FY 2017 Annual Report

State of Michigan
Department of Health and Human Services
Office of Inspector General

Alan Kimichik, Inspector General

Message from the Inspector General

As the Inspector General for the Michigan Department of Health and Human Services (MDHHS), I am honored to release the results of the Office of Inspector General (OIG) accomplishments for Fiscal Year (FY) 2017.

The OIG's primary role is to investigate fraud, waste and abuse in programs administered by MDHHS and to increase program integrity and accountability. Through this endeavor, OIG staff produce impressive results. In this annual report you will note the following OIG staff accomplishments:

- Accounted for $218.6 million in program integrity efforts (fraud detection, cost savings and disqualifications).
- Performed 33,477 public assistance application investigations resulting in cost avoidance of more than $118.2 million.
- Identified $20.2 million of public assistance program fraud.
- Completed 10,883 public assistance fraud investigations.
- Established $12.2 million in cost savings from disqualifications of public assistance recipients for intentional program violations.
- Established $42.7 million in Medicaid provider receivables and cost savings.

These are just some of the achievements detailed in this OIG Annual Report, and are the results of the hard work and dedication of all OIG staff members. It also demonstrates their commitment to maintaining high standards of professionalism and quality of work. The taxpayers of Michigan can be proud of the work performed by these individuals.

I thank the OIG's dedicated employees, fellow state employees, and all Michiganders who reported suspected fraud, waste, abuse and misconduct. The citizens of Michigan expect accountability and integrity in their state government, and as you will read in the following pages, OIG staff strives to meet those expectations.

Sincerely,

Alan Kimichik
Inspector General

Executive Summary

FRAUD DETECTION AND PREVENTION

Enforcement Division
In FY 2017, the Office of Inspector General – Enforcement Division agents:

- Determined $160 million of fraud, cost savings and established program disqualifications.
- Completed 10,883 fraud investigation dispositions.
- Completed 33,477 Front End Eligibility (FEE)[1] investigations.
- Identified $118.2 million in cost avoidance in FEE investigations.
- Established an additional $12.2 million in cost savings from intentional program violation (IPV) disqualifications.
- Identified $20.2 million of program fraud.

Integrity Division
In FY 2017, the Office of Inspector General – Integrity Division agents:

- Sanctioned 29 providers, establishing $3.2 million in fee for service and $5.3 million in managed care encounter payment cost savings.
- Identified $19.9 million in inappropriate Medicaid expenditures, recovering $6.1 million.
- Performed program integrity oversight of Michigan Medicaid's 11 Managed Care Organizations (MCO). These MCOs performed a total of 6,221 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $10.5 million.
- Referred two Medicaid providers to the Attorney General's Health Care Fraud Division for credible allegation of fraud investigations.
- Completed 766 fraud investigation dispositions.

[1] **Front End Eligibility (FEE):** MDHHS caseworkers may request an investigation by an OIG agent when applications or re-certifications for public assistance contain suspicious or error-prone information. FEE agents investigate, substantiate or refute discrepancies and suspicious activities; the results may involve an assistance case not being opened, reduced benefits issued and/or case closure.

Executive Summary
(Continued)

Enforcement Division
Specialized Investigative Units:

In FY 2017, the Special Investigations Unit (SIU) agents:

- Completed 371 investigations.
- Determined $3.4 million of provider, contractor, recipient and employee fraud.

In FY 2017, the Benefit Trafficking Unit (BTU) agents:

- Completed 2,129 benefit trafficking investigations.
- Determined $2.9 million in fraud from trafficking.
- Established an additional $2.2 million in cost savings from IPV disqualifications.

In FY 2017, the Cooperative Disability Investigation Unit (CDI) agents:

- Completed 89 cooperative disability investigations.
- Established $9.4 million in cost savings.

COST EFFECTIVENESS AND PRODUCTIVITY

In FY 2017:

- Every dollar spent on fraud prevention resulted in $33 of cost avoidance and savings for taxpayers.
- For every hour spent on an investigation, $344 of receivables and disqualifications were established.

OIG AUTHORITY

The Office of Inspector General (OIG), created in 1972, is a criminal justice agency in the Michigan Department of Health and Human Services (MDHHS) under Michigan Compiled Law (MCL) 400.43b and Executive Orders No. 2010-1 and No. 2015-4. The primary duty of the OIG is to investigate cases of suspected fraud involving MDHHS assistance programs. In addition, OIG conducts the following activities as required by state and federal laws:

- Makes referrals for prosecution and disposition of appropriate cases as determined by the Inspector General.
- Fulfills the program integrity functions required by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR §455.13-17, 42 CFR §455.21-23 and 42 CFR §455.500-518.
- Conducts and supervises activities to prevent, detect and investigate provider fraud, waste and abuse in Michigan's health services programs.
- Reviews administrative policies, practices and procedures.
- Makes recommendations to improve program integrity and accountability.

OIG MISSION STATEMENT

The mission of the OIG is to assist MDHHS in maintaining integrity and accountability in the administration of its human services programs. The OIG provides investigation and advisory services to ensure appropriate and efficient use of available public resources. The office shall serve as an independent and autonomous entity within the department to lead the integrity efforts of health services programs by seeking out, detecting and investigating provider and recipient fraud, waste and abuse.

VALUES OF THE OIG

The Office of Inspector General (OIG) is accountable to the people of the State of Michigan for maintaining the highest standards of integrity and good moral character. As members of the OIG, we must work together as a team to plan and strive for excellence, realizing that the daily decisions that are made will reflect on the future of the people we investigate as well as our organization as a whole.

Dignity

- OIG employees shall dedicate themselves to treat all people with respect, fairness and compassion.

Innovation

- OIG employees will strive to identify new activities to produce a greater impact on fraud, waste and abuse in programs administered by Michigan's Department of Health and Human Services.

