

FY 2018 ANNUAL REPORT

State of Michigan

Department of Health
and Human Services

Office of Inspector
General

ALAN KIMICHIK
INSPECTOR GENERAL





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) 2018 Annual Report.

The OIG's primary role is to investigate fraud, waste and abuse in programs administered by MDHHS and to increase program integrity and accountability. Now, more than ever, citizens expect accountability and integrity in state government, and OIG takes this to heart. As Inspector General of OIG, I am proud of the dedication, hard work and innovation my staff exhibits in the pursuit to reduce fraud, waste and abuse in public assistance programs. The landscape of fraud is constantly changing as new schemes are developed, and my staff continues to look outside the box to identify these schemes and ensure appropriate action is taken. As a result of my staff's dedication, the following accomplishments were achieved in FY 2018:

- Accounted for \$237.4 million in program integrity efforts (fraud detection, cost savings and disqualifications).
- Performed 34,791 public assistance application investigations resulting in cost avoidance of more than \$123.6 million.
- Identified \$13.1 million of public assistance program fraud.
- Completed 8,738 public assistance fraud investigations.
- Established \$9.2 million in cost savings from disqualifications of public assistance recipients for intentional program violations.
- Established \$30.6 million in Medicaid provider receivables and cost savings.

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 taxpayer's money is spent on its intended purpose. I want to thank the OIG's dedicated employees, fellow state employees and all Michiganders who reported suspected fraud, waste, abuse and misconduct in FY 2018 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 2018, the Office of Inspector General – Enforcement Division agents:

- Determined \$159.4 million of fraud, cost savings and established program disqualifications.
- Completed 8,738 fraud investigation dispositions.
- Completed 34,791 Front End Eligibility (FEE)¹ investigations.
- Identified \$123.6 million in cost avoidance in FEE investigations.
- Established an additional \$9.2 million in cost savings from intentional program violation (IPV) disqualifications.
- Identified \$13.1 million of program fraud.

“For every hour spent on an investigation, \$316 of receivables and disqualifications were established.”

Integrity Division

In FY 2018, the Office of Inspector General – Integrity Division agents:

- Sanctioned 37 providers, establishing \$3.6 million in fee for service and \$5.3 million in managed care encounter payment cost savings.
- Identified \$7.4 million in inappropriate Medicaid expenditures, recovering \$4.8 million.
- Performed program integrity oversight of Michigan Medicaid’s 11 Managed Care Organizations (MCO). These MCOs performed a total of 8,944 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of \$42.1 million.
- Referred four Medicaid providers to the Attorney General’s Health Care Fraud Division for credible allegation of fraud investigations.
- Completed 790 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

Fraud Detection and Prevention

Enforcement Division Specialized Investigative Units:

In FY 2018, the Special Investigations Unit (SIU) agents:

- Completed 350 investigations.
- Determined \$2.05 million of provider, contractor, recipient and employee fraud.

In FY 2018, the Benefit Trafficking Unit (BTU) agents:

- Completed 2,172 benefit trafficking investigations.
- Determined \$2.03 million in fraud from trafficking.
- Established an additional \$2.1 million in cost savings from IPV disqualifications.

In FY 2018, the Cooperative Disability Investigation Unit (CDI) agents:

- Completed 112 cooperative disability investigations.
- Established \$13.4 million in cost savings.

“Every dollar spent on fraud prevention resulted in \$38 of cost avoidance and savings for taxpayers.”

COST EFFECTIVENESS AND PRODUCTIVITY

In FY 2018:

- Every dollar spent on fraud prevention resulted in \$38 of cost avoidance and savings for taxpayers.
- For every hour spent on an investigation, \$316 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.

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.

