billion dollars in Utah's Medicaid program. Other states that have implemented successful inspector general offices report substantial cost savings once independence was achieved.

For example, the Texas OIG reports increased cost recoveries of 322 percent and cost avoidance of 420 percent for the year following the introduction of its OIG program. A 322 percent increase in cost recovery would translate to about \$12.6 million in cost recovery savings for Utah. Utah Program Integrity is not currently tracking cost avoidance, but it is believed that cost avoidance could be several times the size of cost recovery, potentially making total program savings in the tens of millions of dollars.

This chapter is organized into five sections that demonstrate the need for an independent inspector general. These sections are:

Medicaid's \$1.7 billion budget presents significant risk for fraud, waste, and abuse.

An OIG could significantly improve the audit and program integrity's independence and cost savings.

An OIG could ensure adequate independence and oversight of Medicaid funds.

- First, the high risk of fraud, waste, and abuse in a program with the size and growth of Utah Medicaid.
- Second, a summary of the continuing control weaknesses identified in both this review and two previous legislative audits.
- Third, a description of the continuing barriers to independence created by the current structure of internal audit and program integrity.
- Fourth, information on program cost savings that other states experienced with the creation of an OIG, and what this potential savings could mean for Utah.
- And fifth, sound practices for OIG authority and structure, as seen in other states, that should be adopted by Utah if an OIG is created.

We believe that a well-structured OIG is the best solution for ensuring adequate oversight is given to the Utah Medicaid program. We recommend that the Legislature consider creating an inspector general's office with authority to provide oversight to the Utah Medicaid program.

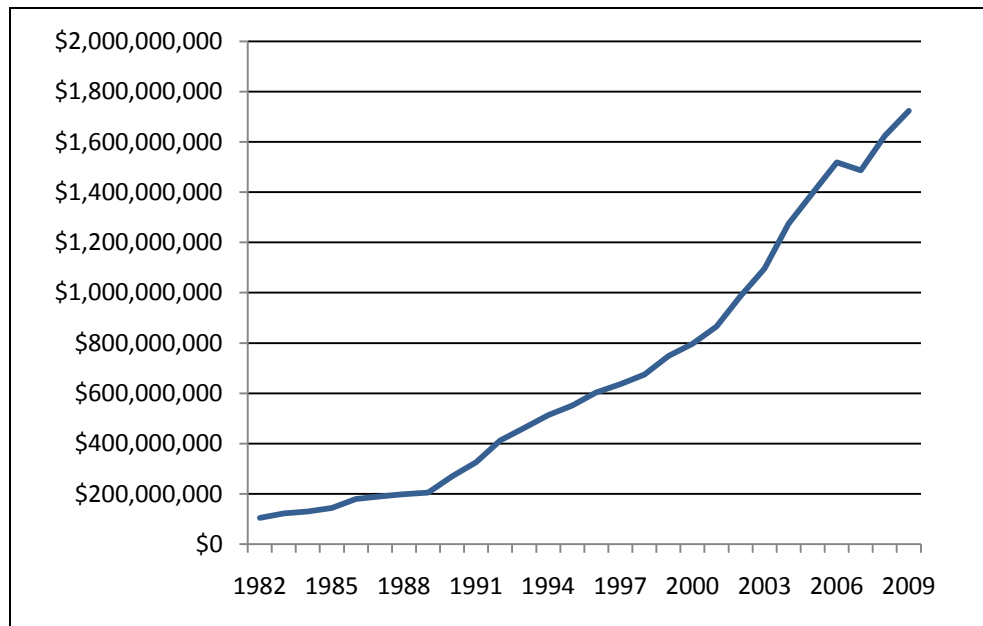
Medicaid's Substantial Budget Requires Increased Oversight

At \$1.7 billion in program funds, Utah Medicaid's increasing budget is larger than that of any other single state entity. In addition, enrollment is at an all-time high, and is anticipated to continue to increase due to federal health care reform requirements. It is vital to minimize and retrieve misspent Medicaid funds in order to ensure that these funds are spent effectively.

Medicaid's budget is the largest single-entity controlled budget in the state of Utah. While public education is the largest expense to the state, those funds are largely controlled by the 41 independent school districts, rather than one entity. The far-reaching nature of DOH's sizeable budget puts it at a higher risk for fraud, waste, and abuse than other state agencies. Figure 4.1 shows that Utah's Medicaid program has grown by \$1.6 billion dollars over the last 25 years and has increased 116 percent in the last 10 years.

Utah Medicaid's budget is second only to public education.

Figure 4.1 Medicaid's Budget Has Continually Grown. In the past 10 years, Medicaid's budget has grown 54 percent.



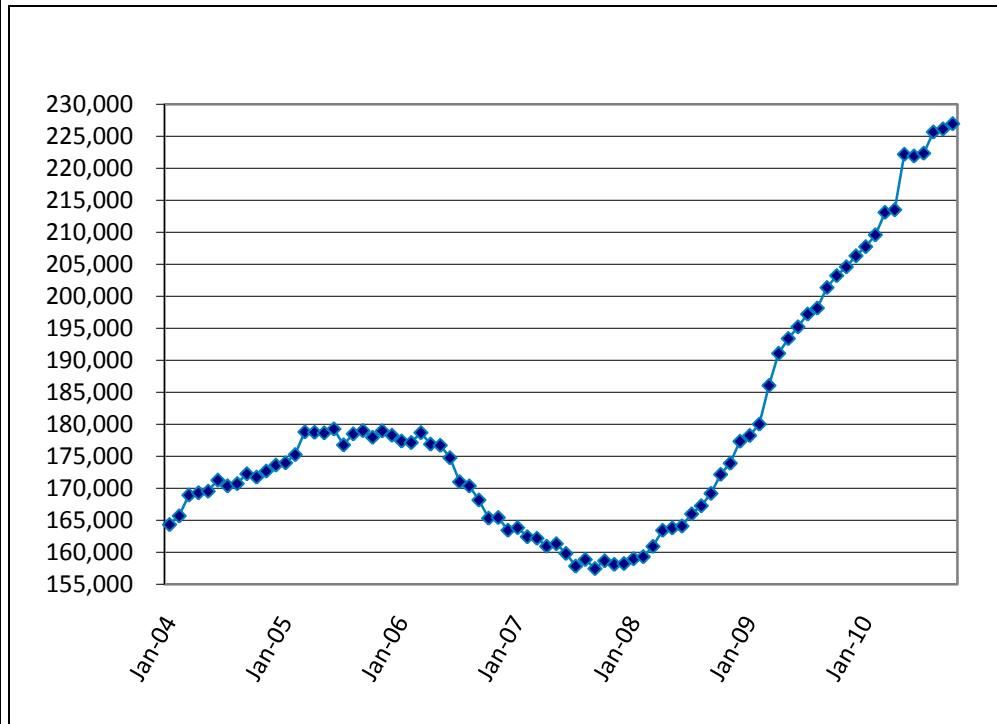
This figure shows program dollars. Total Utah Medicaid funds, including administrative dollars, was almost \$1.9 billion in fiscal year 2010.

In the past three decades, the Medicaid budget has gone up over a thousand percent. In the past 10 years alone, the budget has increased 116 percent. At the current growth rate, in ten more years the Medicaid program could increase an additional \$2 billion. This growth does not take into consideration costs of federal health care reform that is projected to substantially increase the program above current growth estimates.

In connection with the growth in the budget, the Medicaid caseload is at an all-time high. Figure 4.2 shows the historical Medicaid caseload for the past seven years.

If growth rates remain constant, the Medicaid budget will increase another \$2 billion in 10 years.

Figure 4.2 The Number of Medicaid Recipients Has Grown In the Past Seven Years. The current number enrolled is the highest in the history of the program.



In six years, the number of Medicaid recipients increased about 30%.

