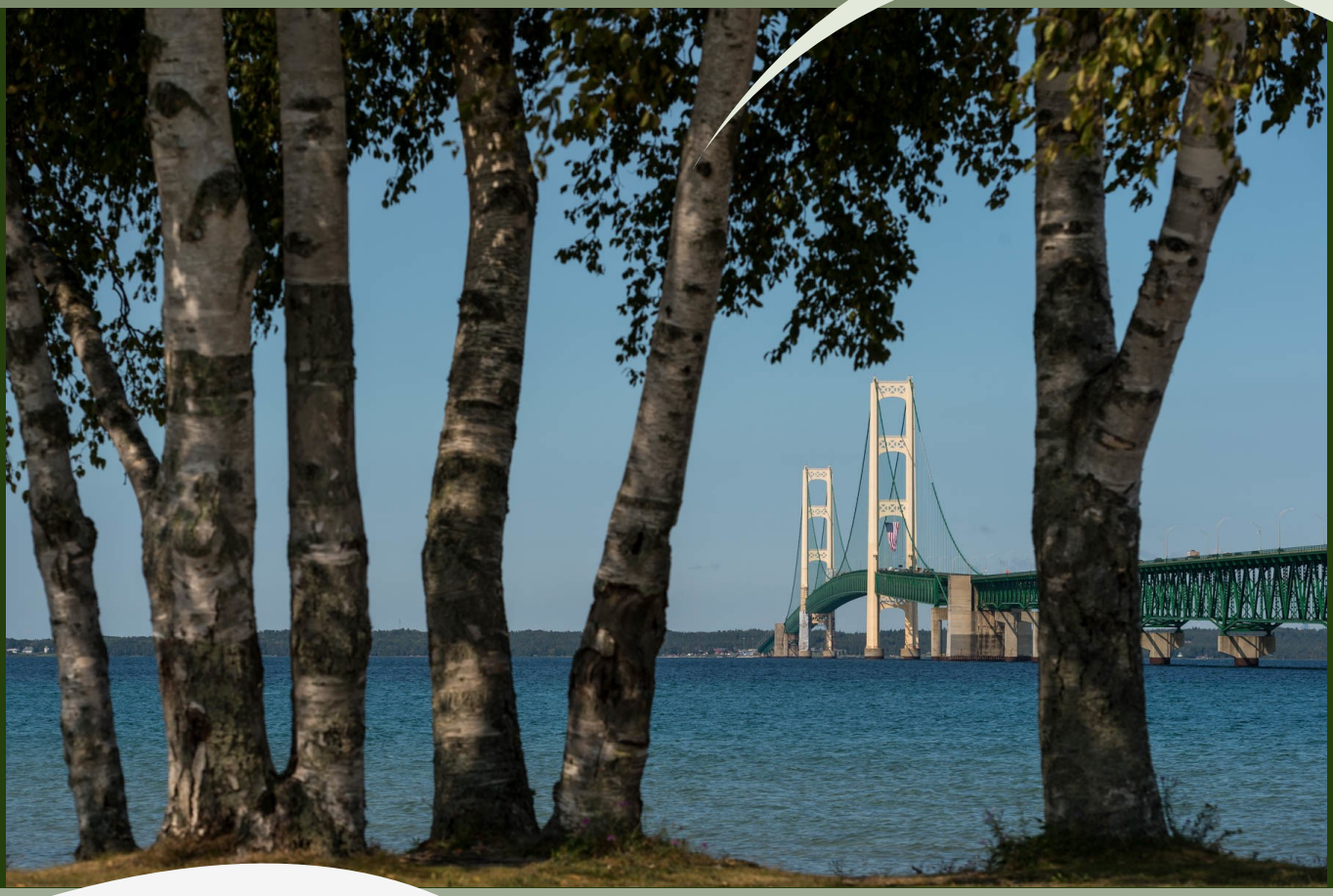
FY 2021 Annual Report



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

Alan Kimichik, Inspector General

Contents

Message from the Inspector General

It is with honor that I present to you the Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG) Fiscal Year (FY) 2021 Annual Report.

The OIG continues to cultivate a diverse, skilled and engaged workforce dedicated to excellence, teamwork and the highest standards of professional conduct in a collaborative work environment. I am privileged to lead such a dedicated team and am proud of our ongoing work to improve program integrity in the programs administered by MDHHS.

The OIG's primary role is to investigate fraud, waste and abuse in programs administered by MDHHS and to increase program integrity and accountability. Citizens expect accountability and integrity in state government, and OIG takes this to heart. The landscape of fraud is constantly changing as new schemes are developed, and my staff continue to innovate to identify these schemes and ensure appropriate action is taken. As a result of my staff's hard work, the following accomplishments were achieved in FY 2021:

- Accounted for approximately $179.2 million in program integrity efforts (fraud detection, cost avoidance and disqualifications).
- Performed 17,381 public assistance application investigations resulting in cost avoidance of more than $52.6 million.
- Established $76.5 million in Medicaid provider overpayment receivables and cost avoidance.
- Completed 4,386 public assistance fraud investigations.
- Identified $8 million of public assistance program fraud.
- Established $4.7 million in cost avoidance from disqualifications of public assistance recipients for intentional program violations.

OIG's actions benefit all citizens by helping ensure that funds for public assistance programs are available to the residents that truly need them, and that taxpayers' money is spent on its intended purpose.

I want to thank the OIG's staff, fellow state employees and all Michiganders who reported suspected fraud, waste, abuse and misconduct in FY 2021 and encourage them to continue in the future. Together, we can further strengthen the integrity of the programs administered by MDHHS.

Sincerely,

Alan Kimichik, Inspector General

EXECUTIVE SUMMARY

Fraud Detection and Prevention

Enforcement Division

In FY 2021, the Office of Inspector General - Enforcement Division Agents:

- Determined $67.4 million of fraud, cost avoidance and established program disqualifications.
- Completed 4,386 fraud investigations.
- Completed 17,381 Front End Eligibility (FEE)[1] investigations.
- Identified $52.6 million in cost avoidance in FEE investigations.
- Established an additional $4.7 million in cost avoidance from intentional program violation (IPV) disqualifications.
- Identified $8 million of program fraud.

Integrity Division

In FY 2021, the Office of Inspector General - Integrity Division agents:

- Sanctioned 51 providers, establishing $16.5 million in fee-for-service and $21.9 million in managed care encounter payment cost avoidance.
- Identified $9.8 million in inappropriate Medicaid expenditures, recovering $2.7 million to date.
- Performed program integrity oversight of Michigan Medicaid's 42 Managed Care Organizations (MCO). These MCOs performed a total of 6,917 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $13.6 million.
- Referred 51 Medicaid providers to the Michigan Department of Attorney General's Health Care Fraud Division for credible allegation of fraud investigations.
- Completed 948 fraud investigations.

[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. OIG 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

Fraud Detection and Prevention

Enforcement Division
Specialized Investigative Units:

In FY 2021, the Special Investigations Unit (SIU) agents:

- Completed 294 investigations.
- Determined $694,000 of provider, contractor, recipient and employee fraud.

In FY 2021, the Benefit Trafficking Unit (BTU) agents:

- Completed 818 benefit trafficking investigations.
- Determined $364,000 in fraud.
- Worked with the Identity Theft Unit (ITU) to establish $6.5 million in cost avoidance from identity theft investigations.