Dignity

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



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

Values of the Office of Inspector General

Dignity *Excellence* *Teamwork*
Innovation *Integrity* *Recognition*

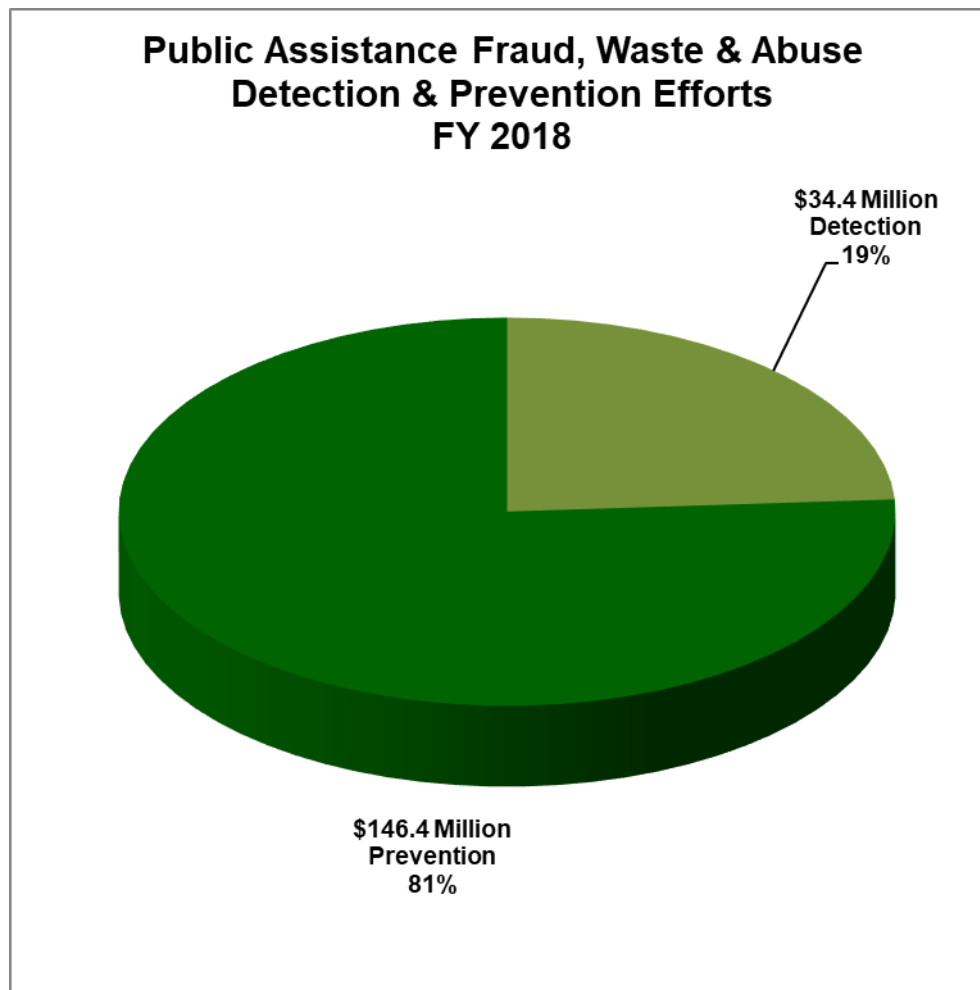


INSPECTOR GENERAL OVERVIEW

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 - \$34.4 million
Fraud prevention in public assistance - \$146.4 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

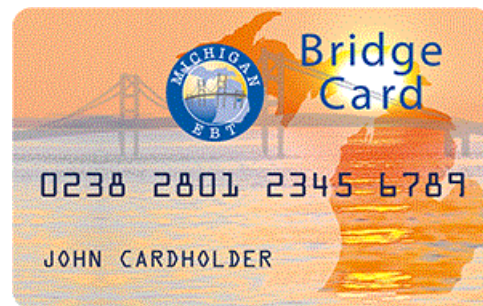
OIG is responsible for investigating instances of alleged fraud in all programs administered by the department, as well as reviewing administrative policies and procedures and recommending ways of improving accountability, fraud deterrence and detection. For example, OIG investigates fraud in the Family 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)

The Benefit Trafficking Unit agents investigate the unauthorized acquisition or trafficking of public assistance benefits, including the use of stolen or fraudulent identities in benefit applications. Trafficking is buying, selling or trading public assistance benefits for cash or other ineligible items, including tobacco, alcohol, firearms, drugs and gambling. The unit also investigates allegations of Medicaid 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 Medicaid card to obtain health services.