Excellence

- OIG employees are expected to meet the responsibilities of their assigned job duties, be responsible for their actions, and be accountable to their supervisors, co-workers and to the citizens they serve.
- Perform the duties of the OIG Mission to their utmost ability.
- Know the laws, rules and policies that will aid them in performing their duties. Be aware of and meticulously adhere to all legal requirements on the release and dissemination of information.

- Understand that when trust and confidence are established within our organization, our stakeholders and the public will support us in fulfilling our duties.
- Are to take pride in themselves and their organization, take ownership of their work and be leaders in their areas of responsibility.

Integrity

- OIG employees will display the highest possible standards of professional and ethical conduct.
- Understand that the integrity of the OIG must never be compromised. The public demands and we must accept that the integrity of an OIG employee must be above reproach. Strive to reach the highest standards of honesty and integrity.
- Conduct themselves in a manner which does not discredit the criminal justice profession or the OIG. Maintain the integrity of their profession through complete disclosure of those who violate laws, those who violate rules of conduct, or those who conduct themselves in a manner which discredits the criminal justice profession.
- Never consider the badge of office as a license designed to provide them with special favor or consideration.

Teamwork

- OIG employees shall recognize that the cooperation of all criminal justice and public agencies is essential for effective, efficient and responsive investigations and enforcement.
- Lead by example and be willing and able to assist any other investigative or public agency when requested.
- Understand the importance of creating a work environment that encourages innovation, input and participation.

Recognition

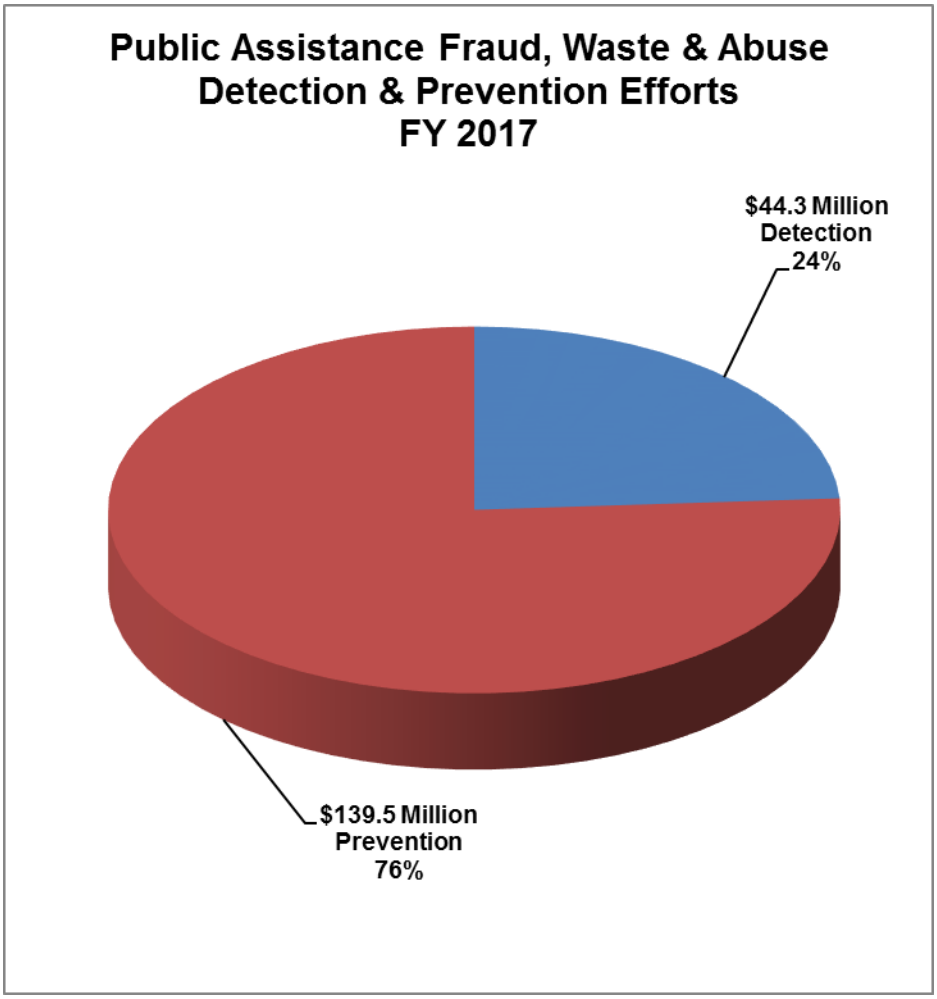
- OIG employees shall recognize the accomplishments of those who make significant contributions toward our mission, values, goals and objectives.

INSPECTOR GENERAL OVERIVEW

The Office of Inspector General (OIG) is the criminal justice agency within the Michigan Department of Health and Human Services (MDHHS) providing program integrity services. OIG agents provide investigation and advisory services to ensure appropriate and efficient use of available public resources in the State of Michigan. Within the OIG there are three divisions: Integrity (Medicaid providers), Enforcement (recipients/vendors and non-Medicaid providers) and Operations (Administrative and Investigative Analytics). OIG agents and their managers are strategically located throughout Michigan to assist MDHHS in maintaining integrity and accountability in the administration of all its programs.

OIG IMPACT ON PUBLIC ASSISTANCE PROGRAMS

Fraud detection in public assistance - $44.3 million
Fraud prevention in public assistance - $139.5 million



Notes: Represents FIP (Family Independence Program), FAP (Food Assistance Program), SDA (State Disability Assistance), SER (State Emergency Relief) and Fee-For-Service Medicaid.