The ITU was established by OIG in July 2021. In FY 2021, the ITU agents:

- Investigated over 40 identity theft criminal entities utilizing over 2,000 stolen and fraudulent identities to illegally obtain and traffic Food Assistance Program (FAP) benefits.
- Determined over $292,000 in fraud from identity theft and established $660,000 in cost avoidance.

In FY 2021, the High Risk Medicaid Unit (HRMU) agents:

- Completed 1,838 high-risk Medicaid investigations.
- HRMU investigations resulted in 600 beneficiaries being confined to a specified pharmacy and/or health care provider.
- Investigations resulted in $8.3 million in Medicaid cost avoidance.

In FY 2021, the Cooperative Disability Investigation Unit (CDI) agents:

- Completed 33 cooperative disability investigations.
- Established $1.9 million in cost avoidance.

COST EFFECTIVENESS AND PRODUCTIVITY

- Over the last five years, every dollar spent on fraud prevention resulted in an average of $25.20 of cost avoidance and savings for taxpayers.
- For every hour spent on an investigation in FY 2021, $229 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.

OIG VALUES

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.

Recognition

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

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 the Michigan Department of Health and Human Services.

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.

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.

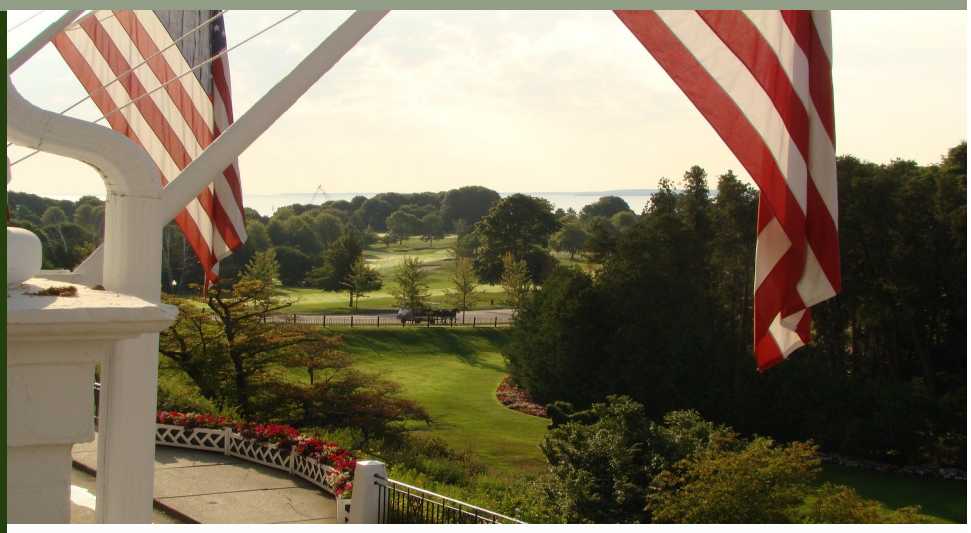
Excellence

- 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.
- Take pride in themselves and their organization, take ownership of their work and be leaders in their areas of responsibility.

INSPECTOR GENERAL OVERVIEW

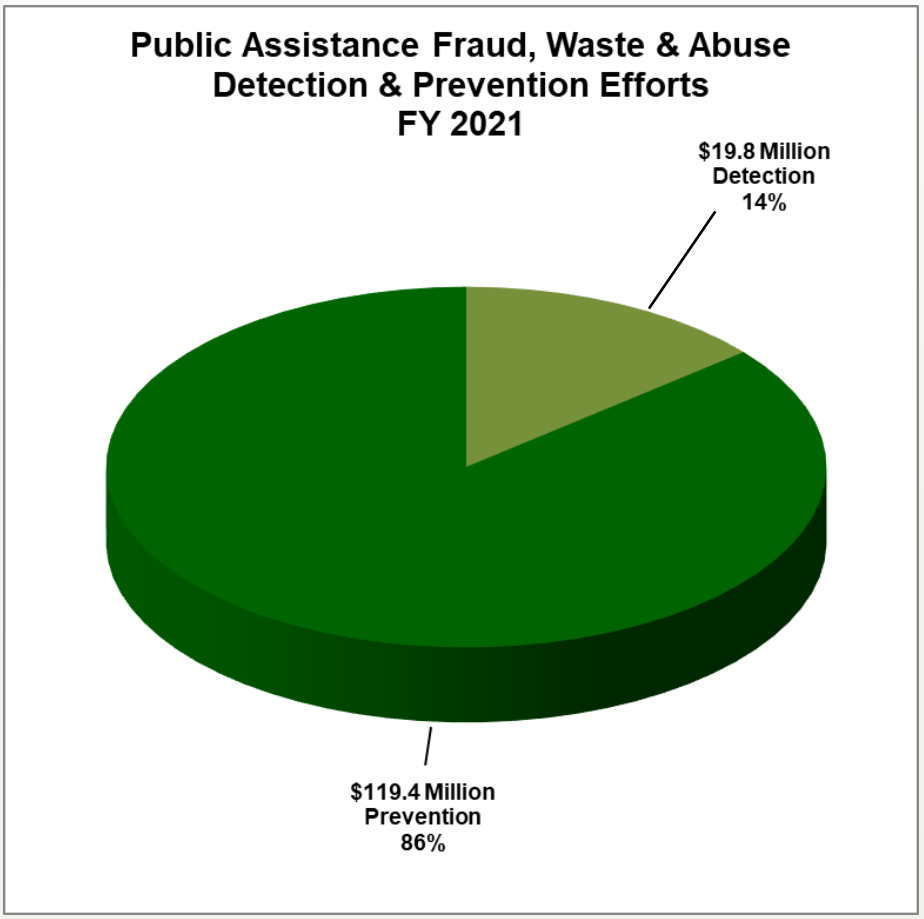
The OIG is the criminal justice agency within the MDHHS providing program integrity services. OIG agents provide investigation and advisory services to ensure appropriate and efficient use of available public resources in the State of Michigan.

Within the OIG there are three divisions: Integrity (Medicaid providers), Enforcement (recipients/vendors and non-Medicaid providers) and Operations (Administrative, Investigative Analytics and Policy & Training). 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 - $19.8 million
Fraud prevention in public assistance - $119.4 million



Notes: Represents FIP (Family Independence Program), FAP (Food Assistance Program), SDA (State Disability Assistance), SER (State Emergency Relief), and FFS (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 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 detection and prevention. 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.

Fraud Investigation Highlights

Dual Assistance
An OIG investigation revealed that a recipient had established a residence in Ohio and continued to submit multiple applications in Michigan for FAP and MA benefits, receiving benefits in both states. OIG submitted the investigation for an administrative hearing. The ALJ ruled for the department and ordered the recipient to repay $11,738 in FAP and MA benefits fraudulently obtained from Michigan.