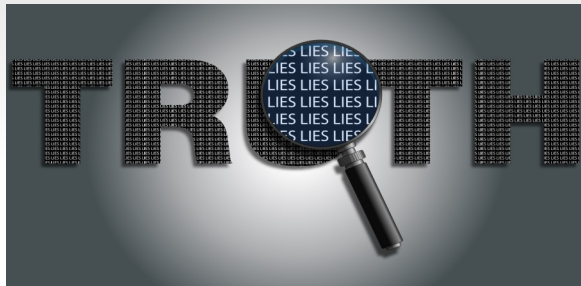
SPECIAL INVESTIGATION UNIT (SIU)

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



ENFORCEMENT DIVISION

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 \$13.4 million.



In June of 2018, the SSA-OIG presented the MDHHS-OIG with a plaque in recognition of the MDHHS-OIG's efforts combating fraud in collaboration with the SSA-OIG. Pictured, from left to right, are: MDHHS Director Nick Lyon, MDHHS-OIG Enforcement Division Director Douglas Woodard, SSA-OIG Special Agent William C. Brown, SSA-OIG Special Agent Ryan Maring, SSA-OIG Special Agent in Charge (SAC) Tracey Thanos, and MDHHS-OIG Inspector General Alan Kimichik.



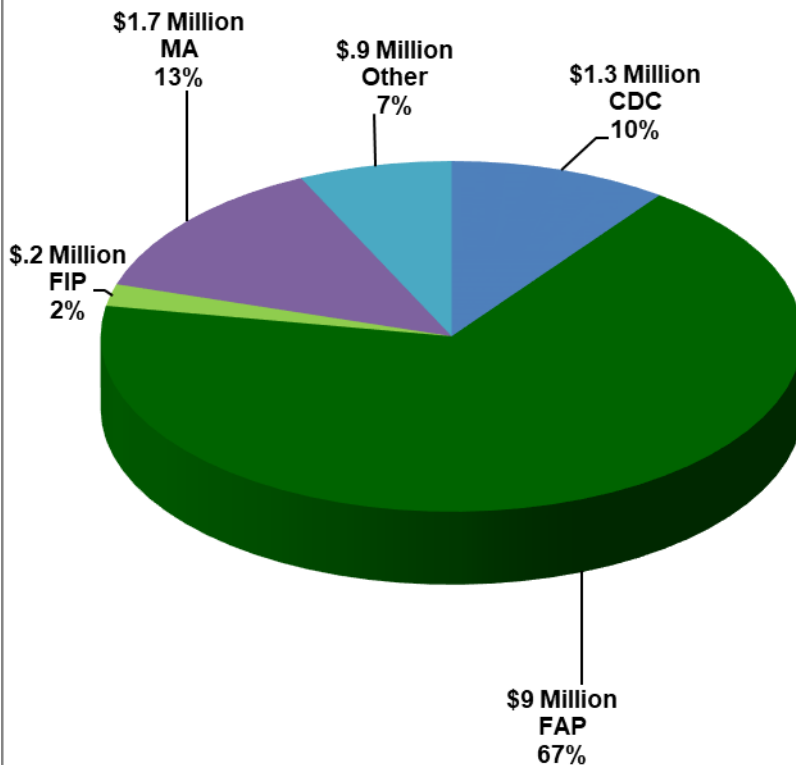
PROGRAM INTEGRITY IMPACTS

OIG’s Enforcement Division determined over \$13.1 million in fraud during FY 2018 within multiple Michigan public assistance program areas. Because of the Enforcement Division efforts, during FY 2018, 255 felony warrants were authorized by county, state and federal prosecutors. Investigations by Enforcement Division agents have uncovered \$57.5 million in fraud during the last three years.

Program Highlights

- FAP accounted for 67 percent of Michigan’s public assistance fraud during FY 2018.
- OIG investigated 8,576 fraud cases in the FAP program, with 3,797 fraud investigative dispositions and 226 criminal warrants issued for a fiscal year total of \$9 million in fraud found.
- OIG completed 132 CDC cases resulting in \$1.3 million in fraud found for the Michigan Department of Education (MDE).
- OIG completed 762 investigations of Medicaid program fraud resulting in \$1.7 million in fraud found.