ENFORCEMENT DIVISION

The Enforcement Division primarily investigates allegations of fraud, waste or abuse by the recipients and the vendors of all public assistance programs, excluding Medicaid providers. In the Enforcement Division, there are several unique programs and units that focus on important aspects of investigation and fraud detection and prevention:

- Fraud Investigations: OIG is responsible for investigating instances of alleged fraud in all programs administered by the department, as well as reviewing administrative policies and procedures and recommending ways of improving accountability, fraud deterrence and detection. For example, OIG investigates fraud in the Family Independence Program (FIP), the Food Assistance Program (FAP), the Child Development and Care program (CDC), and the Medicaid program (MA). In addition, OIG investigates vendor fraud and state employees alleged to be involved in program fraud or certain crimes against MDHHS. All investigations found to contain the elements of fraud or criminal activity are forwarded to the appropriate authority for criminal disposition or are sent to the appropriate area within MDHHS for administrative action.

- Front End Eligibility (FEE): In focusing on fraud prevention, the FEE program provides for pre-eligibility investigations when applications or recertifications for public assistance contain suspicious or error prone information. FEE agents investigate, substantiate or refute discrepancies and suspicious activities. Agents complete the investigation within 10 workdays and respond to the eligibility staff with their findings. The goal of the FEE program is to obtain and maintain a partnership between the local office staff early in the eligibility determination process to reduce errors and mispayments, which results in significant cost avoidance savings for the department.

- Benefit Trafficking Unit (BTU): This unit investigates instances of public assistance trafficking in which individuals either attempt to traffic or actively traffic benefits by buying, selling or trading public assistance benefits for cash or ineligible items including: tobacco, alcohol, firearms, drugs and gambling. The unit also investigates allegations of MA fraud which includes prescription forgery, prescription theft and narcotics “shopping” with multiple prescribers and/or pharmacies. In addition, the unit investigates the sale of a person’s MA card to obtain health services.

- Special Investigation Unit (SIU): The SIU investigates the most complex criminal and civil complaints of fraud, waste and abuse in the programs administered by the department. The SIU identifies and determines existence of sophisticated criminal conspiratorial schemes by employees, contractors, businesses, vendors and recipients to receive program funds. Agents ascertain the nature of offenses committed; determine and initiate appropriate criminal, civil and administrative action to resolve the allegations and recover program funds. The SIU, as well as all OIG, formulates recommendations to address fraud vulnerability, internal control and accountability relating to program law, regulation, policy and procedure.

- Cooperative Disability Investigations (CDI) Unit: In August 2014, OIG partnered with the Social Security Administration Office of Inspector General (SSA-OIG) to create a Cooperative Disability Investigations (CDI) program in Michigan. CDI combats fraud by investigating questionable claims, statements and activities of claimants, medical providers, interpreters or other service providers who are suspected of disability fraud. The results of these investigations are presented to federal and state prosecutors for consideration of prosecution and to the MDHHS Disability Determination Services (DDS) for their use in making timely and accurate disability determinations. The CDI unit supports the strategic goal of ensuring integrity of the Social Security programs with zero tolerance for fraud and abuse. The unit also serves to deter fraud in related federal and state benefit programs. Any person deemed eligible for Supplemental Security Income (SSI) is automatically made eligible for Medicaid. OIG's participation in the CDI unit realizes savings to Michigan taxpayers for stopping both SSI and Medicaid fraud.

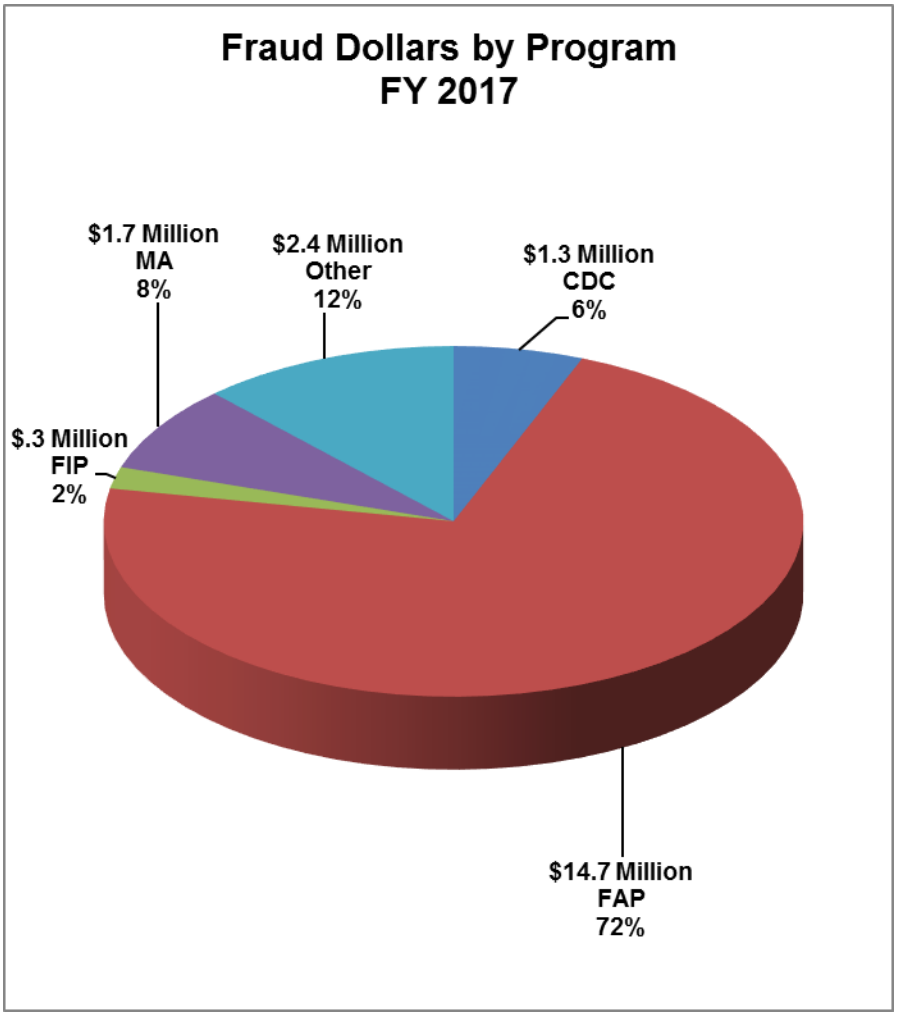
  The two OIG agents, working in partnership with SSA-OIG, produced a total cost savings of $9.4 million.