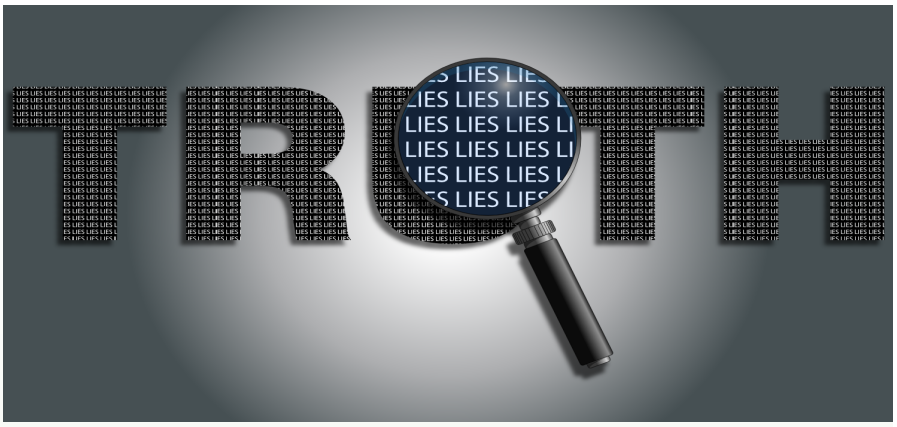
Group Composition
An OIG investigation revealed that a recipient's four children did not reside with them in Michigan. The fraud investigation determined the recipient was not eligible for the FAP and MA benefits they received for group members who did not reside in the household. The investigation was referred to the Macomb County Prosecuting Attorney's office. The recipient pled guilty to welfare fraud and was sentenced to repay $18,833 in FAP and MA benefits and serve 12 months of probation.

Asset Detection
An OIG investigation revealed that a public assistance recipient had unreported bank assets of $181,416, exceeding the $15,000 asset limit for FAP. The initial Front End Eligibility (FEE) investigation resulted in an annual program cost savings of $8,160 in FAP benefits. An Administrative Law Judge (ALJ) ruled for the department and ordered the recipient to repay $2,686 in FAP benefits and serve a 12-month disqualification.

Unreported Income
An OIG investigation determined that a public assistance recipient failed to report income from employment, resulting in an overpayment of FAP benefits for three years. The employment income exceeded the program income limit and made the recipient's household ineligible for all program benefits. The recipient pled guilty to welfare fraud and was sentenced to pay restitution of $49,214, a one year suspended sentence, and to serve a term of probation for 12 months.

Unreported Self-Employment
An OIG investigation revealed that a recipient failed to report ownership of a home cleaning business and the income from that business to the department. As a result of the recipient's failure to report their self-employment, they received $18,121 in FAP benefits they were not eligible for. The recipient pled guilty to welfare fraud and was sentenced to 50 days in jail (suspended), one year of probation and full restitution.

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. OIG agents investigate, substantiate or refute discrepancies and suspicious activities. Agents complete the investigation within 15 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.

Disaster Food Assistance Program Investigations
MDHHS accepted Disaster Food Assistance Program (DFAP) applications in Wayne and Washtenaw counties from August 13, 2021, through August 20, 2021, and Oakland and Macomb counties from November 3, 2021, through November 10, 2021. Disaster assistance benefits are designed to provide disaster cash and disaster food assistance to households affected by federally declared disasters/ mandatory evacuations including but not limited to tornadoes, floods, storms, chemical spills, etc. Eligibility for DFAP is not limited to households that are typically eligible for FAP. During the two eligibility periods, OIG investigated 44 suspicious claims filed with MDHHS, resulting in 33 denials and two applicant withdrawals.

FEE Investigation Highlights

DFAP Residency
OIG received a disaster FEE referral alleging that an applicant and six additional household members reported being impacted by the flooding in Southeast Michigan, resulting in a loss of items in the residence in the amount of $1,232. The recipient reported that six of the household members went to visit Tennessee for the weekend due to housing issues. It was discovered that the other household members on the application were residents of Tennessee and had been receiving assistance in that state since 2015. The applicant also had an established residence and driver's license in Tennessee. The agent interviewed the actual homeowner who verified that neither the applicant nor the other six people resided at the residence, but instead all lived in Tennessee. The applicant was interviewed and admitted to being in Tennessee and failing to properly report their employment and retirement income. A fraud investigation was initiated to recover the overissued benefits.

DFAP Home without "Flooded Basement"
OIG received a disaster FEE referral alleging the applicant reported being impacted by the recent flooding in Southeast Michigan, resulting in a loss of items in the basement of their residence in the amount of $929. The subsequent investigation determined the applicant resided in a mobile home, which was several feet off the ground. The property manager of the complex was interviewed and reported no damage and/or flooding to any of the units. When questioned, the applicant admitted the home did not have a basement and that the items destroyed were left outside. A fraud investigation was submitted for an administrative hearing. The ALJ ruled for the department and ordered the recipient to repay $929 and be disqualified from receiving FAP benefits for 12 months.

BENEFIT TRAFFICKING UNIT (BTU)

BTU agents conduct comprehensive and multifaceted criminal and civil investigations involving the fraudulent acquisition and use of MDHHS program benefits and initiates criminal, civil and administrative action to prosecute offenders and recover program funds. FAP trafficking is a crime that involves the buying, selling or trading of public assistance benefits for cash or other ineligible items, including tobacco, alcohol, firearms, drugs and gambling. The unit also investigates allegations of MA fraud, which includes the sale of a person's MA card to obtain health services.

BTU Investigation Highlights

Fraudulent Acquisition and Use of FAP Benefits

OIG investigated allegations that several MDHHS FAP beneficiaries were also receiving food assistance benefits in another state. Initial review of the information indicated the existence of a potential identity theft scheme, but further investigation indicated that the Michigan residents may be intentionally selling their personal information to an individual who used them to fraudulently obtain the benefits. The investigation identified the perpetrator who was charged and convicted of multiple felony counts and ordered to serve four to 10 years in prison and repay $630,000 in restitution.

Welfare Fraud/FAP Trafficking

An OIG investigation determined that an individual submitted numerous fraudulent MDHHS benefit applications using stolen identities in order to sell the FAP benefits in exchange for cash. The investigation identified the perpetrator who was criminally charged and convicted of felony welfare fraud and sentenced to jail and to pay full restitution of $36,500 to the State of Michigan.

IDENTITY THEFT UNIT (ITU)

Identity theft is a pervasive crime that has increased during the COVID-19 pandemic. In July 2021, OIG established the ITU to combat the growing trend of public assistance fraud where individuals and criminal enterprises utilize stolen identities to apply for and obtain MDHHS benefits. ITU agents ascertain and identify the existence of sophisticated criminal conspiratorial schemes through field investigations, social media and advanced data analysis. The ITU initiates appropriate criminal charges to prosecute offenders and recover program funds.

ITU Investigation Highlights

Welfare Fraud
An OIG investigation determined that fraudulent identities were being used to illegally obtain MDHHS benefits. The investigation uncovered the identity of the perpetrator who was ineligible to receive benefits due to previous criminal convictions. The person was charged with multiple felony crimes, including Food Stamp Fraud, Obtaining a Controlled Substance by Fraud, Medicaid Fraud and Forgery, and Habitual Offender. The perpetrator pled guilty to six felony counts and was sentenced to 30 months imprisonment and to pay more than $31,000 in restitution to the State of Michigan.

Identity Theft
An OIG investigation of a suspicious benefit application led to the discovery of three benefit cases opened using stolen or fictitious identities. The investigation uncovered the identity of the perpetrator who obtained nearly $9,000 in fraudulent benefits. The investigation was referred to the Michigan Department of Attorney General who authorized felony warrants for welfare fraud and violation of the Identity Theft Protection Act. The criminal charges are pending in court.

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 and 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.

SIU Investigation Highlights

Employee Welfare Fraud
OIG investigated allegations that a State of Michigan employee and their spouse received nearly $7,500 in MDHHS adoption subsidy benefits for a child who was no longer in their care. The employee was criminally charged with felony welfare fraud and was convicted of the felony by a circuit court trial jury and ordered to pay full restitution to the state.

