FY 2015 Annual Report

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

Alan Kimichik, Inspector General

Message from the Inspector General

As the Inspector General for the Michigan Department of Health and Human Services (MDHHS), I am honored to release the results of the Office of Inspector General (OIG) accomplishments for Fiscal Year (FY) 2015.

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

- Performed 34,479 public assistance application investigations resulting in cost avoidance of more than $103.3 million, a 10 percent increase over FY 2014.
- Identified $23.5 million of public assistance program fraud.
- Sanctioned 46 Medicaid providers, establishing $14.4 million in fee for service and managed care payment cost savings.
- Completed 11,331 public assistance fraud investigations.
- Established $14.2 million in cost savings from disqualifications of public assistance recipients for intentional program violations.
- Referred 41 Medicaid provider fraud cases to the Michigan Department of Attorney General for prosecution review.
- Recovered over $18.2 million in Medicaid and public assistance overpayments.

These are just some of the achievements detailed in this OIG Annual Report, and are the results of the hard work and dedication of all OIG staff members. Due to the efforts of these employees, the OIG has made great strides in the pursuit of its program integrity mission. The taxpayers of Michigan can be proud of the work performed by these individuals.

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

Sincerely,

Alan Kimichik
Inspector General

Executive Summary

FRAUD DETECTION AND PREVENTION

Recipient Enforcement Bureau
In FY 2015, the Office of Inspector General - Recipient Enforcement Bureau (OIG-REB) agents:

- Determined $141 million of fraud, cost savings and established program disqualifications.
- Completed 11,331 fraud investigative dispositions.
- Completed 34,479 Front End Eligibility (FEE)[1] investigations.
- Identified $103.3 million in cost avoidance in FEE investigations, a 10 percent increase over FY 2014.
- Established an additional $14.2 million in cost savings from intentional program violation (IPV) disqualifications.
- Identified $23.5 million of program fraud.

Provider Enforcement Bureau
In FY 2015, the Office of Inspector General - Provider Enforcement Bureau (OIG-PEB) agents:

- Sanctioned 46 providers, establishing $8.4 million in fee for service and $6 million in managed care encounter payment cost savings.
- Identified $7.3 million in inappropriate Medicaid expenditures, recovering $6.3 million.
- Performed program integrity oversight of Michigan Medicaid's 13 Managed Care Organizations (MCO). These MCOs performed a total of 2,649 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $4.8 million.
- Referred 41 Medicaid providers to the Attorney General's Health Care Fraud Division for credible allegation of fraud investigations.
- Completed 1,467 fraud investigation dispositions.

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

Executive Summary
(Continued)

RECOUPMENT AND DEBT RECONCILIATION DIVISION

In FY 2015, OIG-REB Reconciliation and Recoupment Section staff:

- Increased recoupment claims established by 14 percent and total dollars retained by 13 percent over FY 2014.
- Recovered over $11.9 million from the Food Assistance Program (FAP), Family Independence Program (FIP), Child Development and Care (CDC) and State Disability Assistance (SDA).
- Increased FAP debt recovery through the Federal Treasury Offset Program (TOP) by 19.1 percent, resulting in an average annual increase of $2.0 million, and FY 2015 collections totaling $5.1 million.
- Increased total active claims in TOP by over 12,000 carrying receivables balance of $18.6 million.

SPECIALIZED INVESTIGATIVE UNITS

In FY 2015, the Special Investigations Units (SIU) agents:

- Completed 470 investigations, a 34 percent increase over FY 2014.
- Determined $5.4 million of provider, contractor, recipient/client and employee fraud.

In FY 2015, the Benefit Trafficking Unit (BTU) agents:

- Completed 1,794 benefit trafficking investigations.
- Determined $1.9 million in fraud from trafficking.
- Established an additional $1.7 million in cost savings from intentional program violation (IPV) disqualifications.

In FY 2015, the Cooperative Disability Investigation Unit (CDI) agents:

- Completed 45 cooperative disability investigations.
- Established $4.3 million in cost savings.

COST EFFECTIVENESS AND PRODUCTIVITY

In FY 2015:

- Every dollar spent on fraud prevention resulted in $33 of cost avoidance and savings for taxpayers.
- For every hour spent on an investigation, $357 of receivables and disqualifications were established.