**Fraud Dollars by Program
FY 2018**

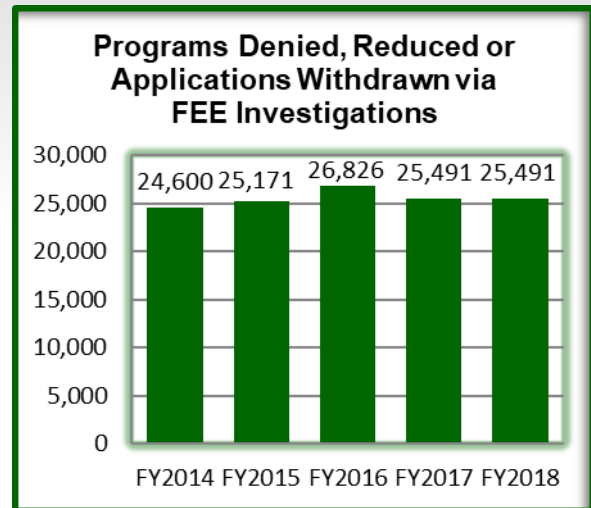
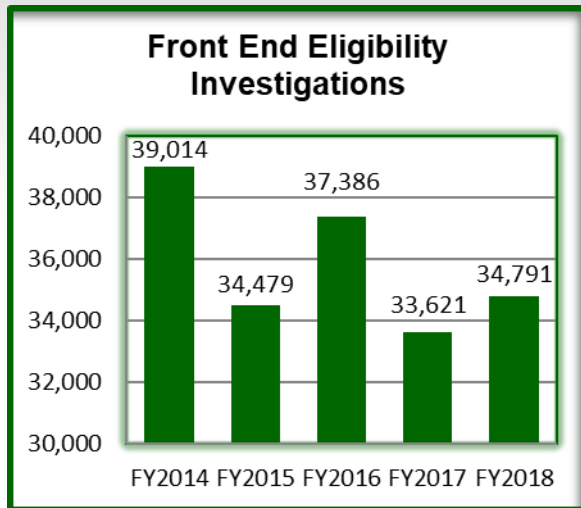


CDC = Child Development and Care Program
FAP = Food Assistance Program
FIP = Family Independence Program
MA = Medicaid Program
Other = Adult/Children’s Services, State Disability, State Emergency Relief

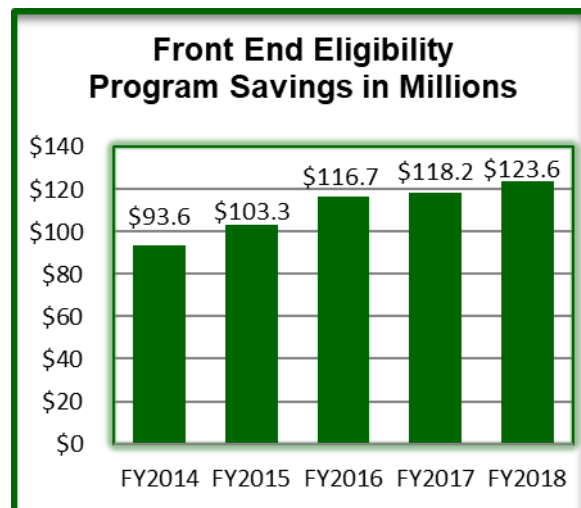


FEE: EARLY FRAUD DETECTION AND PREVENTION

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 34,791 investigations in FY 2018 and identified \$123.6 million in cost savings. Investigations by these agents have resulted in \$358.5 million in program savings for taxpayers over the last three-year period.





2018 ENFORCEMENT DIVISION HIGHLIGHTS

Joint Investigation with SSA-OIG

OIG conducted a joint investigation with the Social Security Administration OIG (SSA-OIG) in which a recipient was suspected of fraudulent activity in both state and federal programs. Agents discovered that, for several years, the recipient failed to disclose that he owned a maintenance business. When the recipient finally began reporting the business, he underreported the income, stating he made approximately \$5,000 a year. Agents found unreported yearly income of over \$123,000 in 2016 alone. The recipient was charged and convicted of welfare fraud. He was sentenced to one year in jail, followed by 60 months of probation. In addition, he was ordered to pay restitution of over \$135,000.

Dual Assistance

OIG received a complaint identifying a recipient that had multiple names and social security numbers assigned to her. The OIG investigation confirmed that she received concurrent FAP benefits under two different names. She also failed to report employment and Retirement Survivors and Disability Insurance benefits. The investigation identified \$8,895 of FAP benefits she received that she was not eligible for. The OIG agent submitted a warrant request to the prosecutor's office requesting welfare fraud charges.