Medicaid Long-Term Care Fraud
OIG investigated allegations that an applicant failed to disclose substantial assets when applying for MDHHS long term care MA benefits for their parent which resulted in the issuance of nearly $8,000 in benefits the parent was not entitled to. The applicant was charged with felony welfare fraud and pled guilty to a reduced charge. They were ordered to pay full restitution to the State of Michigan.

HIGH RISK MEDICAID UNIT (HRMU)

In October 2019, OIG established the HRMU to review beneficiaries' use of MA for potential abuse. HRMU agents investigate beneficiaries who potentially abuse or misuse MA services and benefits. OIG's Investigative Analytics section identifies high risk behaviors such as:

- Beneficiaries who received strong opioid prescriptions with no corresponding diagnosis.
- Beneficiaries who sought opioid prescriptions from multiple doctors and/or pharmacies over a short period of time.
- Beneficiaries who traveled long distances to seek strong opioid prescriptions.

After investigation, OIG's HRMU forwards these beneficiaries to the MDHHS' Benefits Monitoring Program (BMP) for review. BMP and/or the associated health plan makes the determination that the beneficiary's behavior indicates the need that they be confined to care with a specified provider and/or pharmacy for a two-year period. Upon confinement, all non-emergency medical care and/or prescriptions must be authorized by the designated health provider and dispensed by the designated pharmacy to be covered by MA.

HRMU Investigation Highlights

Multiple Doctors and Prescriptions
An OIG investigation determined that a beneficiary received 25 controlled substance prescriptions over a period of three fiscal quarters during 2020 and 2021. The beneficiary utilized seven different prescribers to receive controlled substance prescriptions and paid cash for a controlled substance covered by MA. BMP confined the beneficiary to a specified provider for two years resulting in MA cost avoidance of approximately $13,819.

Excessive Emergency Department Visits
An OIG investigation revealed that a beneficiary visited the emergency room 30 times in 2021 and 22 times in 2020, without any follow-up appointments with their primary care physician. The beneficiary utilized more than three different hospitals to receive treatment. In addition, the beneficiary also used four different pharmacies in the first quarter of 2021. BMP confined the beneficiary to a specified provider for two years resulting in MA cost avoidance of approximately $13,819.

COOPERATIVE DISABILITY INVESTIGATIONS (CDI) UNIT

Since 2014, OIG has partnered with the Social Security Administration Office of Inspector General (SSA-OIG) through 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 its 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 MA. OIG's participation in the CDI unit realizes savings to Michigan taxpayers for stopping both SSI and MA fraud.

The two OIG agents, working in partnership with SSA-OIG, produced a total cost avoidance of $1.9 million.

CDI Unit Investigation Highlight

Disability Fraud

The Detroit CDI unit investigated a 54-year-old individual who received Title 2 Disability Insurance Benefits (DIB) since 1997 due to depression and Post Traumatic Stress Disorder. An anonymous source referred an allegation to the CDI unit that stated the beneficiary was working while faking a traumatic brain injury to collect SSA and other insurance benefits. The beneficiary's work activities were described as carrying heavy objects, driving and working as a welder. Paperwork in the beneficiary's disability file described them as needing 24-hour attendant care, having difficulty with all aspects of daily activities and always using a walker or cane.

A CDI unit investigator obtained copies of a police report where the beneficiary had reported theft from their welding and collision business. The beneficiary had also filed police reports on a report of counterfeit money used by a customer, as well as other police reports involving customer-related complaints of the beneficiary performing work and the customers refusing to pay for the work performed.

Observations were conducted by the CDI unit investigator at the beneficiary's reported business (which contained a sign outside that stated Welding Shop with a phone number listed). During observations, the beneficiary was observed walking with a normal gait, and opening and closing the sliding garage door to the business. The beneficiary was observed doing many activities at the business including moving a four-wheeler and mini-motorcycle frame outside of the building and moving around a mechanical cart and five welding tanks. The beneficiary was also observed towing a large trailer outside of the business where numerous individuals who appeared to be customers were observed going in and out of the business.

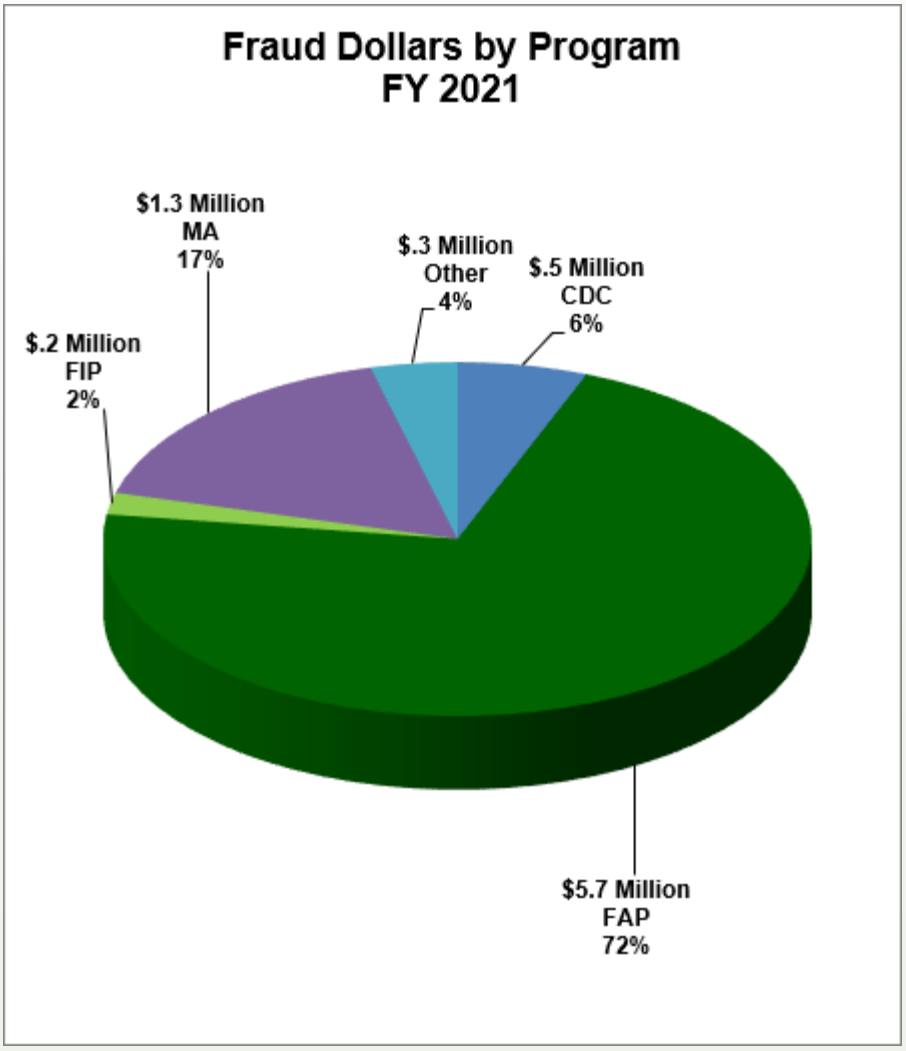
Following the conclusion of the investigation, the DDS found the beneficiary had medically improved and ceased their DIB. That cessation resulted in SSA savings of $76,876 and Medicare/Medicaid savings of $71,042.