As the figure shows, from 2004 to the middle of 2010, the number of recipients of Medicaid increased about 30 percent. These numbers are expected to continue to grow. In fact, some estimates by Utah Medicaid staff show Utah Medicaid's caseload increasing as much as 50 percent when all of the provisions of federal health care reform are implemented. The federal government has recognized the need for more prevention and retrieval of fraud, waste and abuse monies with this growth. They have stated that the health reform bill "contained an unprecedented array of aggressive new authorities to fight waste, fraud and abuse. . . . Health reform increases funding for the Health Care Fraud and Abuse Control Fund by \$250 million over the next decade."

In light of the recognized growth in Medicaid's budget and caseload, as well as the federal government's acknowledgement of the need for increased efforts against fraud, waste, and abuse, Utah needs to strengthen its oversight of this growth. Granting the internal audit

and Program Integrity functions greater independence through an OIG is a strong step toward meeting the need for increased efforts.

Lack of Medicaid Controls Illustrate Need for an OIG

This audit, along with two other legislative audits, has illustrated the need for better controls and oversight in the Utah Medicaid program. A stronger, more independent audit and integrity function could have detected these problems earlier. We reported in August 2009 that “over the last 10 years, only 3 reports out of 251 (less than 1 percent) completed by the DOH internal auditors dealt with Medicaid.” There is a clear need for strengthened controls.

Some control weaknesses that we have identified in previous audit reports (including this one), which an OIG could have controlled, are:

- Inadequate controls existed over prior authorization nurses which led to inappropriate approvals of medical procedures and compromised cost avoidance.
- Insufficient policies and controls over the provider enrollment process that compromised cost avoidance.
- Ineffective fraud, waste, and abuse analytical tool that compromised Program Integrity’s ability to detect fraud, waste, and abuse.
- Unreliable data relating to recovery amounts and types.
- Inefficient utilization of staff time and resources.
- Limited use of performance measures and business metrics.
- Inadequate cost control measures existed in managed care.
- Oversight and performance metrics were not developed which led to overutilization and increased costs.
- Quality review standards had no clear benchmarks.
- Medicaid payment system was overpaying hospitals for emergency room visits.
- Upcoding or overcharging has been occurring at a DOH clinic and a private health clinic.
- Payments for transporting unborn babies have occurred.
- Pharmacy costs controls can be tightened.

**We have identified
Medicaid control
weaknesses in three
audits.**

While our follow-up report (Report #2010-14) shows that improvements are being made to correct these deficiencies, we believe an independent audit and integrity body, such as an OIG, would be better equipped to identify and correct these problems sooner.

Internal Audit and Program Integrity Need Increased Independence

The audit and Program Integrity function at DOH continues to lack sufficient independence, even after a reorganization answering our August 2009 report. Specifically, Internal Audit and Program Integrity do not have adequate independence over audit assignments, scope of audits, budget, and appeals process. The current structure continues to allow Medicaid and other auditees to have oversight and control over the audit and integrity functions. This section describes the following impairments to independence, including auditees:

- Serving on the audit committee and exercising control over the audit and Program Integrity function
- Influencing audit scope and subject matter
- Approving the OIAPI budget and personnel requests
- Maintaining final ruling authority over the results of Program Integrity appeals hearings

These impairments would not be allowed by the established standards of state and federal OIG offices. We believe these standards to be important to functional independence.

Auditees Serve on OIAPI's Audit Committee

The department has an audit committee consisting of the executive director, the chief operating officer, a department deputy director/Medicaid director, the fiscal operations director, and an ex-officio assistant attorney general. As OIAPI reviews and audits both Medicaid and the department's fiscal operations, the structure of this committee compromises integrity.

The audit committee, which they now call a management/advisory committee, was reportedly formed years before an August 2009 restructuring of OIAPI in order to ensure that audit

**Audit committee
membership includes
those being audited.**

recommendations, primarily from audit entities outside the department, were being implemented. After the creation of the new audit and Program Integrity office, the committee membership remained the same. Department management told us at the end of this audit that the committee is merely an advisory management committee, and thus not an audit committee according to *Utah Code* 63I-5, the internal audit statute. However, we believe that this committee has performed some functions consistent with the definition found in *Utah Code*.

Utah Code 63I-5-102 defines an audit committee for state agencies as “a standing committee whose members are appointed by an appointing authority.” For state agencies, the appointing authority is the governor. Further, the statute details the members of the committee as individuals “who do not have administrative responsibilities within the agency.” The statute goes on to describe the purpose of an audit committee as to “monitor the activities of the agency internal audit organization.” Figure 4.3 shows the duties of an audit committee as listed in the same statute, and compares these duties to the activities of the DOH audit committee.

***Utah Code* requires members of a state agency’s audit committee to be appointed by the governor.**

Figure 4.3 DOH's Audit Committee Performed Some of the Duties of a Statutorily Defined Audit Committee. An audit committee is statutorily to be appointed by the Governor to increase independence, but the Governor did not appoint DOH's committee and we do not believe it is independent.

Statutory Committee Duties <i>Utah Code 63I-5-301(3)</i>	DOH Committee Actions
Consent to the appointment or removal of the internal audit director	The Internal Audit and Program Integrity director's interview committee was comprised of members of the audit committee.
Consent to the internal auditing policies	Proposed policies were submitted to the committee for review.
Review and approve the annual internal audit plan and budget	Committee received report on the department-wide risk assessment plan. Budget and staffing requests are submitted to a committee comprised of the same members as the audit committee.
Review internal and external audit reports	All audit reports are presented to the committee. The committee also requires that the reports be submitted for editing prior to their release.
Meet with the internal audit director to discuss pertinent matters, including restrictions on the scope of audits	Memos are sent from the audit director to a member of the committee regarding limits to scope.

We believe that the committee's activities listed above appear to match the duties of an audit committee as listed in *Utah Code*. We question whether this structure conforms to the internal audit statute.

In addition, the internal audit and Program Integrity director stated that up until the end of the audit, he was under the impression that this was an audit committee that he was required to report to, but it has since been explained to him that it is merely advisory. We believe that this committee has been functioning as an audit committee and the membership of that committee is an impairment to independence.

The Medicaid director was promoted to a department deputy director in July 2009, but still continued as the Medicaid director. While audit and Program Integrity now report to the deputy director over operations, the Medicaid director's promotion gave him departmental oversight that at times includes the office whose function it is to review the performance of his Medicaid duties. These

The activities of the department's committee appear to match the duties of an audit committee listed in statute.

The Medicaid director is now also a deputy director.

organizational changes have not given the audit and Program Integrity functions sufficient independence.

Some Medicaid Service Providers Were Exempted from Review In the Past

Prior to the creation of OIAPI, it appears that some Medicaid program areas were excluded from review and were not examined by Program Integrity. Program Integrity staff members state that these exclusions were allowed by previous Medicaid management due either to sensitive relationships with some providers or the perceived difficulty of recovering funds from other governmental entities. Apparently, some thought that inappropriate payments (of primarily federal dollars) to state agencies still benefited the state, so no recovery should be sought.

Current department management report that they were not aware of these exclusions and did not approve them. Nevertheless, this perception existed during the course of our audit. As shown in Chapter II, the DOH health clinics were not reviewed. Further, we understand other programs such as Department of Humans Services programs in youth corrections and foster care were not reviewed, nor were Indian Health Services.

OIAPP's current director has instructed Program Integrity staff to begin including these three areas in their reviews. However, at any time department management could instruct Program Integrity not to review areas of the Medicaid program. An OIG would not have that impairment.

The Association of Inspectors General, an organization formed by inspectors general throughout the country, has published principles and standards for use by inspectors general, informally known as The Greenbook. In addition, the federal government also publishes standards for its own multiple inspectors general, known as The Silverbook. Figure 4.4 shows identified impairments to investigative independence.