MDHHS Employee Fraud

An OIG investigation determined that a MDHHS employee entered false information into a state database to obtain fraudulent Adult Home Help payments. The employee was charged with fraudulent access to computers, computer systems and computer networks and false pretenses. The employee was convicted of false pretenses, ordered to pay over \$77,000 in restitution to MDHHS and serve 60 months of probation.

FAP Trafficking Scheme

An OIG agent uncovered a conspiracy where an individual utilized FAP benefits to supply retail stores with stock. The individual, acting as an intermediary, purchased FAP benefits from recipients at a reduced rate and used the benefits to purchase products which were then sold to convenience stores for retail sales. Over \$100,000 in FAP benefits were misused in the scheme, which resulted in criminal charges and enforcement actions involving multiple suspects.

Group Composition

OIG utilized a data match to identify a Medicaid and FAP recipient that failed to report to MDHHS that her husband, also her children's father, resided in their home. In the course of the investigation, it was determined that the husband was using a stolen Social Security number to hide his income from the department. His income would have made their household ineligible for both programs. OIG gathered evidence to prove he was in the home and the unreported income. The recipient was charged and convicted of welfare fraud and sentenced to 60 months of probation and restitution of over \$40,000.

Identity Theft Investigation

An OIG agent uncovered a scheme involving the use of multiple fraudulent identities to illegally obtain FAP benefits. The investigation identified a business owner and his wife who used nearly \$15,000 in



2018 ENFORCEMENT DIVISION HIGHLIGHTS

fraudulent benefits to purchase stock for his restaurant. The couple also concealed the profits from their business and received personal public assistance program benefits to which they were not entitled. Both were charged with multiple felony counts of conducting a criminal enterprise and food stamp fraud.

CDC Provider Overbilling

OIG received a fraud referral that identified billing irregularities regarding a provider in the Child and Development Care program (CDC). Attendance records maintained by the provider did not match the provider's billing/attendance invoices submitted to MDHHS for payment. Evidence was gathered verifying the dates and times the parents utilized child daycare. OIG's investigation determined that the provider had overbilled the State of Michigan for childcare services. The provider was charged and convicted of false pretenses and welfare fraud. The provider was ordered

to pay \$53,509 in restitution, serve 60 months of probation and 150 hours of community service.

Unreported Business Ownership

OIG received information that a recipient underreported his earned and unearned income, which if it had been reported, the recipient would have been ineligible for Medicaid. During the investigation, OIG discovered that the recipient had applied for a commercial bank loan. OIG obtained records which confirmed the client owned and operated a hotel in Wisconsin, where he also resided. Bank records revealed the recipient had gross earnings that far exceeded the income limits for Medicaid. The recipient's failure to report accurate income and residency to MDHHS resulted in \$15,181 of Medicaid benefits which he was not eligible for. The recipient was charged with welfare fraud, failure to inform and false pretenses.



In FY 2018, OIG initiated a Bridge Card trafficking public awareness campaign, utilizing a federal grant that was awarded to Michigan.



INTEGRITY DIVISION

In FY 2018, Michigan's health services programs had a combined budget of approximately \$17.6 billion and paid approximately 205,387 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 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 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.

RECOVERY AUDIT CONTRACTORS

The Integrity Division has contracted with one 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 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.

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.