PROGRAM INTEGRITY IMPACTS

OIG's Enforcement Division determined over $20 million in fraud during FY 2017 within multiple Michigan public assistance program areas. Because of the Enforcement Division efforts, during FY 2017, 252 felony warrants were authorized by county, state and federal prosecutors. Investigations by Enforcement Division agents have uncovered $67.9 million in fraud during the last three years.

Program Highlights

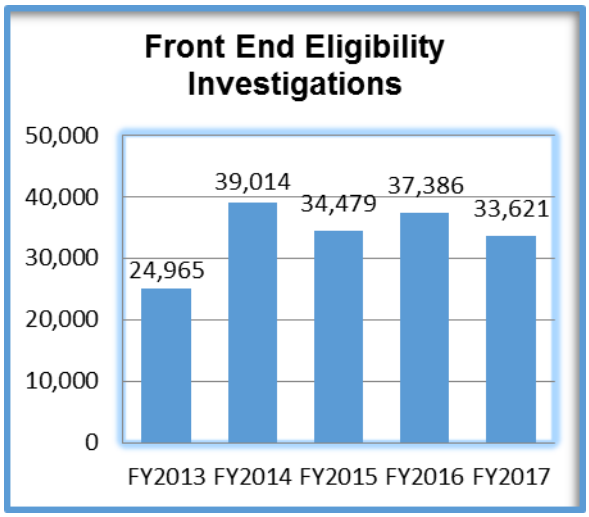
- FAP accounted for 72 percent of Michigan's public assistance fraud during FY 2017.
- OIG investigated 10,290 fraud cases in the FAP program, with 5,504 fraud investigative dispositions and 214 criminal warrants issued for a fiscal year total of $14.7 million in fraud found.
- OIG completed 269 CDC cases resulting in $1.3 million in fraud found for the Michigan Department of Education (MDE).
- OIG completed 485 investigations of Medicaid program fraud resulting in $1.7 million in fraud found.

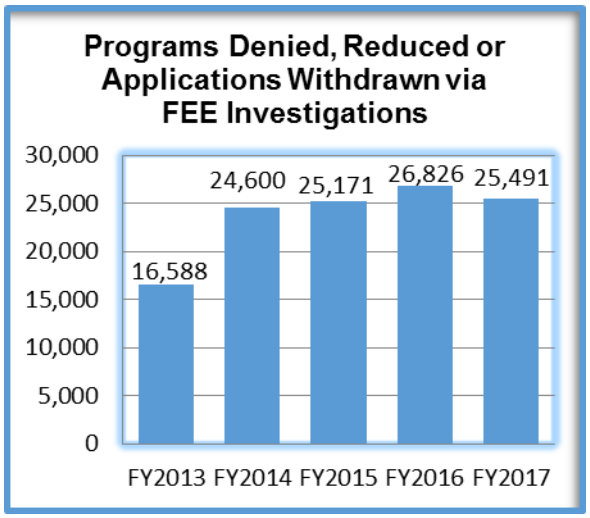


CDC = Child Development and Care Program
FAP = Food Assistance Program
FIP = Family Independence Program
MA = Medicaid Program
Other = Adult/Children's Services, State Disability, State Emergency Relief

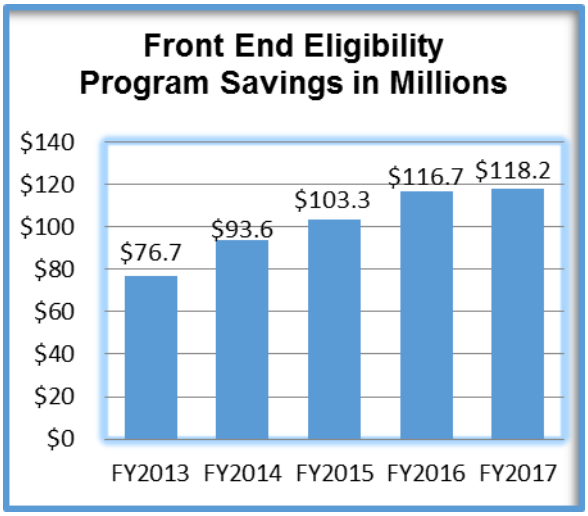
FEE: EARLY FRAUD DETECTION AND PREVENTION

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public assistance. Front End Eligibility (FEE) investigations are initiated when assistance applications or other submitted documentation appear to contain suspicious or error-prone information. In focusing on fraud prevention through FEE, OIG ensures public assistance program integrity and increased savings for the taxpayers.





Working toward fraud prevention, Enforcement Division agents conducted 33,477 investigations in FY 2017 and identified $118.2 million in cost savings. Investigations by these agents have resulted in $338.2 million in program savings for taxpayers over the last three-year period.



INTEGRITY DIVISION

In FY 2017, Michigan's health services programs had a combined budget of approximately $16.8 billion and paid approximately 257,000 providers for goods and services provided to beneficiaries covered under the programs. OIG's Integrity Division (OIG-ID) fulfills the program integrity functions required by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR §455.13-17, 42 CPR §455.21-23 and 42 CFR §455.500-518.

The Integrity Division is responsible for conducting and supervising activities to prevent, detect and investigate provider fraud, waste and abuse in Michigan's health services programs, including Michigan's Medicaid Program, Mental Health Program, MI Child Program and Children's Special Health Care Services Program (for the purposes of this report, these health services programs will be described using the general term "Medicaid").