In the past, the OIAPI has been instructed to avoid reviewing the three state health clinics, Youth Corrections and Foster Care, and Indian Health Services.

Figure 4.4 Established Authorities Identify Investigative Independence Impairments. Audit and Program Integrity scope appears to have been hampered by Medicaid oversight of its investigations.

Authority	Identification of Impairment
Assoc. of Inspectors General	"Interference or undue influence in the OIGs selection of what is to be examined, determination of scope and timing of work or approach to be used."
Federal Offices of Inspectors General	"Influence that could improperly or imprudently limit or modify the scope of OIG work or threaten to do so."
	"External interference with the selection or application of OIG procedures, the selection of transactions to be examined, or access to records or personnel."

The Utah Legislature should consider creating statute that would establish standards to mitigate impairments to the scope of OIAPI's investigation.

Auditees Influence OIAPI's Budget and Staffing

An OIG would have independence from budgetary oversight by the agency that it audits and reviews. Because they do not control their own hiring or budgeting processes, OIAPI does not have budgetary independence. While the executive director has the final budgetary say, both the Medicaid and fiscal operations directors sit on the executive management team which makes recommendations. Program Integrity and Internal Audit review the operations of divisions under the direction of the people approving the OIAPI budget. This creates impairment to reporting their findings, especially when negative.

OIAPI conducts audits of Medicaid providers paid by the Medicaid division and, along with a portion of the internal audit staff, conducts operational reviews of policies, procedures, and operations of the Medicaid division. Inadequate policies and procedures can lead to fraud, waste, and abuse. Having auditees on the committee that oversees the OIAPI budget and staffing creates an impairment to Program Integrity and Internal Audit independence that can hamper OIAPI's ability to avoid and recover fraud, waste, and abuse. Essentially, the office charged with oversight requests operational funding from the auditee.

The OIAPI's budget requests and staffing must go through a committee that includes the Medicaid director.

The Auditees Have Authority Over OIAPI Staffing. When filling a budgeted position, every DOH division, including OIAPI, is required to submit a memo to a departmental review committee. This management committee consists of the Chief Operating Officer (COO), a Department Deputy Director/Medicaid Director, the Manager of the Office of Fiscal Operations, and the Deputy Director of Public Health Practice. Each memo must contain a position description, why the position is needed or currently vacant, and the position's funding source. If an Inspector General were created, he/she would have more independence to control the staffing levels of the office.

DOH Administrators Approve OIAPI Budget Building Block Requests. OIAPI's budget requests must be approved by the department's management committee. As an office within the Department of Health, OIAPI's requests are placed on the Department's budget building blocks request and submitted to the Governor's office. The management committee consists of several auditees including, among others, the Department Deputy Director/Medicaid Director, and the Fiscal Operations Manager.

Handling OIAPI's budget and staffing requests at the department level leaves Program Integrity and audit competing with all the other priorities of the department. In the past, Program Integrity priorities have not been given high consideration. This appears to be continuing. Before it was decided to contract out the medical review portion of Program Integrity, the request for additional staff for medical review was given a low priority by the department. Creating an OIG would allow the inspector general (IG) to directly communicate the office's needs to the Governor and Legislature. This independence is important for an oversight entity that would be watching over nearly \$2 billion in funds.

National Standards for Inspectors General Outline the Need for Budgetary Independence. As shown, Program Integrity currently does not have budgetary independence. The federal IG Silverbook of standards recommends that an IG "hire and control their own staff and contract resources." Figure 4.5 shows the established authorities' statements of impairment related to our concerns with OIAPI's budgetary independence from its auditees.

To fill a staff position, a memo must be submitted including the position, why it is vacant, and where the money comes from.

The committee that approves Program Integrity's building blocks includes the Medicaid Director.

Federal inspector general standards recommend that an IG "hire and control their own staff and contract resources."

Figure 4.5 Established Authorities' Budgetary Independence Impairments. The budgetary structure of OAIPI appears to be hampered by these impairments.

Authority	Identification of Impairment
Assoc. of Inspectors General	"Interference or undue influence in the selection, appointment, and employment of OIG staff."
	"Restrictions on funds or other resources dedicated to the OIG . . . that could prevent the OIG from performing essential work."
Federal Offices of Inspectors General	"Pressure to reduce inappropriately the extent of work performed in order to reduce costs or fees."
	"Interference external to the OIG in the assignment, appointment, promotion, or termination of OIG personnel."
	"Restrictions of funds or other resources provided to the OIG organization that adversely affect the OIG's ability to carry out its responsibilities."

Federal OIGs have the authority to "select, appoint, and employ such officers and employees as may be necessary."

We are concerned with OIAP's independence, having identified several of the impairments listed in the figure within their operation. In addition to these standards manuals, federal law authorizes its OIGs to "select, appoint, and employ such officers and employees as may be necessary." It also allows that "the Inspector General determines the budget needs of OIG . . . By statute, the Inspector General exercises general personnel authority, e.g., selection, promotion, and assignment of employees." The current OIAP budget and staffing processes do not meet these standards.

OIAP's Appeal Process Is Controlled by the Medicaid Director

Any OIAP finding against a provider may be appealed through a hearing process. Provider appeals are brought to the department's administrative law judge, who reports to the Medicaid director, who has the final say on all rulings. The administrative law judge makes a recommendation to the Executive Director of DOH or his designated representative, who is the Medicaid director. At that point,

"The Executive Director of DOH or his designated representative may: (a) adopt the proposed decision, or any portion of the decision; (b) reject the proposed decision, or any portion of the decision, and make his own independent determination based upon the record."

At this point, “the decision of the Executive Director or his designated representative constitutes final administrative action.” Since the Medicaid director is the executive director’s representative, the only other recourse is a judicial process outside the Department of Health. Allowing the Medicaid director to make the final decision on provider appeals can hinder OIAPI independence. The Green and Silver Books recommend against auditee influence in the final resolution of the audit.

We believe that the current appeals process does not give sufficient independence to OIAPI. The standards listed above for an OIG would help provide adequate independence to Program Integrity and audit.

In order to have greater independence from program operation bias, some other states utilize a separate commission or state agency to conduct administrative hearings. In these systems, hearing officers may make the final administrative judgment, which can then be overturned only in the state court system.

OIG Could Increase Utah Medicaid Cost Savings

Other states report that they have been able to increase fraud, waste, and abuse cost avoidance and recovery savings by implementing an OIG model. One state that tracked recoveries pre- and post-OIG reported increased cost recoveries of 322 percent and cost avoidance at 420 percent for the year following the introduction of its OIG program. A 322 percent increase in cost recovery would translate to about \$12.6 million in cost recovery savings for Utah.

States with an OIG Report Increased Cost Savings

Fifteen states have independent audit/Program Integrity systems, most called Office of the Inspector General. We contacted seven states using either an OIG, or an OIG-like program, and found that tracking of cost recoveries varies. Of these states, one tracked recovery collections before and after the creation of its office, five now track

The Medicaid director is the Executive Director’s designated representative to arbitrate Medicaid appeals.

Fifteen other states have an independent audit/Program Integrity system, although some do not call it an Office of the Inspector General.

New York reports substantial savings from the creation of an OIG.

The Texas OIG was created during an economic downturn in an effort to save and recover more funds.

year-by-year collections but do not have information prior to the creation of their offices, and one does not track collections.

Those OIG states that did not track recoveries prior to the formation of their OIG each reported that they believe recoveries have substantially increased. For example, New York said that they believe the creation of the OIG in their state has led to marked improvements in recoveries. The OIG was created because the state needed a substantial amount of money to pay back a federal loan. To date, New York has met and exceeded its loan obligation through savings generated by the OIG.