HEALTH SERVICES PROGRAMS IMPACTS

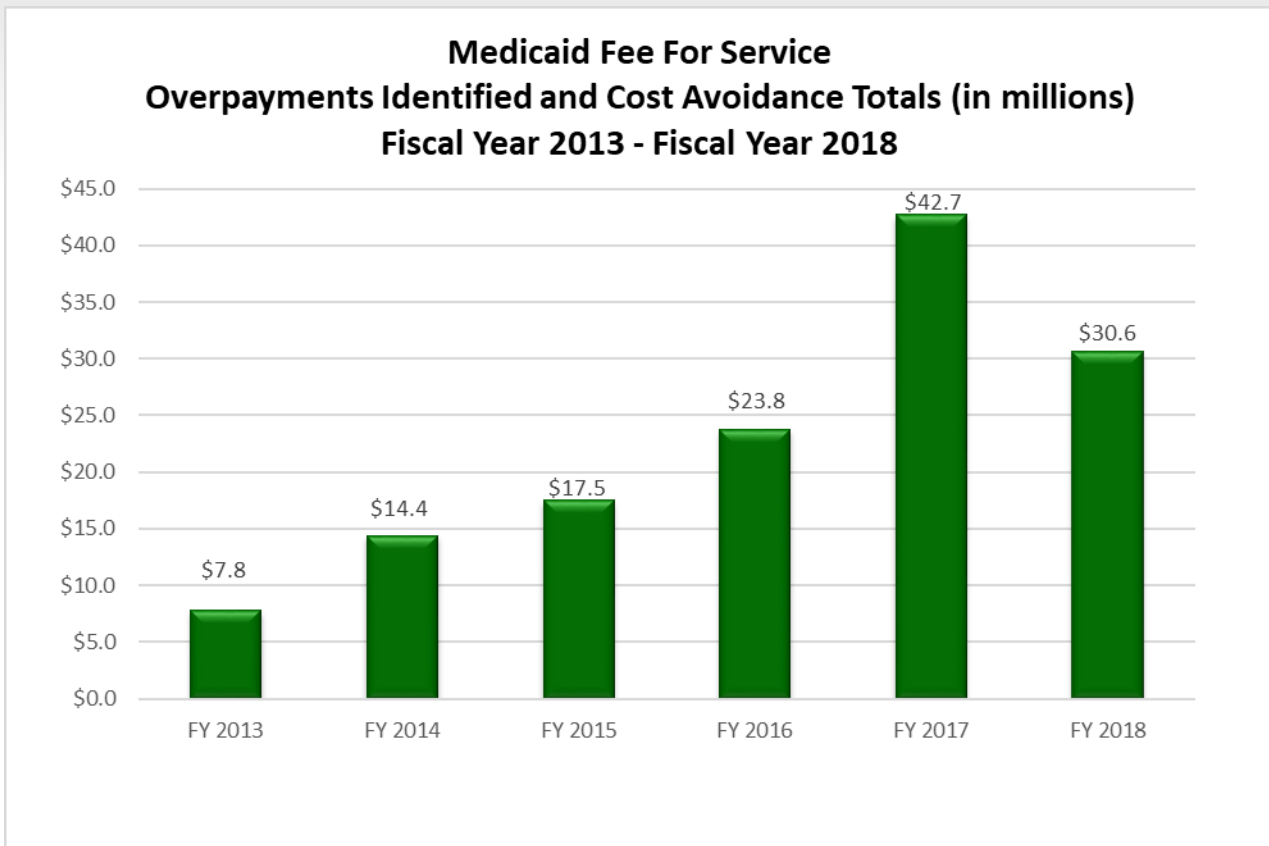
In FY 2018, OIG-ID had an overall impact to direct Medicaid spending (i.e., fee-for-service (FFS)) totaling \$30.6 million through the following activities:

- Identified a total of \$7.4 million in overpayments made to Medicaid providers. To date, \$2.6 million has been recovered while the remaining \$4.8 million is being repaid over time.
- In FY 2018, OIG-ID:
 - * Received 138 allegations of potential fraudulent activity from various sources (e.g., 23 tips from beneficiaries, 54 tips from the public (22 anonymous), 40 referrals from inside MDHHS, six tips from providers).
 - * Identified 844 audit targets through data analytics.
 - * Completed 790 fraud investigation dispositions.
- Prevented an estimated \$10.2 million in future payments, through reduced billing activities as a result of Medicaid provider audits and investigations.
- Prevented an estimated \$5.4 million in future payments, through a provider education campaign aimed at increasing pharmacy compliance with voiding claims for no show prescriptions.
- Sanctioned 37 Medicaid providers, preventing an estimated \$3.6 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 four 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.
 - * Eight previously referred providers were convicted and/or signed civil settlement agreements. These eight providers were required to pay a total of \$470,088 in restitution.

HEALTH SERVICES PROGRAMS IMPACTS

In FY 2018, OIG-ID had an overall impact to indirect Medicaid spending (i.e., MCO encounter claims) totaling \$47.4 million through the following activities:

- \$42.1 million in identified overpayments through program integrity related oversight of the Michigan Medicaid MCOs.
- Sanctioned 37 Medicaid providers, preventing an estimated \$5.3 million in future MCO encounter payments.