OIG AUTHORITY

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

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

OIG MISSION STATEMENT

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

VALUES OF THE OIG

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 work together as a team to plan and strive for excellence, realizing our daily decisions will reflect on the future of our organization as a whole.

- Excellence in the performance of OIG duties.
- Highest possible standards of professional and ethical conduct.
- Innovation from all levels of the organization.
- Support for the accuracy and integrity of all MDHHS programs.

KEY PRINCIPLES

The key principles of the OIG are Responsibility, Excellence, Integrity and Communication.

- Responsibility - OIG employees shall dedicate themselves to treating all people with respect, fairness and compassion.
- Excellence - OIG employees shall know the laws, rules and policies that will aid them in performing their duties and serving the public.
- Integrity - OIG employees shall recognize that the cooperation of all criminal justice and public agencies is essential for effective, efficient and responsive investigations and enforcement.
- Communication - OIG employees shall recognize the accomplishments of those who make significant contributions toward our mission, values, goals and objectives.

INSPECTOR GENERAL OVERVIEW

In 2015, the former Department of Community Health and Department of Human Services merged into the new Michigan Department of Health and Human Services (MDHHS). With this merger, the two former departments' inspector general positions and offices were also merged. The Office of Inspector General (OIG) is the criminal justice agency within this new department. OIG agents are peace officers in the state of Michigan and OIG provides investigation and advisory services to ensure appropriate and efficient use of available public resources. Within the OIG there are two bureaus: Recipient Enforcement Bureau and Provider Enforcement Bureau. Agents and their supervisors are strategically located throughout Michigan to assist MDHHS in maintaining integrity and accountability in the administration of all its programs.

Recipient Enforcement Bureau (REB)
The REB primarily investigates allegations of fraud, waste or abuse by the recipients and the vendors of all public assistance programs with the exception of Medicaid providers. In REB, 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), as well as the Medical Assistance program (MA). OIG also investigates vendor fraud as well as department employees alleged to be involved in program fraud. All investigations found to contain the elements of fraud 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 re-certifications for public assistance contain suspicious or error prone information. FEE agents investigate, substantiate or refute discrepancies and suspicious activities. Agents complete the investigation within 10 workdays and respond to the eligibility staff with their findings. The goal of the FEE program is to obtain and maintain a partnership between the local office staff early in the eligibility determination process to reduce errors and mispayments, which results in significant cost avoidance savings for the department.

- Benefit Trafficking Unit (BTU): This unit investigates instances of public assistance trafficking in which individuals either attempt to traffic or actively traffic benefits by buying, selling or trading public assistance benefits for cash or ineligible items including: tobacco, alcohol, firearms, drugs and gambling. Medicaid assistance trafficking includes prescription forgery, prescription theft and narcotic shopping with multiple prescribers/pharmacies.

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

- Investigative Analytics Unit (IAU): The IAU is responsible for providing system and analytic support for ongoing investigations and fraud referrals. Fraud referrals are derived from analyzing data from various sources.

- Cooperative Disability Investigations (CDI) Unit: The CDI unit combats fraud by investigating questionable statements and activities of claimants, medical providers, interpreters or other service providers who facilitate or promote disability fraud. The unit investigates individual disability claims and identifies lawyers, doctors, translators, or other third parties who facilitate disability fraud.

- Recoupment and Debt Reconciliation Division (R&DR): The R&DR Division is responsible for the establishment, recovery and reconciliation of payments received for over-issued benefits to clients and overpayments to service providers. Recovery of over-issued benefits helps to maintain the integrity of the programs and specifically for Food Assistance is required under Federal Code 7 CFR 273.18. The division's work results in the recovery of millions of dollars per year of over-issued state and federal funds and provides a source of revenue for the State of Michigan due to the retention percentage allowable from the recovery of over-issued federal benefits.

Provider Enforcement Bureau (PEB)

The PEB is charged with 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, MIChild 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, PEB works to ensure that the money spent on health services is used for the best care of the beneficiaries.