Texas OIG Increased Medicaid Cost Savings Substantially

Texas, the only identified state with pre- and post-OIG cost recovery information, is an example of what a unified, independent office can do. The impetus for forming the Texas OIG was that state's economic downturn in 2001, after which the state wanted to be able to save and recover more Medicaid funds. The statutory goals in forming the Texas OIG were:

- Coordinating efforts to aggressively recover money
- Allocating resources to cases with "the strongest supportive evidence and the greatest potential for the recovery of money"
- "Maximizing opportunities for referral of cases to the office of the attorney general"

The Texas OIG has delivered cost savings in Medicaid for the State of Texas. Costs recovered increased 322 percent in the first year of the OIG's operations. This value represents gains as a result of increased recoveries and some improvement in tracking systems. Figure 4.6 compares Texas' collections from 2000 to 2008, prior to and after the OIG was created.

Figure 4.6 Costs Recovered and Avoided Both Increased in Texas After the Formation of Their OIG. Some of these increases were probably due to enhanced record keeping.

	Fiscal Year	Costs Recovered (in Millions)	Costs Avoided (in Millions)
Pre-OIG	2000	\$ 85.4	\$ 57.2
	2001	70.6	86.2
	2002	67.3	67.4
	2003	77.1	56.9
	Average	\$ 75.1	\$ 66.9
Post-OIG	2004	325.7	296.1
	2005	407.1	263.8
	2006	431.5	391.9
	2007	307.3	358.7
	2008	134.2	383.1
	Average	\$ 321.2	\$ 338.7

Of note in the Texas data is the importance an OIG can have for Medicaid cost avoidance. Post-OIG creation, Texas' cost avoidance has steadily increased. In calculating cost avoidance, Texas includes: sanctions, provider prepayment review, third party resources, disqualifications, income eligibility verification, recipient data matches, and WIC vendor monitoring. Utah could develop a more state-specific method of cost avoidance calculation for Medicaid. During the same period, cost recoveries initially increased fivefold and then dropped to twice the pre-OIG recovery level. The post-OIG recoveries have most likely dropped due to the sentinel effect an OIG can have on the provider community. Successful cost avoidance savings is the best way of protecting Medicaid dollars.

Also of note in the Texas data is that in the first year of the OIG's operation, both costs avoided and recovered were more than the total collections for the previous four years. Costs avoided increased 420 percent, and costs recovered increased 322 percent in the first year alone. A Texas official stated that the primary reason for the marked increase in recoupment was the separation of auditing and collecting operations from Medicaid. It is difficult to get someone who works with Medicaid-contracted providers day-in and day-out to make the providers pay the money back.

The average cost recovery increased about \$246 million in Texas.

In Texas, costs avoided increased 420% and costs recovered increased 322% with the creation of an OIG.

A Texas official stated collections went up because of the separation of auditing and collections operations.

Figure 4.7 shows what Utah's cost recoveries could be if we experienced increases similar to those seen in Texas.

Figure 4.7 Utah's Cost Recoveries Could Increase Dramatically if Increases Are Similar to Those in Texas. Cost avoidance has not yet been tracked by Utah.

	Texas Percent Increase	Utah 2009 Recoveries	Utah Potential Factoring in Texas Increases
Cost Recovered	322%	\$3,900,000*	\$12,600,000
Cost Avoided	420%	Not Tracked**	Unknown

* This number was reported to us by Program Integrity and has not been audited.

**This number is not currently tracked by Program Integrity.

Utah cost recovery increases similar to Texas would result in \$12,600,000 in cost savings. Cost avoidance could also be similar to that achieved by Texas.

Although there is no guarantee that the creation of an OIG would increase recoveries by a similar percentage in Utah, we believe there is significant potential for increased cost recoupment. Also, we believe that better reporting and tracking is needed. It appears there are some recoveries or adjustments being made by Medicaid administration that are not being reflected in the above numbers. For example, emergency room cost recoveries that were reported in our January 2010 audit do not appear to be included in the above numbers.

In the current economic climate and beyond, additional increases and transparent reporting of recoveries would be very helpful to Medicaid's budget. If Utah could achieve returns similar to those seen in Texas, cost recovery could increase to about \$12.6 million and cost avoidance increases would likely be a similar percentage. An OIG could help Utah reach this level of avoidance and recovery.

OIG Structure Should Be Established on Sound Practices

Important structural considerations include setting an IG term of service, designating the appointing authority, and establishing a budgetary line of authority.

During the course of our audit, we were able to identify some accepted practices for independent OIGs. It appears that no two IG offices operate exactly the same. Therefore, we compiled a list of sound practices from state and federal authorities that have an OIG. These sound practices can be categorized into three areas, as follows:

- A chief executive or entity independent of Medicaid should hire/fire the IG, with the advice and consent of a Legislative body. In addition, specific terms of service should be stipulated.
- The OIG should have control over its legislatively appropriated budget.
- Certain statutory powers and authorities should be granted to the IG.

The last section of this chapter discusses how an OIG could be structured to utilize existing DOH employees.

Certain Powers and Authorities Should Be Granted to the OIG

State and federal authorities recommend other established practices for Utah to consider. In researching other states' and federal OIGs, we found several accepted practices that should be considered when establishing an OIG. Figure 4.8 shows these recommended practices.

Federal and multi-state OIG standards exist and should be considered in Utah.

Figure 4.8 Some Powers and Authorities Must Be Established by Statute. Without some of these authorities, an OIG is less effective.

Necessary Powers and Authorities
Specific, detailed establishing statute
Organizational placement outside of Medicaid
Access to all necessary records, regardless of department
Control of line-item budget
Specific term of office
Removal only for cause
Adherence to specific standards
Subpoena power
Legal authority to take sworn statements and administer oaths
Reviews and audits to be made public and transparent
Specific annual report requirements to Legislature and Governor
Internal control over claims appeal process
Ability to attend Medicaid management and staff meetings and provide insight and direction

Some of these suggested practices and authorities are discussed in more detail below.

Various authorities recommend a four to six-year term of service.

Chief Executive Should Appoint the IG With Advice and Consent of Legislative Body

Though state and federal authorities' practices differ, in general, they agreed on sound practices for the establishment of an OIG. We found that terms of service vary among OIGs and the US Comptroller General; some are not appointed and serve at the will of the governor. However, these states reported that the IG usually fills the same term as the governor. The federal government OIGs serve during the same period as the elected president.

Most of the entities we surveyed agreed that Utah should consider a four to six-year term for an IG. Figure 4.9 describes suggested sound practices for both the appointment process and term of service.

Figure 4.9 IG Term of Service and Appointment Process Should Be Specified. Term and appointment differ among states, but there are common ranges and thoughts that seem to be generally accepted.

Term of Service	Appointment Process
Four to Six Years	<ul style="list-style-type: none">• By chief executive. In one instance, a bipartisan legislative body submits three names to the chief executive.• The appointment should be ratified and confirmed by the senate

Another option is presented by the process for the United States Comptroller General's appointment. Before presidential submission of a name to the Senate, a congressional committee, including members from both houses, submits three names for the President to choose from. Whatever process is chosen, it is vital for the IG to be appointed independent of Medicaid operational bias.

An IG's service should span the entire set term, with the only exception being removal for cause. This stipulation minimizes the possibility of unpopular findings affecting the IG's tenure.

An IG's term of service should be shortened only by removal for cause.

IG Should Have Full Office Budgetary Authority

Other states' Medicaid audit/Program Integrity units' budgetary authority ranges from independent line-item authority over their legislatively appropriated budgets to very little independence, with the single state agency over Medicaid controlling the budget. The most sound practice gleaned from other states is that clear budgetary independence is necessary. Staff from one state in which Medicaid is involved in determining the OIG's budget expressed concerns with their budgetary process.