Through its audits and investigations, the Integrity Division works to ensure that the money spent on health services is used for the best care of the beneficiaries. There are several unique programs and units that focus on important aspects of investigation and fraud detection and prevention:

- Investigations: The Integrity Division conducts investigations into alleged Medicaid fraud, waste and abuse and receives referrals from the public, beneficiaries, providers and other government and/or state law enforcement and regulatory agencies.

  Examples of health services provider fraud, waste and abuse:
  - Billing for medical services not actually performed.
  - Billing for unnecessary services.
  - Billing for more expensive services than actually performed.
  - Billing for services separately that should legitimately be one billing.
  - Billing more than once for the same medical service.
  - Dispensing generic drugs but billing for brand-name drugs.
  - Billing for supplies/medication not dispensed.
  - Giving or accepting something of value (e.g., cash, gifts, services) in return for medical services and/or patient referrals (i.e., kickbacks).

- Managed Care Oversight: The Integrity Division is responsible for monitoring the program integrity activities of each of Michigan Medicaid's Managed Care Organizations (MCO). Quarterly, each MCO is required to report the program integrity activities performed. These activities include data mining, audits, investigations, overpayment recoveries, etc.

- Recovery Audit Contractors: The Integrity Division has contracted with one vendor to perform audits and recover overpayments from Medicaid providers.

HEALTH SERVICES PROGRAMS IMPACTS

In FY 2017, OIG-ID had an overall impact to direct Medicaid spending (i.e., fee-for-service (FFS)) totaling $42.7 million through the following activities:

- Identified a total of $19.9 million in overpayments made to Medicaid providers. To date, $6.1 million has been recovered while the remaining $13.8 million is being repaid over time.

- In FY 2017, OIG-ID:

    - Received 277 allegations of potential fraudulent activity from various sources (e.g., 56 tips from beneficiaries, 75 tips from the public (16 anonymous), 74 referrals from inside MDHHS, 56 referrals from MCOs, four tips from beneficiary family members/friends, three referrals from law enforcement agencies, nine tips from providers).
    - Identified 394 audit targets through data analytics.
    - Completed 766 fraud investigation dispositions.

- Prevented an estimated $9.5 million in future payments, through reduced billing activities as a result of Medicaid provider audits and investigations.

- Prevented an estimated $6.5 million in future payments, through a provider education campaign aimed at increasing pharmacy compliance with voiding claims for no show prescriptions.

- Sanctioned 29 Medicaid providers, preventing an estimated $3.2 million in future payments.

    - OIG-ID is responsible for making the determination to sanction a provider based on the grounds specified by MCL 400.111e and 42 CFR §455.23.

- Made formal recommendations to the Medical Services Administration (MSA) to prevent an estimated $3.5 million in future claims from being paid.

    - When OIG-ID agents identify vulnerabilities where a more robust Medicaid policy and/or system edits would have prevented an identified fraud, waste or abuse; OIG-ID makes formal recommendations to prevent future claims from being paid.

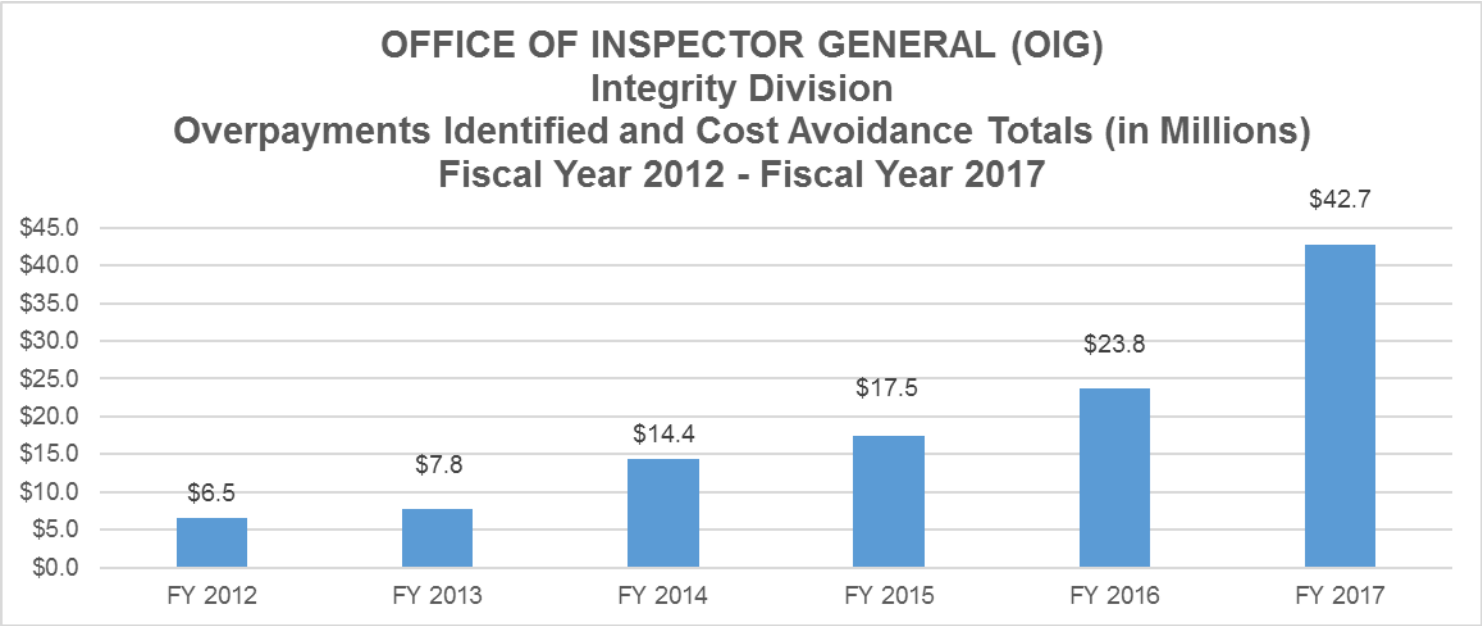
- Referred two Medicaid providers to the Medicaid Fraud Control Unit (MFCU) for criminal investigation.