PROGRAM INTEGRITY IMPACTS

OIG's Enforcement Division determined over $8 million in fraud during FY 2021 within multiple Michigan public assistance program areas. Because of the Enforcement Division efforts, during FY 2021, 214 felony warrants were authorized by county, state and federal prosecutors. Investigations by Enforcement Division agents have uncovered $28.4 million in fraud during the last three years.

Program Highlights

- FAP accounted for 72 percent of Michigan's public assistance fraud during FY 2021.
- OIG investigated 4,241 fraud cases in the FAP program, with 3,858 fraud investigative dispositions and 182 criminal warrants issued for a fiscal year total of $5.7 million in fraud found.
- OIG completed 38 CDC cases resulting in $481,000 in fraud found for the Michigan Department of Education (MDE).
- OIG completed 854 investigations of MA fraud resulting in $1.3 million in fraud found.



CDC = Child Development and Care Program

FAP = Food Assistance Program

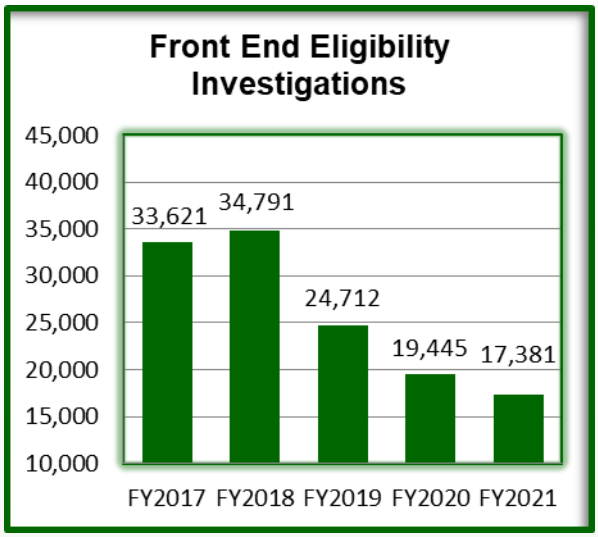
FIP = Family Independence Program

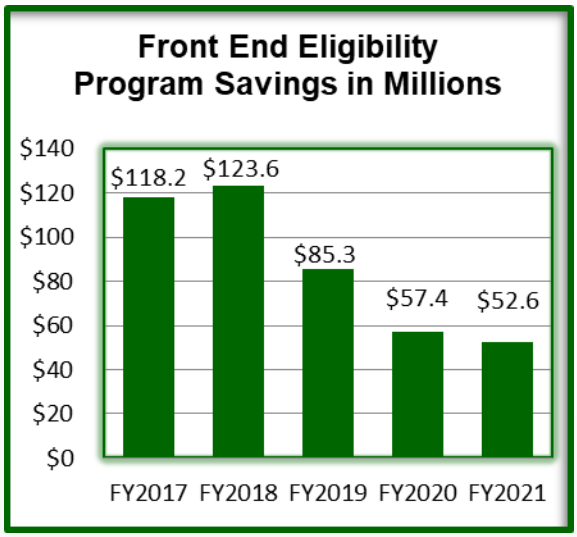
MA = Medicaid Program

Other = Adult/Children's Services, State Disability, State Emergency Relief

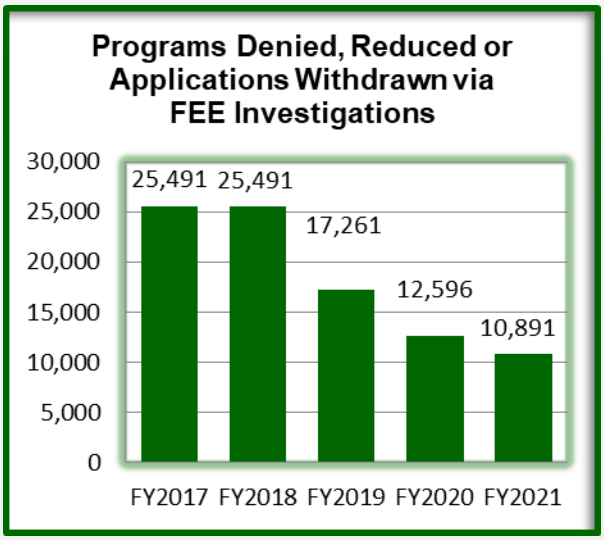
FEE: EARLY FRAUD DETECTION AND PREVENTION

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public assistance. 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 17,381 investigations in FY 2021 and identified $52.6 million in cost avoidance. Investigations by these agents have resulted in $195 million in program savings for taxpayers over the last three-year period.



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.

INTEGRITY DIVISION

In FY 2021, Michigan's health services programs had a combined budget of approximately $20.4 billion and paid approximately 232,000 providers for goods and services provided to beneficiaries covered under those 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 CFR §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 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.

RECOVERY AUDIT CONTRACTOR

The Integrity Division has contracted with a vendor to perform audits and recover overpayments from Medicaid providers.

MANAGED CARE OVERSIGHT

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

HEALTH SERVICES PROGRAMS IMPACTS

In FY 2021, OIG-ID had an overall impact to direct Medicaid spending (i.e., fee-for-service (FFS)) totaling $76.5 million through the following activities:

- Identified a total of $9.8 million in overpayments made to Medicaid providers. To date, over $2.7 million has been recovered while the remaining $7.1 million is being repaid over time.

- In FY 2021, OIG-ID:
    - Received 321 allegations of potentially fraudulent activity from various sources (e.g., 39 tips from beneficiaries, 107 tips from the public (39 anonymous), 151 referrals from inside MDHHS, three tips from providers).
    - Identified 403 audit targets through data analytics.
    - Completed 948 fraud investigations.

- Prevented an estimated $22.2 million in future payments through reduced billing activities as a result of Medicaid provider audits and investigations.

- Sanctioned 51 Medicaid providers, preventing an estimated $16.5 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.