In PEB, there are several unique programs and units that focus on important aspects of investigation and fraud detection and prevention:

- Investigations: PEB conducts investigations into alleged Medicaid fraud, waste and abuse and receives referrals from the public, beneficiaries, providers and other government and/or state law enforcement and regulatory agencies.
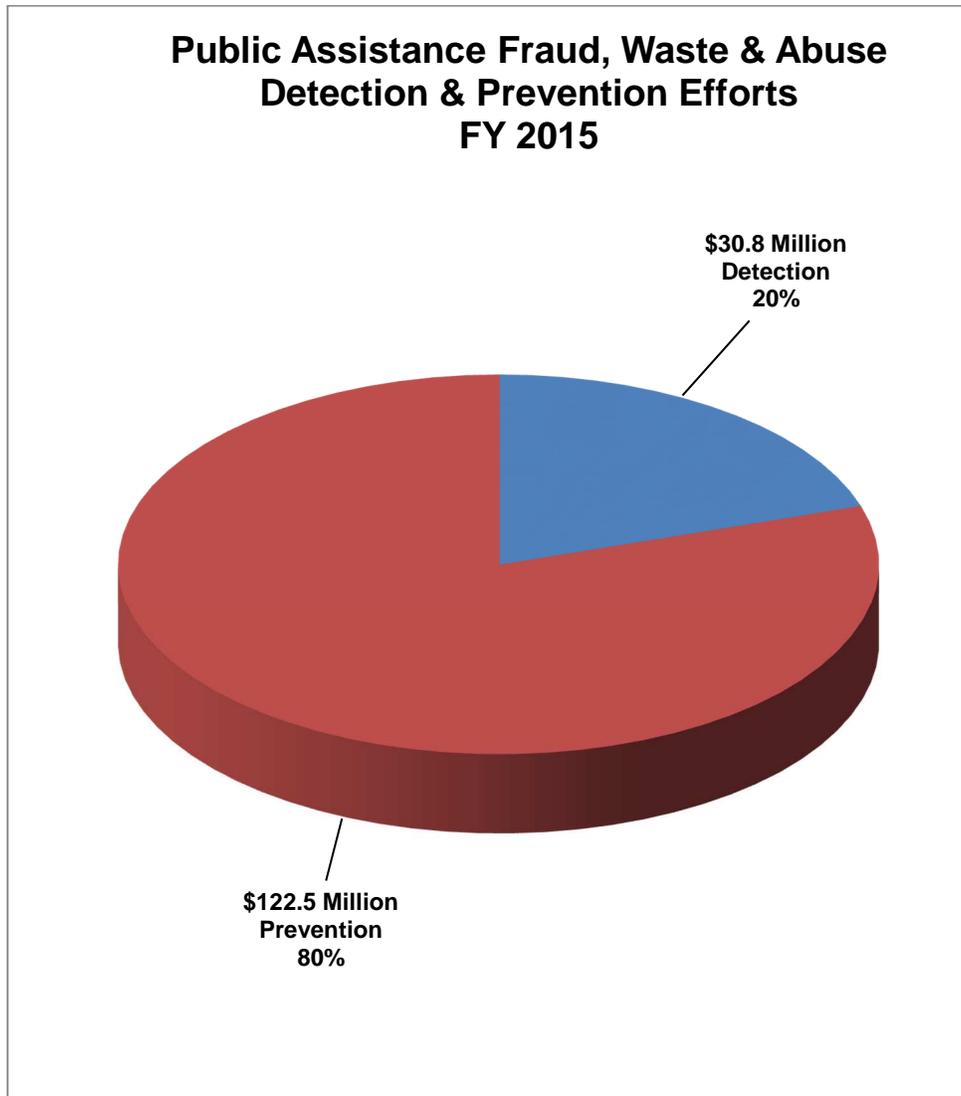
  Examples of health services provider fraud, waste and abuse:
  - Billing for medical services not actually performed.
  - Billing for unnecessary services.
  - Billing for more expensive services than actually performed.
  - Billing for services separately that should legitimately be one billing.
  - Billing more than once for the same medical service.
  - Dispensing generic drugs but billing for brand-name drugs.
  - Billing for supplies/medication not dispensed.
  - Giving or accepting something of value (e.g., cash, gifts, services) in return for medical services and/or patient referrals (i.e., kickbacks).