    - In accordance with federal regulation (42 CFR §455.21), the MFCU is the first referral destination for all cases of suspected Medicaid provider fraud.
    - Five previously referred providers were convicted and/or signed civil settlement agreements. These five providers were required to pay a total of $578,143 in restitution.

In FY 2017, OIG-ID had an overall impact to indirect Medicaid spending (i.e., MCO encounter claims) totaling $15.9 million through the following activities:

- $10.5 million in identified overpayments through program integrity related oversight of the Michigan Medicaid MCOs.

- Sanctioned 29 Medicaid providers, preventing an estimated $5.4 million in future MCO encounter payments.



FIELD INVESTIGATION SECTIONS OVERVIEW

Due to the magnitude and complexity of Michigan's health services program, OIG-ID utilizes four specialized investigative teams, each team primarily investigates cases dealing with the following provider types in their assigned region:

Dental	Hospital	Pharmacy
Durable Medical Equipment (DME)	Laboratory	Physical Therapy
Emergency Transportation	Local Health Departments	Physician
Federally Qualified Health Centers	Maternal Infant Health Program	Private Duty Nursing
Hearing and Vision	Mental Health	Rural Health Clinics
Home Help	MI Choice Waiver	Substance Abuse Clinics
Home Health Agency	Non-Emergency Transportation	Tribal Health Centers
Hospice	Nursing Home	Urgent Care Centers

These specialized teams enable OIG-ID to better coordinate efforts, thereby enhancing the accuracy, completeness and overall effectiveness where OIG can achieve its mission.

OIG-ID's field investigation sections are primarily responsible for:

- Identifying vulnerabilities where a more robust Medicaid policy and/or system edit would have prevented fraud, waste or abuse and making formal recommendations to prevent future claims from being paid.
- Investigating allegations of Medicaid provider fraud, waste and abuse, leading to the following outcomes:
    - Referring Medicaid provider fraud to the Attorney General's Health Care Fraud Division.
    - Suspending payments to Medicaid providers when it is determined there is a credible allegation of fraud for which an investigation is pending.
    - Identifying and recovering non-fraud overpayments from Medicaid providers.

2017 FIELD INVESTIGATION SECTIONS HIGHLIGHTS

Pharmacy
Pharmaceutical inventory audits are performed to validate that items supplied to Medicaid beneficiaries are supported by purchase invoices, as required by Medicaid policy.

In FY 2017, 29 pharmacy providers agreed to repay the Medicaid program a total of $5 million as a result of pharmaceutical inventory audits.

Home Help
In FY 2017, receivables were established for 229 home help providers totaling $559,798 for payments made while their beneficiaries were hospitalized and/or after their death or while the provider was incarcerated.

Maternal Infant Health Program (MIHP)
In FY 2017, 54 MIHP providers agreed to repay the Medicaid program a total of $550,374 that they received as a result of billing for services that violated Medicaid MIHP Policy.

Dental
In FY 2017, 11 dental providers agreed to repay the Medicaid program a total of $345,547 that they received as a result of billing for services that violated Medicaid Dental Policy.

Laboratory
In FY 2017, nine laboratory providers agreed to repay the Medicaid program a total of $132,268 that they received as a result of billing for services that violated Medicaid Policy regarding referring providers of genetic testing.

Transportation
In FY 2017, nine ambulance providers agreed to repay the Medicaid program a total of $99,972 that they received as a result of billing for advanced life support, when basic life support was more appropriate.

Injectables
In FY 2017, eight providers agreed to repay the Medicaid program a total of $78,701 that they received as a result of double billing for injectables.

Obstetric
In FY 2017, 23 providers agreed to repay the Medicaid program a total of $42,982 that they received as a result of unbundling and/or double billing for obstetric delivery services.

CONTRACT OVERSIGHT SECTION OVERVIEW

The Contract Oversight Section is comprised of two units, the MCO Oversight Unit and the Vendor Oversight Unit.

MCO OVERSIGHT UNIT

The MCO Oversight Unit is responsible for monitoring the program integrity activities of each of Michigan Medicaid's Managed Care Organizations (MCO).

- In coordination with the Managed Care Plan Division, OIG-ID requires each of Michigan Medicaid's physical health MCOs to complete section six of the Managed Care Compliance Review tool.

- Section six requires each MCO to report to OIG-ID their program integrity activities performed each quarter. Program integrity activities include information relating to tips/grievances received (including explanation of benefits), data mining activities, audits performed and provider dis-enrollments.
- As MCOs submit their quarterly reports, OIG-ID's MCO Oversight Unit analysts review each report for compliance. An MCO's report can receive a pass, incomplete or failure. MCOs who receive an incomplete or fail must submit a Corrective Action Plan (CAP).
- Corrective Action Plan submissions are reviewed by the MCO Oversight Unit analysts to ensure the CAP meets contract requirements.

- MCOs are required to refer all credible allegations of fraud to the MCO Oversight Unit.

    - An OIG-ID analyst is assigned to each MCO fraud referral to evaluate the referral and determine if the allegation was credible and if the fraudulent activity occurred system wide among other health plans and Medicaid fee-for-service.
    - If the allegation is deemed to be credible, a formal referral is made to the Attorney General's Medicaid Fraud Control Unit (MFCU).

2017 MCO OVERSIGHT UNIT HIGHLIGHTS

Provider Audits/Reviews
In FY 2017, Michigan Medicaid's 11 MCOs performed a total of 6,221 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $10.5 million.

Provider Sanctions
In FY 2017, OIG-ID agents prevented an estimated $5.4 million in Medicaid MCO encounter payments as a result of provider suspensions.