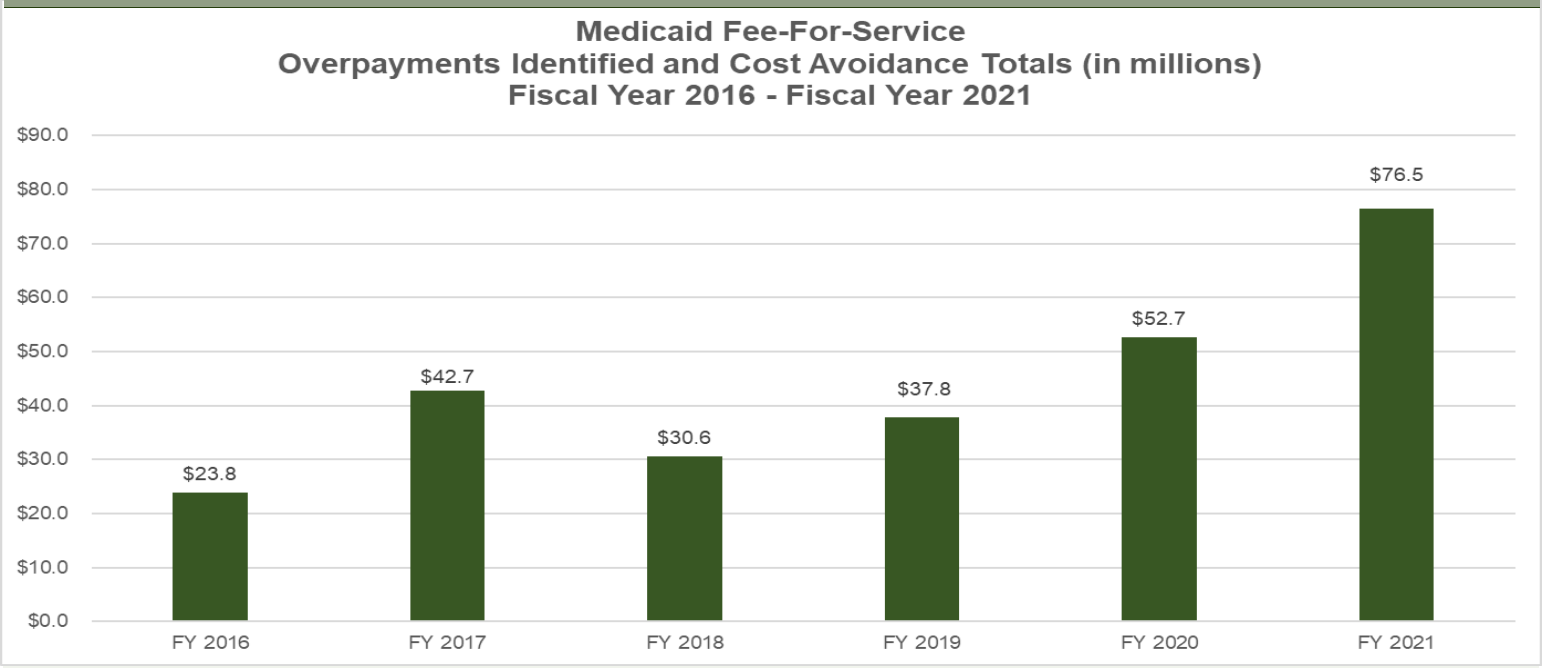
- Made formal recommendations to the Medical Services Administration to prevent an estimated $426,204 in future claims from being paid.
    - When OIG-ID agents identify vulnerabilities where a more robust Medicaid policy and/or system edits would have prevented an identified fraud, waste or abuse, OIG-ID makes formal recommendations to prevent future claims from being paid.

- Referred 51 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 $468,243 in restitution.

In FY 2021, OIG-ID had an overall impact to indirect Medicaid spending (i.e., MCO encounter claims) totaling $35.5 million through the following activities:

- Sanctioned 51 Medicaid providers, preventing an estimated $21.9 million in future MCO encounter payments.

- $13.6 million in identified overpayments through program integrity related oversight of the Michigan Medicaid MCOs.



NOTE – Approximately $19.3 million in FY 2021 identified overpayments were pending appeal decisions, litigation or repayment terms negotiation at the end of the year and are not included in the above chart

FIELD INVESTIGATION SECTION OVERVIEW

Due to the magnitude and complexity of Michigan's health services program, OIG-ID utilizes six regionalized investigative units. Each unit primarily investigates fraud allegations dealing with the following provider types in its assigned region:

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

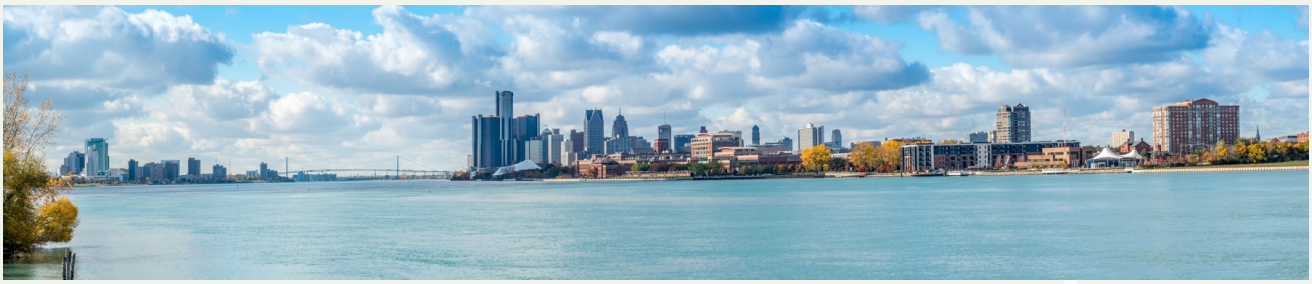
These regionalized teams enable OIG-ID to better coordinate efforts, thereby enhancing the accuracy, completeness and overall effectiveness where OIG can achieve its mission.

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 Michigan Department of 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 and MCOs.
    - Educating providers on proper Medicaid billing practices.
    - Referring information and evidence to regulatory agencies and licensure boards.



Fraud Investigation Highlights

Home Help

In FY 2021, receivables were established for 582 home help providers totaling approximately $4.2 million for payments made while either their beneficiaries were hospitalized or after their death, while the provider was incarcerated, or for other noncompliance with Medicaid policy.

Integrated Care Organizations

Integrated Care Organizations (ICOs) are health plans for Medicaid beneficiaries who also have Medicare coverage. Medicaid pays the ICO a monthly capitation (i.e., insurance premium), and the ICO pays the providers directly for services provided.

As a result of OIG efforts, in FY 2021, five ICOs repaid Michigan Medicaid $134,490 in capitation payments that were paid on behalf of Medicaid beneficiaries who were not enrolled in the ICO program at the time of the capitation payment.

Additionally, in FY 2021, four long-term care facilities agreed to repay a total of $50,501 due to improperly being paid by the Medicaid program directly for service periods when its beneficiaries were enrolled in the ICO program and the ICO received capitation payments for those same service periods. These four long-term care facilities were to be reimbursed by the ICO for those services.

Medical

In FY 2021, three medical providers agreed to repay the Medicaid program a total of $66,138 that they received as a result of billing for services that were double billed between Medicaid and Medicaid health plans, lacked documentation to support billing and/or upcoded hospital discharge day management procedure codes.

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 2021, nine pharmacy providers agreed to repay the Medicaid program a total of approximately $1.5 million as a result of pharmaceutical inventory audits.

Additionally, in FY 2021, 13 pharmacy providers agreed to repay the Medicaid program a total of $1.3 million as a result of billing for pharmaceuticals using the wrong unit of measurement (i.e., mg instead of ml) or billing above the actual acquisition cost for 340B claims.

The 340B Drug Discount Program is a federal program created by Congress to help provide relief from escalating drug prices to safety-net hospitals and other healthcare providers serving vulnerable patient populations. If participating in the 340B program, Medicaid policy states providers must bill Medicaid at the discounted price they purchased medications.

Dental

In FY 2021, 43 dental providers agreed to repay the Medicaid program a total of $183,379 that they received as a result of billing for services that violated Medicaid Dental Policy.

Maternal Infant Health Program (MIHP)

In FY 2021, 25 MIHP providers agreed to repay the Medicaid program a total of $276,412 that they received as a result of billing for services that violated Medicaid MIHP Policy.

CONTRACT OVERSIGHT SECTION OVERVIEW

The Contract Oversight Section is comprised of two units, the Managed Care Organization (MCO) Oversight Unit and the Vendor Oversight Unit.

MCO OVERSIGHT UNIT

The MCO Oversight Unit is responsible for monitoring the program integrity activities of Michigan Medicaid's MCOs.