- Data Analytics: PEB utilizes sophisticated data analytics activities for detection and identification of patterns of fraudulent behavior.

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

- Recovery Audit Contractors: PEB has contracted with two vendors to perform audits and recover overpayments from Medicaid providers.

OIG IMPACT ON PUBLIC ASSISTANCE PROGRAMS

Fraud detection in public assistance - $30.8 million
Fraud prevention in public assistance - $122.5 million

**Public Assistance Fraud, Waste & Abuse
Detection & Prevention Efforts
FY 2015**

$30.8 Million
Detection
20%

$122.5 Million
Prevention
80%

Notes: This is in addition to $8.8 Million in Client & Agency Error Claims established. Represents FIP (Family Independence Program), FAP (Food Assistance Program), SDA (State Disability Assistance), SER (State Emergency Relief) and Fee-For-Service Medicaid.
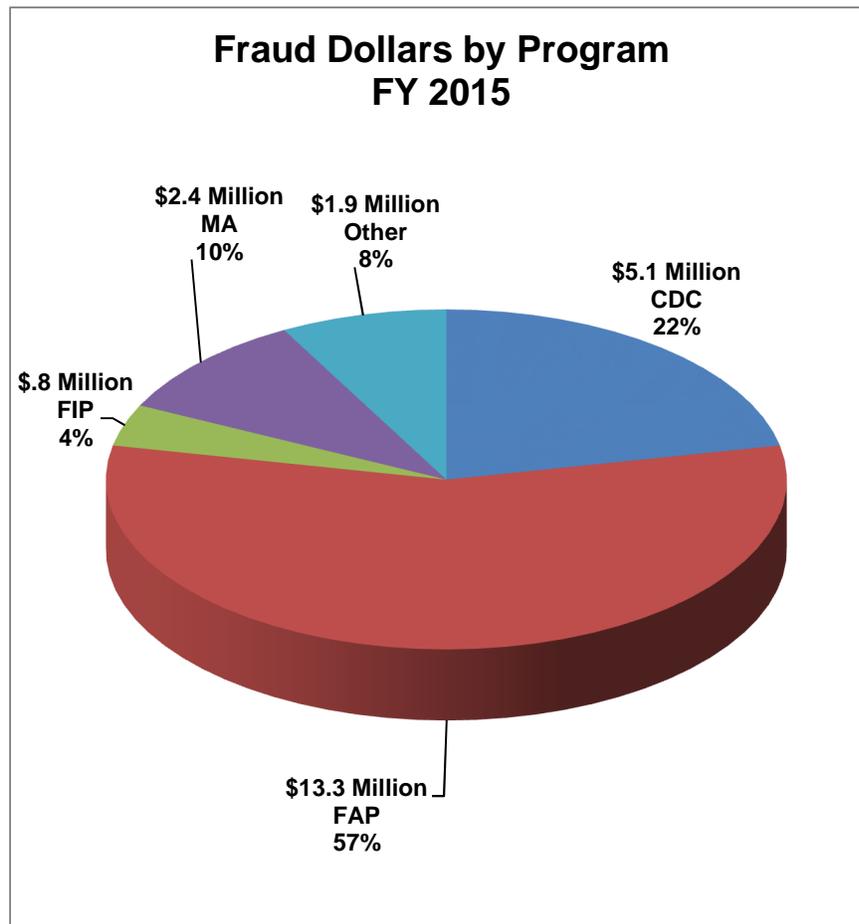
RECIPIENT ENFORCEMENT BUREAU (REB)