An OIG Would Need Authority to Audit and Review All Agencies and Providers that Oversee the Use of Medicaid Funds. The IG should have access to Medicaid operations and records of all Medicaid-related departments. The IG would also need authority to conduct Medicaid-related performance and financial audits within these departments.

Two National Manuals of OIG Standards Are Available. As discussed previously, the Association of Inspectors General, a group comprised of different inspector general offices across the country, has developed operating standards called the Greenbook. Similarly, federal departmental inspectors general have developed their own Silverbook for standards of operation. Various state OIGs use either of these established standards books or create their own internal standards. If a Utah OIG is created, it should determine which standards model would work best, given the parameters of its defining statute.

An Annual Report Should Be Required to Promote Accountability from the OIG. Multiple states are required to publish an annual report, including Texas, Kansas, Tennessee, New York, and Illinois. An official for the federal Centers for Medicare & Medicaid Services (CMS) told us that an annual report is an essential requirement for an OIG. He also recommended that the establishing legislation should specify the required contents of an OIG annual report.

Other states are required to include things such as:

- Findings of the OIG by department
- Specific findings

Standards should be selected and employed by a Utah OIG.

The OIG should be required to submit an annual report with specific information.

- Control weaknesses
- Areas they have successfully strengthened
- Budgetary considerations

Including the information above and requiring the annual report to be submitted to the OIG's oversight authority and the Legislature will increase the OIG's accountability to all of its oversight entities.

OIG Can Utilize Existing DOH Employees

Employees from the Internal Audit and Program Integrity unit could be transferred with an administrative cost assigned to be transferred with each FTE to create the OIG. Some of the internal auditors could remain at DOH to perform management oversight at the discretion of the executive director. The office could be setup to have independence but still provide internal audit services and support as is done in the federal OIG offices. The intent of this section is to simply provide the Legislature with information on current staffing levels.

Figure 4.10 lists a pool of staff that the Legislature can choose from when contemplating the staffing of an OIG. Staff listed in Figure 4.10 come directly from an organization chart provided to us by the director of Internal Audit and Program Integrity. See Appendix B for the complete organization chart. The method of establishment could impact which of the staff listed below are moved to the OIG. The department desires to maintain the ability to coordinate internal audits based on risk areas they identify. Federal and some state OIG's take on the internal audit function and still work and coordinate with the agency, and an OIG could be structured to allow this to occur in Utah as well. The figure should be seen as a starting point for the Legislature when considering the creation of an OIG.

The OIG could be set up to have independence but still provide internal audit services and support.

Figure 4.10 Some of These DOH Positions Could Be Used in Staffing an OIG. These numbers are taken from an internal organization chart, included as Appendix B.

Current Location	Number of FTE
Director	1
Internal Audit	10
Program Integrity and Post Payment Review	12.2
Administration	1
Vacant Positions*	4
GRAND TOTAL	28.2

** It was reported to us that they do not currently have funding for these positions.*

We have been cautioned that when it becomes apparent that an OIG will be instituted, agencies may transfer less desirable employees into positions that are to be transferred to the OIG. We recommend that the Legislature consider a time-certain requirement that all employees in relevant positions as of a certain point in time are the employees who would be transferred.

Lastly, one inspector general told us that while he believes the implementation of an inspector general over Medicaid is the most effective way to conduct oversight and reduce fraud, waste, and abuse, it is still vital that a state's Medicaid director be completely supportive of the OIG's efforts, or even the best-run OIG can never be fully successful.

Recommendations

1. We recommend that the Legislature consider establishing independence standards for Medicaid Program Integrity operations.
2. We recommend that the Legislature consider creating an Office of the Inspector General, based on sound practices identified in this report, with oversight responsibility for Medicaid programs and funds.

This Page Left Blank Intentionally

Appendices

This Page Left Blank Intentionally

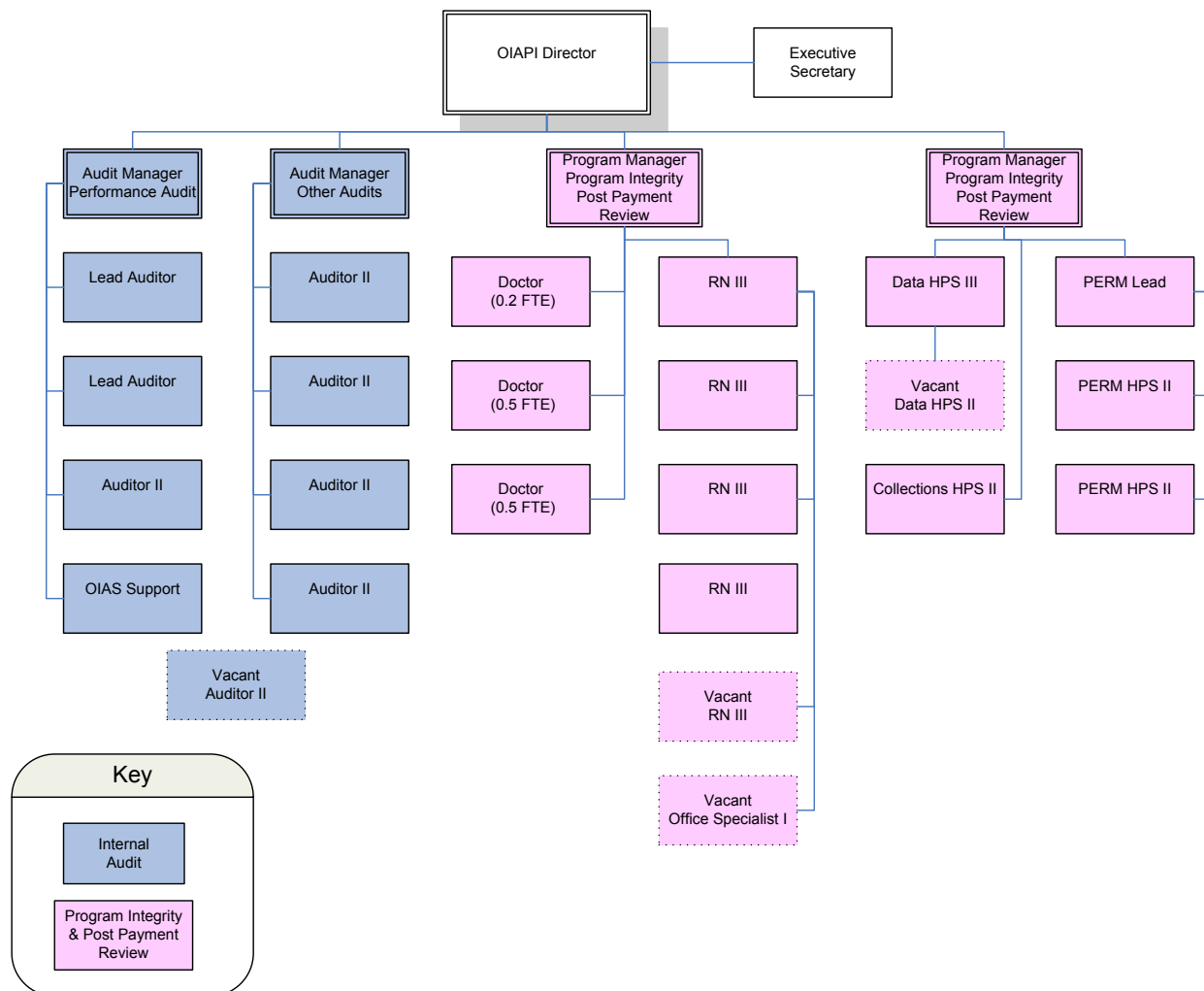
Appendix A Optional and Mandatory Medicaid Services for Fiscal Year 2008