****NOTE – Approximately \$17 million in FY 2018 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 four specialized investigative units, each unit 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.

In FY 2018, OIG-ID had an overall impact to direct Medicaid spending (i.e., fee-for-service (FFS)) totaling \$30.6 million.



2018 FIELD INVESTIGATION SECTION 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 2018, 22 pharmacy providers agreed to repay the Medicaid program a total of \$3.9 million as a result of pharmaceutical inventory audits.

An additional 28 pharmacy provider cases are pending appeal decisions, litigation or repayment terms negotiation. These cases represent approximately \$14.7 million.

Home Help

In FY 2018, receivables were established for 506 home help providers totaling \$989,540 for payments made while their beneficiaries were hospitalized, after their death, while the provider was incarcerated or for other noncompliance with Medicaid policy.

An additional 20 home help provider cases are pending appeal decisions, litigation or repayment terms negotiation. These cases represent approximately \$2.3 million.

Injectables

In FY 2018, 32 providers agreed to repay the Medicaid program a total of \$553,903 that they received as a result of double billing for injectables.

Laboratory

In FY 2018, 11 laboratory providers agreed to repay the Medicaid program a total of \$255,592 that they received as a result of billing for services that violated Medicaid Policy regarding referring providers of genetic testing.

Durable Medical Equipment (DME)

In FY 2018, 17 DME providers agreed to repay the Medicaid program a total of \$182,917 that they received as a result of billing for oxygen and oxygen supplies for patients who did not meet the Medicaid requirements for oxygen saturation.

Pharmacy

In FY 2018, 11 pharmacy providers agreed to repay the Medicaid program a total of \$141,550 as a result of billing for pharmaceuticals using the wrong unit of measurement (i.e., mg instead of ml).

Transportation

In FY 2018, 18 ambulance providers agreed to repay the Medicaid program a total of \$113,833 that they received as a result of billing for advanced life support, when basic life support was more appropriate.

Dental

In FY 2018, 10 dental providers agreed to repay the Medicaid program a total of \$76,938 that they received as a result of billing for services that violated Medicaid Dental Policy.

Maternal Infant Health Program (MIHP)

In FY 2018, 21 MIHP providers agreed to repay the Medicaid program a total of \$69,194 that they received as a result of billing for services that violated Medicaid MIHP Policy.

Private Duty Nursing (PDN)

In FY 2018, ten PDN providers agreed to repay the Medicaid program a total of \$62,987 that they received as a result of billing for services that violated Medicaid Policy, including billing for services while the beneficiaries were hospitalized.



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).

2018 MCO OVERSIGHT UNIT HIGHLIGHTS

Provider Audits/Reviews

In FY 2018, Michigan Medicaid's 11 MCOs performed a total of 8,944 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of \$42.1 million.

Provider Sanctions

In FY 2018, OIG-ID agents prevented an estimated \$5.3 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.
 - * 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 the Vendor Oversight Unit analysts.
 - * Vendor Oversight Unit analysts also review and pre-approve each proposed UPIC audit target as well as their sample selection prior to record review.





OPERATIONS DIVISION

OIG's Operations Division (OIG-OD) is comprised of three units: Administrative Services, Investigative Analytics and Policy & Training. OIG-OD also is responsible for independent Quality Assurance oversight.

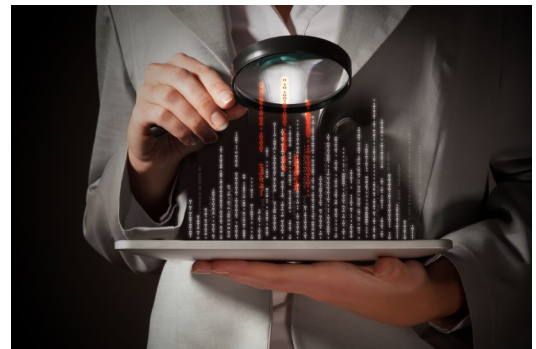
OIG-OD's Administrative Services is responsible for overall administrative support of the office. It manages budget development and monitoring, system security, fraud hotlines, OIG policy, investigative process support as well as overseeing of the day-to-day business operations. In FY 2018, OIG's Administrative Services provided extensive quality control reviews on over 2,584 investigative packets referred to the Michigan Administrative Hearing System for debt collection and program disqualification requests.