PROGRAM INTEGRITY IMPACTS

OIG's Recipient Enforcement Bureau (REB) determined $23.5 million in fraud during FY 2015 within multiple Michigan public assistance program areas. During FY 2015, 303 felony warrants were authorized by county, state and federal prosecutors. Investigations by OIG agents have uncovered over $66.7 million in fraud during the last three years.
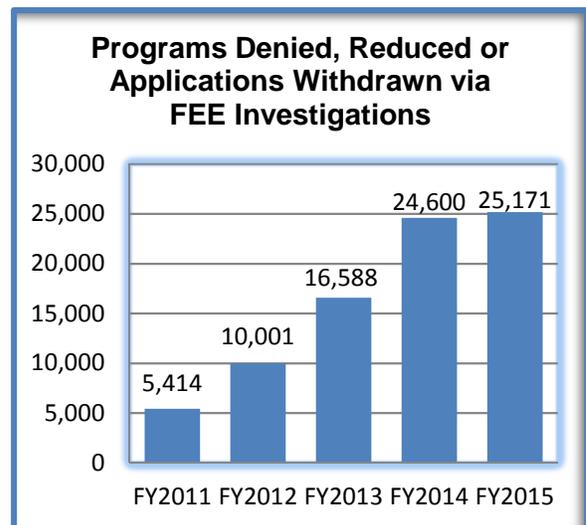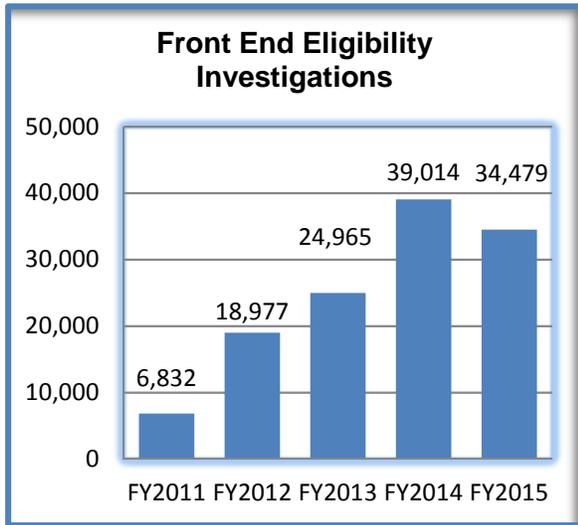
Program Highlights

- FAP accounted for 57 percent of Michigan's public assistance fraud during FY 2015.
- OIG investigated 9,604 fraud cases in the FAP program, with 4,796 fraud investigative dispositions and 269 criminal warrants issued for a fiscal year total of over $13.3 million in fraud found.
- OIG completed 628 CDC cases resulting in $5.1 million in fraud found for the Michigan Department of Education (MDE).
- OIG completed 970 investigations of Medicaid beneficiary fraud resulting in $2.4 million in fraud found.

**Fraud Dollars by Program
FY 2015**

Pie chart data:
- $5.1 Million CDC 22%
- $13.3 Million FAP 57%
- $.8 Million FIP 4%
- $2.4 Million MA 10%
- $1.9 Million Other 8%

CDC = Child Development and Care Program
FAP = Food Assistance Program
FIP = Family Independence Program
MA = Medicaid Assistance 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.

Front End Eligibility Investigations

FY2011	FY2012	FY2013	FY2014	FY2015
6,832	18,977	24,965	39,014	34,479

Programs Denied, Reduced or Applications Withdrawn via FEE Investigations

FY2011	FY2012	FY2013	FY2014	FY2015
5,414	10,001	16,588	24,600	25,171

Working toward fraud prevention, OIG agents conducted 34,479 investigations in FY 2015 and identified over $103.3 million in cost savings. Investigations by OIG agents have resulted in over $273.6 million in program savings for taxpayers over the last three-year period.

Front End Eligibility Program Savings in Millions

FY2011	FY2012	FY2013	FY2014	FY2015
$30.3	$69.6	$76.7	$93.6	$103.3

Group Composition

A client's husband applied to win a honeymoon for his wife and himself by writing a letter stating that they had been married since 2012 and never had a "real" honeymoon. Both husband and wife were receiving benefits on two separate cases and never listed on the applications submitted that they were married. A FEE investigation was initiated for each of the cases.

During the course of the investigation, the agent discovered that they were in fact married and residing together. When interviewed, they both denied they were married until they were informed of the honeymoon they won on the news station. As a result, the husband's case was closed which resulted in cost avoidance in the amount of $6,329. A full investigation was initiated that identified the couple were issued over $21,097 in State Emergency Relief (SER) and FAP (Food Assistance Program) benefits to which they were not entitled. The couple signed repayment and disqualification agreements.