VENDOR OVERSIGHT UNIT

The Vendor Oversight Unit is responsible for ensuring the success of OIG-ID's Vendor Audit Program. OIG-ID financial recovery activities include third party audit contractors to improve program integrity.

- The Affordable Care Act (ACA) requires Medicaid agencies to contract with a Recovery Audit Contractor (RAC) to identify and recover overpayments.
    - HMS Holdings Corp (HMS) was contracted as the Michigan Medicaid RAC.
    - HMS performs data mining algorithms on the Medicaid database to identify potential areas of recovery. These scenarios are preapproved by the Vendor Oversight Unit analysts.
    - Vendor Oversight Unit analysts review and approve each HMS data scenario prior to implementation as well as their sample selection prior to record review.

2017 VENDOR OVERSIGHT UNIT HIGHLIGHTS

Inpatient Hospital
In FY 2017, HMS performed a data mining scenario identifying beneficiaries with short lengths of stay for inpatient hospital claims. Medicaid beneficiary medical records were requested and reviewed by HMS to determine if the hospital stays were medically necessary (i.e., services could have been provided in an outpatient hospital or observation environment.)

A total of 83 inpatient hospitals repaid $1.9 million back to Medicaid for those inpatient stays that were determined not to be medically necessary hospital stays.

Inpatient Hospital
A data mining scenario was performed by HMS to identify incorrect Diagnostic Related Grouping (DRG) codes. (DRG is a unit of classifying patients by diagnosis, average length of hospital stay and therapy received. The result is used to determine the payment amount for a patient's hospital stay.)

This scenario identified situations where demographics, billing attributes, diagnosis codes, procedure codes, and factors affecting the DRG assignment were inconsistent with other attributes of the claim, case or medical records.

In FY 2017, a total of 63 inpatient hospitals repaid $820,524 back to Medicaid for claims where the medical records did not validate the billing of the DRG code paid by Medicaid.

Hospice
HMS performed a data mining scenario, which profiled hospice providers by average length of services, patient diagnosis, percent of patients in nursing facilities and total Medicaid payments. Medicaid beneficiary medical records were requested and reviewed by HMS to determine if the hospice stays followed Medicaid eligibility guidelines, service coverage and/or documentation requirements.

In FY 2017, a total of four hospice providers repaid $163,864 back to Medicaid for those hospice stays that were determined to be uncompliant with Medicaid eligibility, service coverage and/or documentation requirements.

Outpatient Hospital
In FY 2017, HMS performed a data mining scenario, which validated the units billed with the Healthcare Common Procedure Coding System (HCPCS) code for Herceptin injections.

The HCPCS is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicaid beneficiaries.

Medicaid beneficiary medical records were requested and reviewed by HMS to determine if providers only billed for units of Herceptin associated with the amount of the drug actually administered to the patient.

As a result, a total of three outpatient hospitals repaid $71,544 back to Medicaid for Herceptin injections billed for but not administered.

OPERATIONS DIVISION

OIG's Operations Division (OIG-OD) is comprised of two sections: Administrative Services and Investigative Analytics. OIG-OD Administrative Services is responsible for overall administrative support of the office. It manages budget development and monitoring, system security, fraud hotlines, OIG policy, investigative process support as well as overseeing of the day-to-day business operations. In FY 2017, OIG's Administrative Services provided extensive quality control reviews on over 4,200 investigative packets referred to the Michigan Administrative Hearing System for debt collection and disqualification requests.

OIG-OD also is responsible for technical and analytic support for ongoing investigations and fraud referrals via its Investigative Analytics Unit (IAU). This unit is responsible for a multitude of complex analytical and data mining solutions to highlight potential fraud. It also creates reports for internal, state and federal needs. The IAU provides system administrator support as well as unique and specialized skills for program integrity efforts.

INVESTIGATIVE ANALYTICS UNIT (IAU)

OIG Operations Division's IAU is responsible for providing system and analytic support for ongoing investigations and fraud referrals. IAU uses analytical tools and techniques, as well as knowledge of all program rules, to mine state-owned data to determine fraud, waste and abuse events and trends. Data analytics allows for detection and identification of patterns of fraudulent behavior that may not otherwise be clear. It is often the critical first step in the investigative process. OIG investigators use information from data analytics to focus their efforts and resources to areas with the greatest risk and return, leading to greater recoveries and discouraging future abuse.

Examples of additional IAU functions and responsibilities include:

- Management Reports for Performance Measurement
- OIG's Case Management System Development, Maintenance and Enhancement
- Executive Office Reports: Scheduled and Upon Demand
- Out-of-State Bridge Card Transaction Project
- Internet Protocol Locator Project
- Standardized Medicaid Claims Activity Reports
- Public Assistance Reporting Information System (PARIS) Match Analysis
- County Jail Match Analysis
- Multiple Bridge Card Replacement Analysis
- Food Assistance Program Trafficking Data Mining
- Medicaid Fraud, Waste and Abuse Data Mining
- Social Media Analysis
- MDHHS Policy Analysis
- Provider & Recipient Vital Records Match
- USDA-FNS Client Integrity Referral Analysis
- USDA-FNS Management Evaluation Analysis/Liaison
- Identity Theft/Application Fraud
- Office of Auditor General (OAG) Audit Liaison
- Ad-hoc Investigative Support Data Requests

2017 IAU HIGHLIGHTS

Medicaid Provider Overpayment Detection
In FY 2017, approximately 75 percent of OIG's Medicaid provider recoupment cases were generated as a part of IAU data analytics/data mining. The investigated cases resulted in $13.1 million in identified overpayments.

Public Assistance Program Fraud Detection
In FY 2017, approximately 65 percent of the public assistance program fraud investigations conducted by OIG were generated as a part of IAU data analytics/data mining efforts.