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

OIG created a new Policy & Training Unit and Quality Assurance (QA) Specialist role in late FY 2018 to provide focused services to the office. OIG-OD's new Policy & Training Unit is responsible for ensuring accurate and timely policy review, development and implementation. The unit reviews, researches and analyses 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's new Quality Assurance Specialist conducts reviews of investigative efforts focused on identifying opportunities for improvement and the consistent application of policies and procedures.

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

2018 INVESTIGATIVE ANALYTICS UNIT HIGHLIGHTS

Medicaid Provider Overpayment Detection

In FY 2018, approximately 70 percent of OIG's Medicaid provider recoupment cases were generated as a part of IAU data analytics/data mining.

Public Assistance Program Fraud Detection

In FY 2018, approximately 62 percent of the public assistance program fraud investigations conducted by OIG were generated as a part of IAU data analytics/ data mining efforts.

Medicaid Provider Profile Reports

A new addition to the Integrity Division Reporting Tool provides investigators the ability to generate provider-specific reports using information from multiple data sources with an easy to use graphical interface. The investigators can create reports based on provider types such as Facility, Individual and Pharmacy. The output is a report generated in PDF format. This tool is simple to use and is expected to save significant time compared to previous methods of profile report generation. This time savings is

expected to translate into an additional \$600,000 in established cost savings and disqualifications annually.

Enforcement Division Reporting Tool

A new in-house reporting tool utilizes more than 40 newly created and refined algorithms to aid OIG investigations. The reporting tool provides investigators the ability to query information from multiple data sources with an easy to use graphical interface. The tool assists investigators by giving them access to transactional reports, ranking reports, eligibility reports and summary information. The reporting tool will significantly decrease the data request times for investigative information. This time savings is expected to translate into an additional \$5 million in established cost savings and disqualifications annually.

In-House Investigative Algorithms

Over the course of FY 2018, the IAU devised or refined over 20 algorithms used in the generation of investigative leads. As an example, one new algorithm identified Home Help providers delivering services to their spouse in violation of MDHHS policy. This



2018 INVESTIGATIVE ANALYTICS UNIT HIGHLIGHTS

match was developed by combining Medicaid date with the tax filing status from the Michigan Department of Treasury. To date, several investigations have been completed with an associated overpayment identified of \$46,673. Additionally, some individuals quickly identified themselves as divorced and provided documentation. This information was passed along to Treasury, as they were filing their taxes as “Married Filing Jointly.”



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 2018, PARIS matches resulted in \$40.5 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.

Out-of-State Spending

Exclusive out-of-state spending for an extended period of time is an indicator that the individual may no longer be a Michigan resident. IAU utilizes the EBT transaction data to identify individuals with EBT FAP spending exclusively outside the state of Michigan for at least three months. Border county residents have considerations for spending in border states. In FY 2018, the out-of-state spending project resulted in \$27.7 million in annualized cost avoidance.

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. This project is also an instrumental tool in the identification, tracking, and management of large-scale identity theft cases. In FY 2018, the IP Locator Project resulted in \$425,000 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.

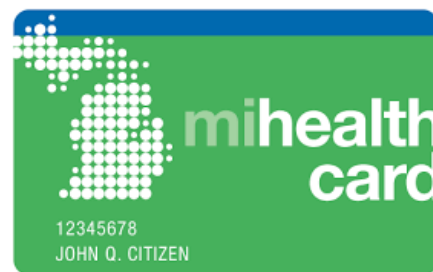
Electronic Benefit Transfer (EBT): Food assistance and cash assistance benefits are electronically transferred to an account accessible by the client debit card called the Michigan Bridge Card. Transactions are analyzed for fraud trends to include out-of-state purchases for more than 30 days, non-recipients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

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.

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.



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 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 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.).

Quality Assurance (QA): OIG's QA Specialist proactively monitors and reviews work completed by OIG staff, the various impacts of OIG investigative results, and the consistent implementation of office policies and procedures.

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 WELFARE 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 your food benefits or Bridge Card.
- 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:

www.michigan.gov/reportwelfarefraud or 800-222-8558



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:

www.michigan.gov/fraud or 855-643-7283

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