Unreported Husband in the Home

A MDHHS caseworker submitted a FEE investigation referral after it was observed on media that the subject currently had a pending embezzlement case against her with the local prosecutor's office. The caseworker said that the subject's husband was living in the home, and his income would affect the FAP and FIP case. It was also alleged that the subject never reported income she earned from her place of employment from which she had embezzled. The subject also reported on her public assistance applications that her husband had moved out of the home.

The FEE investigation verified that the subject's husband was currently living in the home, was employed, and providing financial assistance. It was also verified that the subject did not receive income from her job, and it was a volunteer position. The FEE investigation was expanded into a full fraud investigation, which verified that the subject's husband was employed and had never left the home. The subject was charged with felony embezzlement and felony welfare fraud/failure to inform. The subject was ordered to pay restitution of $3,964 to MDHHS.

Unreported Business Ownership

After a nearly five-year investigation, three brothers were sentenced in U.S. District Court for their respective roles in fraudulent activities while they were co-owners of a grocery store. None of the brothers reported to MDHHS that they owned the store, instead reporting that they worked there for minimal wages. In addition, OIG teamed with the USDA-OIG as it was identified that the brothers were trafficking FAP benefits with other MDHHS clients for cash and other non-food items. All three brothers were found guilty and are serving between 12 and 34 months in a federal penitentiary. Combined restitution was ordered at $363,676 for the brothers in regards to their personal public assistance benefit fraud. The total over issuance loss for the store was recorded at over $1.1 million.

No Child Care Needed

A complaint alleged that the client did not have a CDC need. The OIG investigation revealed that the client had not attended the Work First! program for ten months, but received CDC benefits during the period. The investigation also revealed that client's CDC provider had been admitted to a nursing home and could not care for herself nor provide child care. An administrative hearing found that the client was in violation of MDHHS policy and ordered her to repay $9,542 in CDC benefits.

Unreported Assets

A local MDHHS employee saw an article in the newspaper which reported that a client had received a $70,000 cash settlement from the city of Benton Harbor during the previous year. The OIG investigation revealed that in addition to the subject's failure to report the cash settlement to MDHHS, the subject also failed to report multiple drug felony convictions which would make him ineligible for FAP benefits. The subject subsequently pled guilty to felony welfare fraud and was ordered to pay

restitution of $25,421. While this investigation was pending, OIG partnered with the SSA-OIG, which also obtained a felony guilty plea from the subject for defrauding the Social Security Administration.

After the subject's guilty plea but prior to sentencing, MDHHS-OIG and SSA-OIG agents discovered that the subject still had assets in a bank totaling over $50,000. Communications with the bank along with jail recordings revealed that the subject was scheming with his brother to have the remaining cash assets withdrawn from the bank so that they could be hidden and kept from being seized for restitution.

The bank enacted an administrative stop on withdrawals from the subject's account and the local prosecutor obtained a court order for the seizure of the account balance. Lump sum payments were split between state and federal agencies with MDHHS receiving a lump sum of $10,000.

Unreported Income in Home
OIG received a complaint alleging the client provided MDHHS with altered payroll checks in order to receive MA benefits. The investigation revealed that the subject's spouse was a chiropractor and his income was under-reported. Because of the income, the subject's household was not eligible for Medical Assistance from May 2008 through February 2011. The OIG agent was able to locate the subject residing in Naples, Florida. The subject is repaying $40,083 in over-issued payments.

BENEFIT TRAFFICKING UNIT (BTU)

Definition of Trafficking:
Public assistance trafficking is the buying and selling of benefits for cash or other ineligible items including tobacco, alcohol, firearms, drugs and gambling. Violations of the Food Assistance Program (FAP) occur when food assistance is redeemed for cash or offered for sale in person or via the internet, or when unauthorized items are bought or sold with FAP. Medicaid Assistance trafficking includes prescription forgery, prescription theft and narcotics "shopping" with multiple prescribers/pharmacies.