- In coordination with the Managed Care Plan Division, OIG-ID requires each of Michigan Medicaid's physical health and dental 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 disenrollments.
- MI Choice Waiver Agencies and Prepaid Inpatient Health Plans are also required to submit these program integrity activity reports quarterly.
- 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).
    - CAP 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 Michigan Department of Attorney General's MFCU.

MCO Oversight Unit Highlights

Provider Audits/Reviews
In FY 2021, Michigan Medicaid's 42 MCOs performed a total of 6,917 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $13.6 million.

Provider Sanctions
In FY 2021, OIG-ID agents prevented an estimated $21.9 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 requires Medicaid agencies to contract with a Recovery Audit Contractor (RAC) to identify and recover overpayments.
    - In FY 2018, CMS approved a waiver to allow OIG to utilize their Unified Program Integrity Contractor (UPIC) as the Michigan Medicaid RAC.
    - The UPIC performs data mining algorithms on the Medicaid database to identify potential areas of recovery. These scenarios are preapproved by OIG's Vendor Oversight Unit analysts.
    - OIG's Vendor Oversight Unit analysts also review and preapprove each proposed UPIC audit target as well as their sample selection prior to record review.
- In FY 2021, the UPIC identified $1.5 million in overpayments made to Medicaid providers and prevented an estimated $27.5 million in future payments through reduced billing activities as a result of Medicaid provider audits.

OPERATIONS DIVISION

OIG's Operations Division (OIG-OD) is comprised of three areas: Administrative Services, Investigative Analytics and Policy & Training.

OIG-OD's Administrative Services is responsible for overall administrative support of the administration. It manages budget development and monitoring, system security, fraud hotlines, investigative process support as well as overseeing of the day-to-day business operations. For example, in FY 2021, OIG's Administrative Services provided extensive quality control reviews on over 1,870 investigative packets referred to the Michigan Office of Administrative Hearings and Rules for debt collection and program disqualification requests.

OIG-OD's Policy & Training Unit (P&T) is responsible for ensuring accurate and timely policy review, development and implementation. The unit reviews, researches and analyzes current and proposed department policy, state laws, federal legislation and associated MDHHS and OIG policy changes. It is responsible for developing and delivering training to OIG staff as the need develops. This includes planning, coordinating and facilitating both internal and external training events.

OIG-OD's Investigative Analytics is responsible for the analytic solutions that support ongoing investigations and fraud referrals. This section is responsible for a multitude of complex analysis, predictive analytics and data mining solutions to highlight potential fraud. Investigative Analytics provides system administrator support as well as unique and specialized skills for program integrity efforts.

OIG-OD's Investigative Analytics section also houses the Technical Systems Unit (TSU), which oversees the development and maintenance of technical systems that support OIG's investigators and analysts. The TSU also creates reporting solutions for internal, state and federal needs. TSU is responsible for ensuring timely and accurate data is available for analysis and fraud referral generation.

Administrative Services Highlight

COVID-19 Staff Support

OIG's Administrative Services continued to support the administration through the COVID-19 pandemic so operations could continue safely. Staff provided enhanced support with equipment and supplies delivery, printing and mail management, all to keep workflows intact and productive.

POLICY & TRAINING (P&T) UNIT

OIG's P&T is responsible for the new hire orientation program for all new OIG employees. This provides a consistent introduction and overview of the department, the administration and OIG's mission. The unit oversees the program to ensure employees are educated on OIG's values, history and an understanding of the importance of all three divisions that make up OIG. P&T continues to identify and implement on-the-job training materials to create a highly skilled workforce. The unit reviews and analyzes proposed department policies to ensure program integrity and offer recommendations as needed. The unit analyzes the impact of those proposed polices and the effect it could potentially have on OIG business processes as well as the potential global impact on the department.

P&T Highlights

OIG's Training Institute

OIG's P&T continued leading the development of OIG's Training Institute (OTI). OTI provides a solid foundation for new employees through formal instruction followed by on-the-job training. It is designed to develop critical skills and judgement along with professional habits that will prepare staff for a successful career with OIG. OTI classes that have been developed are now being used for training, preceding OTI's full launch in early 2022. Once launched, OTI will be housed in a secure location on MDHHS's Learning Management System (LMS). OIG's LMS allows staff to take training courses on its own, or as assigned by management. It also provides for testing, monitoring on-the-job training(s) and tracking outcomes.

OTI now has over 60 courses available for new and existing employees to utilize. Developers are actively transforming courses to Computer Based Trainings which will be available on-demand. As additional courses are developed, they are injected into the curriculum. Once launched, OTI will be a valued asset to all OIG employees and has truly been an example of a monumental team effort between the administration's divisions, their subject matter experts and P&T.

Training Events

The unit facilitated 24 training events for OIG staff in FY 2021. Some of those trainings included partnering with other MDHHS administrations to offer training on HIPAA and FOIA. The unit provided additional soft skill trainings as well as hosting training webinars for investigators to further their professional development.

Final Department Reviews

The unit reviewed and analyzed 48 proposed department polices associated with MDHHS.

Promoting Diversity, Equity and Inclusion (DEI) at OIG

P&T assisted OIG's DEI Council member with hosting 12 DEI workshops for OIG staff. These workshops facilitated awareness of unconscious bias, cultural competence and other barriers to diversity, equity, inclusion (DEI) and belonging. The discussions in these workshops helped to promote an inclusive workplace culture, assisting in employee engagement and employee retention by fostering relationship building, communication and empathy. These workshops were a chance to bring people together who may not typically work together to hear different perspectives or experiences.

INVESTIGATIVE ANALYTICS

OIG OD's Investigative Analytics section is responsible for providing analytic support for ongoing investigations and fraud referrals. Investigative Analytics 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 Investigative Analytics functions and responsibilities include:

- Food Assistance Program Trafficking Data Mining
- Medicaid Fraud, Waste and Abuse Data Mining
- Social Media Analysis
- Internet Protocol Locator Project
- Identity Theft/Application Fraud Analysis
- Asset Detection
- Out-of-State Bridge Card Transaction Analysis
- Provider and Recipient Vital Records Match
- Ad-hoc Investigative Support Data Requests
- Public Assistance Reporting Information System (PARIS) Match Analysis
- USDA-FNS Client Integrity Referral Analysis
- County Jail Match Analysis

Investigative Analytics Highlights

In-House Investigative Algorithms
Over the course of FY 2021, Investigative Analytics devised or refined over 20 algorithms used in the generation of investigative leads. For example, one algorithm identified recipients with a reported household size of "one," where other data sources identify a spouse with income. When the algorithm was tested, OIG identified over $175,000 in cost avoidance from 160 investigations completed during the fiscal year.

Medicaid Provider Overpayment Detection
In FY 2021, approximately 70 percent of OIG's Medicaid provider recoupment cases were generated as a part of Investigative Analytics assisted data analytics/data mining.

Out-of-State Spending
Exclusive out-of-state spending for an extended period is an indicator that the individual may no longer be a Michigan resident. Investigative Analytics utilizes the Electronic Benefit Transfer (EBT) transaction data to identify individuals with EBT FAP spending exclusively outside of Michigan for at least three months. In FY 2021, the out-of-state spending project resulted in $11.2 million in annualized cost avoidance.

Public Assistance Program Fraud Detection
In FY 2021, approximately 55 percent of the public assistance program fraud investigations conducted by OIG were generated as a part of Investigative Analytics assisted data analytics/ data mining efforts.