Mandatory Services		Optional Services	
Service	Amount Spent	Service	Amount Spent
Inpatient Hospital	\$ 334,395,265	Mental Health Care	\$ 237,983,163
Outpatient Hospital	103,731,625	Inpatient Hospital	1,004,894
Nursing Home	148,480,542	Intermediate Care Facility	30,338,713
Intensive Care	11,483,800	Home Health	14,726,484
Home Health	13,234,528	Substance Abuse	10,011,553
Lab Services	2,387,783	Surgical Services	7,816,616
Rural Health Care	1,387,783	Kidney Dialysis	4,491,883
Medical Supplies	12,017,283	Physician/Nursing	12,232,519
Medical Transportation	6,229,456	Pharmacy	133,944,774
Physician/Nursing	88,890,942	Dental Services	32,842,886
Well Child Care	9,527,902	Psychologist Services	262,109
Federal Health Centers	5,436,757	Physical Therapy	42,597
Osteopathic Services	5,773,449	Speech and Hearing	490,251
Pre/Post Natal Care	396,432	Podiatry	432,503
Molina	129,130,960	Vision Care	1,924,537
Healthy U	89,752,809	QMB-Only	526,392
Miscellaneous	111,759	Contract Services	155,537,236
		Chiropractic	201,668
		Waiver	23,385,169
		Early Intervention	6,312,680
		Buy Out	493,469
		Miscellaneous	153,862
Total	\$ 962,369,074	Total	\$ 675,362,099
GRAND TOTAL		\$1,637,731,173	

Source: Utah Medicaid

This Page Left Blank Intentionally

Appendix B Office of Internal Audit and Program Integrity Organizational Chart as of September 28, 2010.



This Page Left Blank Intentionally

Agency Response

This Page Left Blank Intentionally



State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

**Utah Department of Health
Executive Director's Office**

DAVID N. SUNDWALL, M.D.
Executive Director

W. DAVID PATTON, PH.D.
Chief Operating Officer

TERESA GARRETT, RN MS
Deputy Director, Public Health Practice

MICHAEL HALES, MPA
Deputy Director, Medicaid and Health Finance

December 7, 2010

Mr. John M. Schaff, CIA
Legislative Auditor General
315 House Building
Salt Lake City, UT 84114-5315

Dear Mr. Schaff:

Thank you for the opportunity to respond to the audit entitled "A Performance Audit of Utah Medicaid Provider Cost Control" (Report No. 2010-16). The Utah Department of Health is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need to be improved.

We appreciate the effort and professionalism of you and your staff in this review. Collectively over the last two years and four reviews, your office has committed thousands of hours in reviewing the Medicaid program. Likewise, our staff has spent significant time collecting information for your review, answering questions, and implementing changes to improve the program. We believe that the results of our combined efforts will be a better, more efficient Medicaid program.

The Department has been diligent in its efforts to address recommendations included in prior legislative audits. As reported in the review entitled "A Follow-up of Utah Medicaid's Implementation of Audit Recommendations," the Department has either implemented, partially implemented, or is in the process of implementing all recommendations identified in these prior two audits.

The Department understands the importance of oversight and accountability and is committed to addressing the 63 recommendations from the four reviews. Although the follow-up report highlights the Department's success in implementing certain audit recommendations, we acknowledge that many changes are still in process and that continued focus on these areas along with the new areas identified in this report will be necessary. We are fully committed to implementing all audit recommendations.

The following discussion will provide additional information relating to information presented in this report and describe our plans to address the findings.

Chapter II

Health Clinics of Utah

The Department is very concerned that so many high level evaluation and maintenance codes were incorrectly billed at its Salt Lake clinic. We agree that upcoding represents improper billing and we will do an extensive review of claims to help determine how much money should be returned to the payers of care, including Medicaid.

The Department believes its clinics should operate as a model of correct billing practices. The clinics provide services to primarily low-income individuals – most of whom qualify for Medicaid or the Primary Care Network (PCN). Because of the “safety-net” nature of these clinics, they have difficulty breaking even financially. Members of Department management who volunteer as physicians at the clinics help ease the financial burden on the clinics and provide services that otherwise might result in clients going to emergency rooms for care. However, even in these volunteer situations, the Department expects correct billing practices.

The auditors’ work demonstrates that throughout the clinic there has been a widespread problem of either failing to appropriately document services provided to clients or improperly coding these services for payment. Immediately upon learning of the pervasive problem of incorrect coding, Department management strengthened medical coding training provided to providers in all Department-operated clinics and implemented stronger oversight of clinic operations.

The management of the Department’s clinics has already initiated the following actions to begin correcting the billing problems identified by the auditors:

1. Immediate e-mail to providers, management, and billers regarding the problems identified.
2. Immediate consultation with the Department’s Director of Internal Audit and Program Integrity (OIA-PI) to plan further reviews and suggest areas for improvement.
3. Immediate consultation (face to face) with the medical providers in the Salt Lake clinic informing them of these serious findings.
4. Completion of an in-house review of chart notes billed with high evaluation and maintenance codes to further understand upcoding in the Salt Lake clinic.
5. Established a mandatory coding training course for Health Clinics of Utah providers, managers, and billers. The first training occurred on December 1, 2010, and was done in conjunction with OIA-PI staff and clinic management. This will be followed by bi-annual coding training in future.
6. Have proposed a plan for regular internal chart note/billing form audits by medical providers for discussion and education at monthly staff meetings.
7. Have asked for and will welcome audits by OIA-PI to assist in process improvement.
8. Will seek upgrades to our current EHR software that may be able to help with this problem.
9. Intend to review 2008 and 2009 billing of 99214 & 99215 codes, identify upcoding problems, and issue refunds.

10. Have instructed clinic management to hold staff meetings twice a month with one of these meetings dedicated to provider discussion of coding, medical necessity, charting, medical complexity, etc. (as in 6 above).
11. Have met with Family Dental Plan clinics to review their billing and coding.

Program Integrity

The Department agrees with the August 2009 report's description of the Program Integrity unit as a "watchdog for fraud, waste, and abuse in the Medicaid program." The Department believes that it is critical for Program Integrity to review all types of Medicaid payments. The current Department management did not know that Program Integrity considered the Department run clinics off limits for review.

Fortunately, this perceived scope limitation was not universal throughout the Department. The Department's Financial Auditors have performed four financial reviews of the medical and dental clinics' cash and funds controls, the latest being 2007.

The Department has sought to immediately change this perception. Department management has reiterated to the Director of OIA-PI that all types of Medicaid payments are subject to review. The Director of OIA-PI has instructed Program Integrity to expand reviews and audits to all Medicaid providers.

Response to Recommendations

Recommendation 1

We recommend that the Department of Health, as required in Utah Code, regularly report to the Legislature regarding the progress that is being made in avoiding and recovering fraud, waste, and abuse in Utah Medicaid.

Department response:

We concur. Prior to receiving this report, OIA-PI had already prepared the first report to the Legislature which is scheduled to be issued by December 31, 2010. We will continue to make reports to the Legislature in compliance with Utah Code 26-18-2.3(5).

Recommendation 2

We recommend that the Department of Health continue to facilitate state-wide Medicaid provider training of frequently used or potentially abused codes to help promote cost avoidance.

Department response:

We concur. Program Integrity and Medicaid Operations already conduct annual provider training classes around the State on topics of concern. The Program Integrity annual training class scheduled for Fall 2010 was postponed to Spring 2011 because of funding restrictions on interstate travel. The primary emphasis of the next class in the spring of 2011 will be on “upcoding.”

In addition, this recommendation has prompted Program Integrity to make a change to its testing methodology. Program Integrity had previously only tested high-risk providers for upcoding, but will now include all providers based on the high incidents of upper-level codes being billed.