Public Assistance Reporting Information System (PARIS)
IAU utilizes the national PARIS Interstate Match as an investigative tool to identify individuals who may be concurrently receiving public assistance in two or more states. The match data provides a concise description of the individual's circumstances in both states at the point of the match, as well as contact information. OIG actively investigates individuals identified in the PARIS match for receiving public assistance benefits in another state. This often results in the assistance case being closed in Michigan and for some, a warrant request for welfare fraud. The utilization of the PARIS Interstate Match has been instrumental in lowering public assistance program expenditures by removing ineligible non-resident clients. In FY 2017, PARIS matches resulted in $26 million in annual cost avoidance. OIG has representation on the national PARIS Board of Directors, providing guidance to all 50 states and territories utilizing the program.

In-House Investigative Algorithms
Over the course of FY 2017, the IAU devised or refined over 20 algorithms used in the generation of investigative leads. As an example, one new algorithm which identified a combination of physicians and pharmacies billing for the same drug that was only administered once to the beneficiary resulted in 45 investigations. To date, the 45 investigations have an associated overpayment identified greater than $500,000.

Internet Protocol Locator Project
The Internet Protocol Locator Project was created to give OIG the capability to identify the physical location of individuals using MI Bridges to apply for Michigan public assistance benefits online. This capability increases the chances of catching potential and current clients who are residing outside Michigan and are improperly applying for public assistance benefits in Michigan. In FY 2017, the IP Locator Project resulted in $1.2 million in annualized cost avoidance.

OIG ACTIVITIES

OIG is involved in many areas of the department that affect program integrity. Included are examples of operational activities:

Claims Establishment: OIG makes recommendations directly to MDHHS concerning all aspects of the recipient claims establishment process. Responsibilities include program content development, policy, procedures, program monitoring and measurement of outcomes and program advocacy.

Electronic Benefit Transfer (EBT): Food assistance and cash assistance benefits are electronically transferred to an account accessible by the client debit card called the Michigan Bridge Card. Transactions are analyzed for fraud trends to include out-of-state purchases for more than 30 days, non-recipients using Bridge Cards, and other patterns of FAP trafficking.

Employee Fraud: Part of the OIG mission and activities is to conduct criminal and administrative investigations into State of Michigan employees. Investigations have included embezzlement, failure to report employment when receiving state public assistance and creating and maintaining fictitious public assistance cases. Employees that have committed a criminal offense are referred to the Michigan Department of Attorney General for review of criminal charges.

Estate Recovery Fraud Investigations: The OIG collaborates with the MDHHS' Third Party Liability division to investigate potential fraud by individuals who received long-term care Medicaid payments. The estates of individuals who received Medicaid payments fraudulently are subject to repayment.

Fraud Hotline – Health Services: The public and other state/federal entities report allegations of potential fraudulent activity in the Medicaid program to OIG through a variety of methods including email, telephone and toll-free hotline.

Fraud Hotline – Human Services: Recipient fraud referrals that come through the toll-free MDHHS fraud number or website go to a designated fraud coordinator in each local office. The referral is routed to the appropriate caseworker and manager for review and the Enforcement Division is notified directly if the referral meets certain criteria.

Front End Eligibility (FEE): MDHHS caseworkers may request an investigation by an OIG agent when applications or re-certifications for public assistance contain suspicious or error-prone information. FEE agents investigate, substantiate or refute discrepancies and suspicious activities; the results may involve an assistance case not being opened, reduced benefits issued and/or case closure.

LEIN (Law Enforcement Information Network): OIG, through its Terminal Agency Coordinator (TAC), is responsible for the integrity and security of sensitive and confidential information contained in the LEIN system. OIG provides extensive training for LEIN operators, maintains the LEIN policy and procedure manuals for LEIN use by MDHHS and investigates LEIN violations.

MCO Program Integrity Activities: Each MCO reports their program integrity activities performed each quarter to OIG. As MCOs submit their quarterly reports, OIG-ID staff review each of the 11 reports for compliance. An MCO's report can receive a pass, incomplete or failure. MCOs who receive an incomplete or fail must submit a Corrective Action Plan (CAP).

Policy Recommendations: OIG provides a leadership role in recommendations for policy changes to enhance prevention and detection

of fraud by the continuous review of proposed and current department policy.

Provider Fraud – Health Services: OIG uses an investigative process to detect and deter potential instances of fraud, waste and abuse in health services programs. Provider fraud may include giving or receiving bribes or kickbacks, unacceptable medical and/or billing practices, misusing or abusing Medicaid services, falsifying records or giving false information. Cases involving credible allegations of fraud or other illegal activities are forwarded to the Attorney General's Health Care Fraud Division for pursuit of appropriate civil or criminal prosecution.

Provider Fraud – Human Services: Intentional false billings or intentional inaccurate statements by a provider in areas such as a child development and care, foster care, and adoption subsidy, as well as contractors or other related businesses.

Provider Sanctions: Participation as a provider in the Medicaid program is subject to denial, suspension, termination or probation on the grounds specified by section 400.11e of the Social Welfare Act (Act 280 of 1939). OIG is responsible for making the determination to sanction a provider based on these grounds (e.g., provider is convicted of violating the Medicaid false claims act or a substantially similar statute of another state or the federal government; provider is convicted of, or pleads guilty to, a criminal offense or attempted criminal offense relating to the provider's practice of health care; provider's failure to comply with professionally accepted standards of medical practice, etc.).

Recipient/Client Fraud: An Intentional Program Violation (IPV) by a person on, or applying for, public assistance. IPV occurs when there is intentional deception or misrepresentation, with the knowledge that the deception could result in the receipt of unauthorized benefits.

Social Media: OIG actively monitors social media sites such as Facebook, Craigslist and Twitter for FAP trafficking solicitations. OIG's Benefit Trafficking Unit conducts investigations on these hits.

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