High Risk Medicaid Utilization (HRMU) Analytics
Investigative Analytics leverages technical expertise and Medicaid program knowledge to identify recipients and associated providers that may be abusing the program's resources. More than 99 percent of referrals to the HRMU are generated from analytics.

Public Assistance Reporting Information System (PARIS)
Investigative Analytics utilizes the national PARIS Interstate Match to identify individuals receiving public assistance benefits in Michigan and another state at the same time. The resulting OIG investigation increases program integrity in Michigan's public assistance programs by removing ineligible beneficiaries. In FY 2021, PARIS matches resulted in $8.7 million in annual cost avoidance.

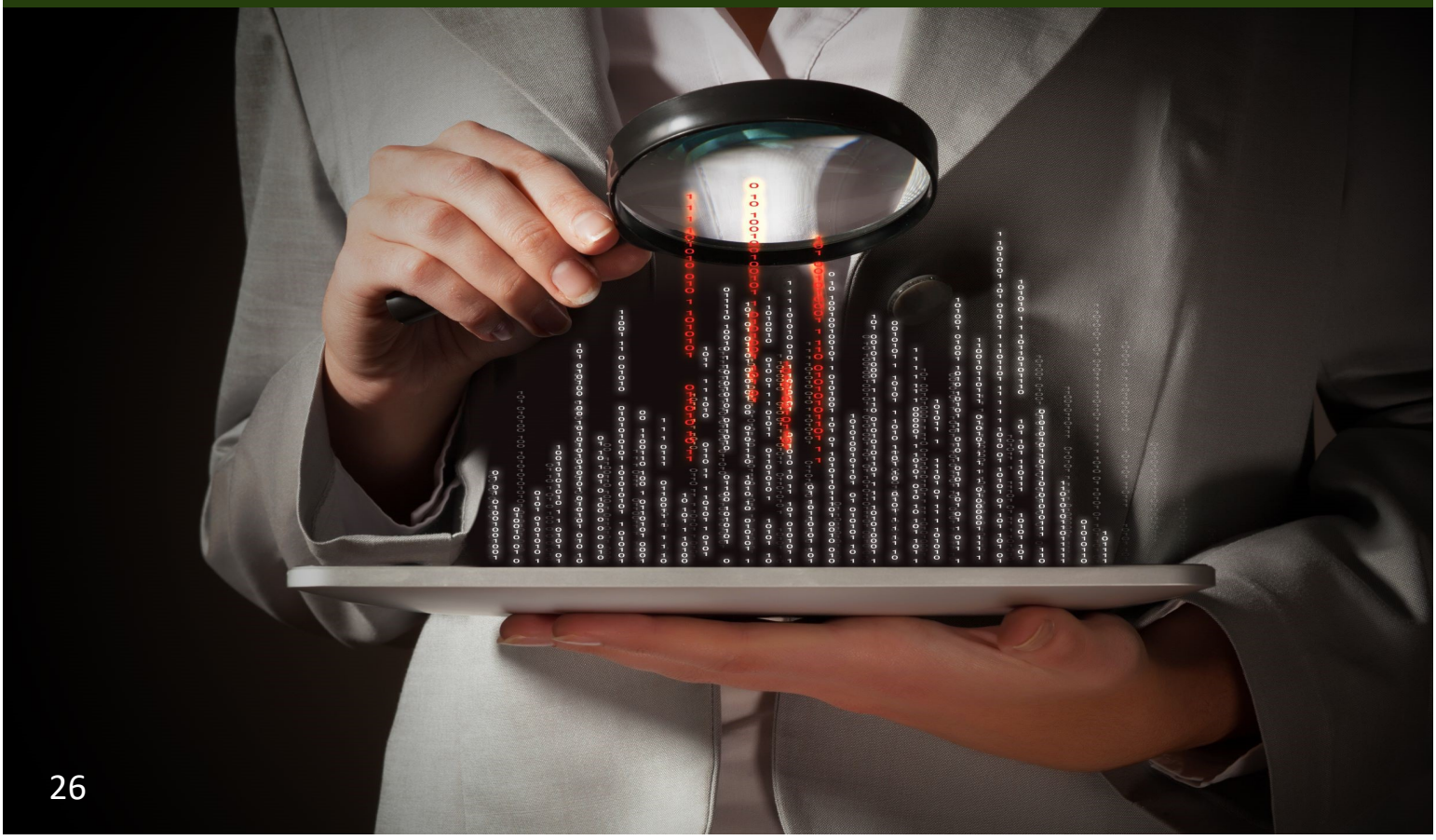
TECHNICAL SYSTEMS UNIT (TSU)

OIG's Investigative Analytics section houses the TSU, which is responsible for maintaining and enhancing OIG's two major case management systems: 1) Michigan Inspector General System (MIGS) and 2) Medicaid Audit Recovery & Investigation System (MARIS). TSU also develops and maintains investigative data reporting tools for use by OIG agents. The unit provides OIG leadership with comprehensive reporting solutions to monitor the administration's productivity. TSU ensures timely and accurate data for use by Investigative Analytics specialists.

TSU Highlights

In late 2020, OIG was approved for the USDA Food and Nutrition Service's SNAP Fraud Framework Implementation Grant. This grant covers major updates to OIG's case management system, MIGS. TSU has undertaken a major requirements gathering process to identify needed changes and updates supported by this grant. Working with vendors, the Michigan Department of Technology, Management and Budget, OIG leaders and agents, the project represents a major focus for TSU. The updated system will provide enhanced case tracking, digital signatures, redaction functionality and new reporting features.

Also, in FY 2021, TSU made a significant update to OIG's Enforcement Division's reporting tool. As a result, Michigan Unemployment Insurance Agency application data is now available for OIG agents to query as part of their investigations. This centralizes data that was previously time consuming for agents to collect. By linking it to the reporting tool, it allows investigators a more complete data research process. By continuing to add new sources of data to the reporting tool, TSU is able to generate time savings with a comprehensive and easy-to-use source of information.



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 who 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.

Front End Eligibility (FEE): MDHHS caseworkers may request an investigation by an OIG agent when applications or recertifications 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.

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

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.

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 OIG 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 42 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 Michigan Department of 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 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.

REPORT FRAUD

Examples of Welfare Fraud:

- Providing false or untrue information to receive MDHHS assistance benefits.
- Not reporting income.
- Hiding assets (bank accounts, property, etc.).
- Not reporting mandatory group members that also reside in the home.
- Trading or selling food benefits or Bridge Cards.
- Purchasing beverage(s) that require a bottle deposit, dumping/discarding beverage(s) and then returning the container(s) to obtain the cash deposit refund.
- Accepting food benefits/Bridge Card for unauthorized items (retailers only).

Report Welfare Fraud at:
Michigan.gov/Reportwelfarefraud

Examples of Medicaid Provider Fraud:

- Billing for patients who did not really receive services.
- Billing for nonexistent patients or patients of other providers.
- Billing for a service and/or equipment that was not provided.
- Billing for items and services that the patient no longer needs.
- Overcharging for equipment or services.
- Billing for lengthy counseling sessions when only short sessions were provided.
- Concealing ownership or associations in a related company.
- Paying or accepting a “kickback” in exchange for a referral for medical services or equipment.
- Billing more than once for the same service.
- Billing for medical services that were actually provided by unlicensed or excluded personnel.
- Ordering tests or prescriptions that the patient does not need.

Report Medicaid Provider Fraud at:
Michigan.gov/Fraud or 855-643-7283

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