Chapter III

Medicaid management welcomes the review and findings of the auditors related to the program’s payment system and policies. The program requires many different activities in order to function properly – ranging from obtaining approval from the federal government for program changes to paying pharmacies in real time to walking clients through the process of picking a health plan. Although many processes and controls are in place for Medicaid activities, the program is thinly staffed and the additional perspective of the auditors helps identify problems that the program does not have the resources to adequately review.

The report raises questions about various Medicaid practices. As indicated in the report, the auditors spoke with program staff about these concerns. Once Medicaid management was informed of these potential problems, we started reviewing these areas to validate the auditors’ concerns. We are committed to investigate our practices to confirm that these problems exist, identify the causes of the problems, and implement appropriate changes.

One concern identified by the auditors relates to payments for unborn children made under a transportation contract. We agree that this issue has been a problem in the past and we have taken several key steps over the last seven months to address the problem. In May 2010, Medicaid clarified with its contracted actuary that unborn children were not part of the rate setting process for this contract. In the same month, Medicaid completed system changes to ensure that no additional payments would be made to this vendor for unborn children. In August 2010, Medicaid started recouping previous payments back to 2006 that had been made for unborn children. Medicaid management believes proper controls are now in place to ensure that these payments are not made again and that previous overpayments will be collected.

The report also identified several concerns related to Medicaid pharmacy payments. One test that the auditors conducted was a comparison of Medicaid pharmacy costs to those of the Public Employees Health Plan (PEHP). There are some questions about whether or not this data is available to Medicaid because the PEHP costs are considered proprietary. If the Legislature would like Medicaid to conduct this type of analysis, the assistance of the Legislature and its staff may be necessary in order to provide Medicaid with access to this information.

Response to Recommendations

Recommendation 1

We recommend that Utah Medicaid report all collections, recoveries, and overpayments that they process to OIA-PI for tracking and reporting.

Department response:

We concur. Medicaid will work with OIA-PI to determine how to best identify the collections, recoveries, and overpayments for reporting. Medicaid will also work with OIA-PI to determine an appropriate method and schedule for the reporting. Then Medicaid will institute a regular reporting process.

Recommendation 2

We recommend that OIA-PI conduct an analysis on pharmacy maximum-allowed costs (MAC) policies and practices to determine the potential cost savings if Medicaid changes policies and MAC prices.

Department response:

We concur. OIA-PI is currently in the process of conducting a department-wide risk assessment to prioritize future audits. This proposed audit will be included in our risk assessment and audit prioritization which will be completed in early 2011. The results of the assessment and the recommendations for audit prioritization will be presented to the Department's Executive Director for approval.

Recommendation 3

We recommend that Utah Medicaid, in conjunction with OIA-PI, review the cost and benefits of contracting with a firm to manage prescription costs.

Department response:

We concur. OIA-PI is currently in the process of conducting a department-wide risk assessment to prioritize future audits. This proposed audit will be included in our risk assessment and audit prioritization which will be completed in early 2011. The results of the assessment and the recommendations for audit prioritization will be presented to the Department's Executive Director for approval.

Recommendation 4

We recommend that OIA-PI should continually audit for internal weaknesses, including payment and policy weaknesses. OIA-PI should make any findings available to the Legislature on an annual basis and provide the Legislature a status report on corrective action that the Department takes.

Department response:

We concur. OIA-PI's ongoing audit risk assessment evaluates internal control weaknesses, including policy weaknesses, with an emphasis on reducing costs and preventing and detecting fraud, waste, and abuse. Audit recommendations and follow-up summaries on previous reports will be included in the annual report to the Legislature as required in Utah Code 26-18-2.3(5).

Recommendation 5

We recommend that Utah Medicaid change its dental cleaning policy to be in line with other accepted insurance policy standards.

Department response:

We concur. We believe the policy was originally structured to allow two cleanings at each dentist in recognition of the fact that when a dentist sees a new Medicaid client they do not know if the client has already received two cleanings from a different dentist. As with many other policies, it was an attempt to balance the needs of a limited provider base with the need to control costs. We will make this change and monitor the response from the dental community.

Chapter IV

The Department agrees with the report's assertion that "Medicaid fraud, waste, and abuse is a concern in Utah." The Medicaid program has many processes including prior authorizations, system edits, and cost settlements to prevent fraud, waste, and abuse. The Department believes that healthcare providers willing to see Medicaid patients (often a relatively small number in some professions) should be reimbursed as quickly as possible and to the full extent permissible consistent with current legislative appropriations. The Department fully supports efforts to identify providers who are guilty of fraud, waste, or abuse in their interactions with the Medicaid program.

Fraud Investigation and Prosecution Efforts in Utah

In discussing the future of the Medicaid Program Integrity function, it may be helpful to review the history regarding the statutory authority to investigate and prosecute alleged civil or criminal fraud in Medicaid. Prior to the 2000 Legislative Session, primary responsibility for investigation of allegations of fraud committed against the Medicaid program fell under the jurisdiction of the Department of Public Safety. The federally mandated Medicaid fraud control function was housed there.

Faced with many complaints from Medicaid providers in 1999, the Legislature passed and the Governor signed Senate Bill 191. The majority of the complaints came from Medicaid providers in rural portions of Utah. Many of the complaints alleged that investigators were overly aggressive in their investigative methods.

Senate Bill 191 was sponsored by Sen. D. Edgar Allen. It repealed the authority of the Department of Public Safety from Title 53, Chapter 10, Section 302. The Medicaid Fraud Control Unit (MFCU) was transferred to the Attorney General's office. MFCU's jurisdiction was limited to investigation and prosecution of allegations of criminal wrongdoing. Title 26, Chapter 20, Section 13 was enacted.

The Utah Department of Health was given sole responsibility for investigation and prosecution of civil fraud, waste and abuse committed by providers against the Medicaid program. As appropriations allowed, staffing was added to the Medicaid program to strengthen program integrity functions to identify fraud, waste, and abuse. During this process, shortcomings in outdated information technology systems that would otherwise expedite identification of fraud, waste, and abuse were identified and plans made to address those problems.

During the 2007 General Session, Rep. Brad Last sponsored House Bill 242. This bill updated many sections of the Utah False Claims Act as well as amending Title 26, Chapter 26, Section 13 to confer concurrent jurisdiction on the Attorney General and the Department for investigation and prosecution of civil fraud, waste and abuse allegations. This bill was enacted and signed by the Governor.

For over a decade, MFCU and the Department have had a written Memorandum of Understanding to facilitate cooperation in the detection, investigation, and prosecution of fraud, waste, and abuse. Regular meetings take place to discuss the respective parties' investigations.

Department's Support for Medicaid Controls

The Department has taken several key actions to increase the role of Program Integrity within the Department and to increase the number of tools in place to reduce fraud, waste, and abuse. Some actions occurred before the legislative audits began and some actions came in response to specific audit recommendations.

- In 2007, Medicaid management added three staff to carry out a federal requirement for Payment Error Rate Measurement (PERM). The State is required to conduct these

mandated reviews once every three years. Utah's two reviews have covered eligibility decisions and provider payments made during federal fiscal years 2007 and 2010.

- In 2008, Medicaid management raised the Program Integrity function to bureau status within the Medicaid division. Previously, the unit had been one of many units within a larger bureau that included assorted functions such as establishing medical policy and setting provider reimbursement rates.
- In 2010, the Department has issued three requests for proposals to bring in outside contractors to analyze Medicaid claims. One contract reviews claims before they are paid. Another contract will conduct an in-depth review of 2008 and 2009 claims, identify potential payment errors, and collect overpayments. A third contract will provide a new tool for Program Integrity to detect potential fraud, waste, and abuse and may also lead to the outsourcing of certain Program Integrity functions.
- In the last six months, the Department's internal audit group within OIA-PI has issued three reports on Medicaid. In addition, another report is currently in process.

Independence of the Internal Auditor

Under the direction of the Executive Director, the internal audit function requires independence to freely review all programs within the Department without interference or undue influence from those who could be subjects of the auditors' review. As a result of the findings and recommendations made in the August 2009 audit, the Department reorganized its audit activities to remove barriers to internal audit independence and to ensure the internal audit unit was independent of all divisions, bureaus, and programs within the Department of Health. This report notes that several Department practices have limited the independence of the new OIA-PI. The Department is committed to honor the principle of audit independence and will act quickly to change practices that are seen as a barrier to this group's independence.

Following the recommendations from the Fraud, Waste and Abuse audit and this audit, the Department has done (or commits to do) the following to increase independence for these functions:

- Moved Medicaid auditors and Program Integrity personnel out of the Medicaid Division and have the Director of OIA-PI report directly to the Executive Director.
- Transferred the staffing and budget for OIA-PI to the Executive Director's Office.
- Established the Director of OIA-PI position with funding from other areas within the Executive Director's Office. The creation of this position represented a significant commitment as at the same time the Department was experiencing significant budget reductions. At a time when we were eliminating positions, implementing furlough days, and rolling back programs, we made this commitment of resources to improve internal auditing in the Department.
- The Director of OIA-PI was selected by the Executive Director. A search committee was comprised of senior management in the agency including the Chief Operating Officer, Chief Finance Officer, and Deputy Director over Medicaid.

- Hired two new Audit Managers from the Office of the Legislative Auditor General to supervise the staff in the internal audit section within OIA-PI. Increased salaries of these positions to ensure the best qualified applicants.
- Have removed the designation of final ruling authority for Program Integrity appeals from the Medicaid Director back to the Executive Director or his designee who would have no responsibilities within programs reviewed by Program Integrity.
- Have disbanded our Audit Committee. The Executive Director will consult with the Internal Audit Director and seek input from Department personnel to assure that audit findings are fully and expeditiously addressed.
- The Executive Director and Director of OIA-PI will determine the Department's audit plan and scope based on a risk assessment performed by OIA-PI.

These steps have brought the internal audit function closer to compliance with the Institute of Internal Auditor's standards and Government Auditing Standards (Yellow Book). The Department plans to take additional steps to make sure that its internal audit group meets all of those standards and guidelines.

Managerial Importance of Internal Audit

Internal Audit is an invaluable management tool to identify potential weaknesses and bring these deficiencies to management's attention in a timely manner so that corrections can be made. Internal audit performs a vital function for management. The Institute of Internal Auditors' standards define internal audit activity as:

A department, division, team of consultants, or other practitioner(s) that provides independent, objective assurance and consulting services designed to add value and improve an organization's operations. The internal audit activity helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes.

As we have strengthened the operations of the Department, we have considered internal audit as an important piece of responsible management and have acted to increase resources to bring in the most capable auditors possible. An agency's Executive Director needs to be able to direct internal auditors to investigate areas of concern within the agency in order to provide information on improving the operation of the agency. Internal auditors work closely with agency management to strategically direct the agency. Their function is distinct from external auditors whether they come from the federal government, the state legislature, or a new layer of oversight such as the recommended Office of Inspector General (OIG). These external auditors perform their functions at the direction of external actors such as a federal department head, legislative leadership, or the governor. Internal auditors operate at the direction of the agency's Executive Director to assist the director in the management of the agency.

Office of Inspector General

The report makes the recommendation that the Legislature consider creating an OIG for Medicaid. As the Legislature and other policymakers contemplate the need for an OIG, there are several questions that should be considered:

- What unit of the executive branch will have the independence, authority, and appropriate staffing necessary to review the work of the Medicaid OIG?
- Should MFCU from the Attorney General's Office be included in the Medicaid OIG?
- What will be the role of the Medicaid OIG with other state agencies that receive Medicaid funding and have their own internal audit units – Department of Human Services, Department of Workforce Services, and the University of Utah?
- How will the Medicaid OIG be funded?
- Will the Medicaid OIG be big enough to justify its own budget, human resource, information technology, billing, and legal staff? If not, how will the Medicaid OIG be best structured to maintain its status as a separate government entity without losing some of its independence to whatever entity provides the OIG with its support services?
- Collections and cost avoidance from an independent Medicaid OIG are predicted to increase significantly (the report states that Texas saw an increase of 322 to 420 percent). How will the new Medicaid OIG be held accountable for achieving increased collections? Will a failure to meet collection targets result in a reduction of the Medicaid OIG budget?

While we feel the creation, staffing, scope and function of an OIG deserves careful consideration, the establishment of an OIG is not within the authority of the Department. We are concerned that the OIG would be staffed with personnel from the Department's newly established OIA-PI and the capacity to perform internal audit activities in support of agency management would be diminished. This office has not had time to fully organize itself and perform the full range of audit activities that are expected of it. In particular, the Department believes it is very important for OIA-PI to conduct a complete and thorough risk assessment of all Department activities and then develop an appropriate audit plan for the Department. We strongly recommend that the internal audit staff of the Department remain intact and be given a chance to accomplish the purposes and objectives it was assigned as a result of a legislative audit barely a year old.

Over this next year, policymakers should evaluate the outcomes of the many steps the Department has taken to improve accountability. The new Director of OIA-PI was only hired this past June. This director has begun to address the significant management issues identified in the first legislative audit report on Program Integrity.

The Department agrees with the auditors that Program Integrity collections can improve and that additional resources for this function may be needed. Our RFP related to this work will provide an opportunity to see if certain elements of this function can be increased by outsourcing some of this work to private contractors. The Department would welcome additional resources for the Program Integrity function whether it is located within the Department, is partially outsourced, or is moved to a separate OIG.

The Department maintains, however, that the resources existing within the Department dedicated for internal auditing should remain within the Department. It is an important and, as demonstrated by these recent legislative audits, a vital management resource for identifying issues and correcting them in a timely manner. Internal auditing's ability to provide Department management with objective analyses, recommendations, counsel, and information on the quality of internal controls is critical

The Department believes that the creation of an OIG as recommended in this audit deserves careful study. Further time should be given to determine the effectiveness of the remedial actions already implemented by the Department, as well as in-depth study of the interaction between the current parties involved in the investigation of fraud, waste, and abuse in the Medicaid program. Medicaid providers should also be brought into the discussion to seek their input on how to avoid discouraging current providers from continuing their participation in the program, while identifying those that abuse the public trust. As noted in the report, fifteen states have some form of an OIG. We hope that the study of this question provides the Legislature and other policymakers an opportunity to investigate the various structures of an OIG in these 15 states.

Response to Recommendations

Recommendation 1

We recommend that the Legislature consider establishing independence standards for Medicaid Program Integrity operations.

Department response:

Although this recommendation is directed to the Legislature, the Department is also committed to increasing independence for Program Integrity and will be pursuing changes to the Department's organizational structure and operating practices to ensure appropriate independence for this function.

Recommendation 2

We recommend that the Legislature consider creating an Office of the Inspector General, based on sound practices identified in this report, with oversight responsibility for Medicaid programs and funds.

Department response:

This recommendation is directed to the Legislature.

In summary, I want to reiterate my personal commitment to make sure that the Utah Department of Health applies the principles highlighted in these four legislative audit reviews. Any fraud, waste, or abuse in the Medicaid system raises costs for taxpayers and drains potential funding away from the needs of some of Utah's most vulnerable citizens. These audits have highlighted areas where we can improve. As shown in your follow-up review, the Department has taken many steps to address concerns from the first two audits. I will ensure we continue to implement these changes and also begin new efforts to address these latest recommendations.

Sincerely,

A handwritten signature in cursive script that reads "David N. Sundwall". The ink is dark and the signature is fluid.

David N. Sundwall, M.D.
Executive Director
Utah Department of Health