FY 2015 BTU HIGHLIGHTS

Identity Theft
BTU agents in collaboration with the OIG Investigative Analytics Unit (IAU), completed a large scale identity theft investigation resulting in the identification of more than 300 fraudulent public assistance cases. The total fraud amount identified as a result of this investigation was $504,342. OIG agents became aware of an identity theft scheme, as a result of the IAU's analytic efforts. The investigation revealed the suspect used stolen identities and multiple computer access points to obtain benefits that were later sold for profit. The investigation resulted in the issuance of search warrants, uncovering substantial evidence of the suspects' fraud scheme. The subject was convicted and is serving a minimum of 72 months in federal prison.

Prescription Fraud Abuse
An OIG-BTU investigation determined an MA recipient attempted to illegally obtain a Scheduled III Narcotic, Lortab, with a fraudulent prescription. The subject attempted to acquire the drug at a local pharmacy. The pharmacist noted it was unusual for a doctor to prescribe narcotics in this manner and reported the suspicious activity to OIG. It was determined that the subject violated Public Health Code Act 368 Sections C and F. Ultimately, the subject was convicted of one count of violating section 333.7401 of the Michigan Public Health Code Controlled Substance Act. The subject received a one-year suspended sentence if the subject maintained participation in a drug rehabilitation program and complied with all terms and conditions of probation.

SPECIAL INVESTIGATIONS UNIT (SIU)

The SIU investigates the most complex cases assigned within OIG. These cases involve criminal employee wrongdoing, multiple suspects, co-conspirators, multiple jurisdictional venues, program financial and service contracts as well as providers. The SIU develops, recommends and advocates methodology for MDHHS to deter or detect fraud through internal control development and departmental policies and procedures.

FY 2015 SIU HIGHLIGHTS

State Employee Convicted for Fraud

A MDHHS employee applied for assistance and misrepresented her spouse as being out of the home. She failed to report all assets and income to the department as required by policy. The investigation confirmed the employee's spouse was determined to be illegally in the United States and between his deportations, he resided with the employee and either worked under an alias or would split paychecks under another individual's alias (also illegally in the U.S.). The OIG agent located the employment income in accounts that were not reported to MDHHS. As part of the investigation it was determined that the employee was also a CDC provider for her sister and was unable to provide attendance records to support the billings to the state of Michigan as required by policy. During the investigation, the subject resigned. The now ex-employee was convicted of "Welfare Fraud-Failure to Inform under $500" and ordered to pay full restitution in the amount of $7,840.

Provider Fraud

An investigation assigned from an OIG data mining project revealed billing irregularities for a CDC program provider. A review was conducted on all attendance records for the center which did not support the number of CDC hours billed to the State of Michigan. The attendance records reviewed indicated the provider overbilled for an average of 52 percent during the time period in question. The center signed a repayment agreement and paid the full restitution in the amount of $356,561.

Support Subsidy/Food Assistance Fraud

The former Michigan Department of Community Health requested OIG to investigate allegations of fraud by a subject who falsified and submitted 10 Family Support Subsidy Program (FSSP) applications or renewals to obtain monthly FSSP for three of her children from July 2009 through September 2013. The investigation confirmed the subject submitted fraudulent forms and also submitted false educational information for her children. This resulted in $25,320 improperly paid to the subject in FSSP benefits.

The subject also falsified a number of MDHHS FAP applications by not reporting or under-reporting earned and unearned income and household information. As a result, the subject improperly received $35,587 in FAP benefits.

The subject pled no contest to four felony charges and requested a restitution hearing. The subject was sentenced to a five year probation term and ordered to pay $60,907 in restitution.

Adoption Subsidy Fraud

The MDHHS Adoption Subsidy Unit (ASU) requested OIG to investigate allegations of fraud by an adoptive mother of two teenage girls. It was alleged that from 2001 through 2014, both girls experienced voluntary and involuntary out of home placements. During one incident, the adoptive mother dropped the teenage girls off at the Sheriff's Department and refused to come back and pick them up. Children's Protective Services filed a motion to have both girls permanently removed from their adoptive mother's care. The investigation confirmed that the girls did not reside in the home of the adoptive mother for a total of 21 months during the time period in question. As a result, OIG pursued criminal charges against the adoptive mother. During court proceedings, the subject plead guilty to the charges. She

was sentenced to 18 months of probation and ordered to pay $27,050 in restitution.

MDHHS Employee FAP Trafficking

Information was received from a cashier at a local food store, alleging that a state employee was utilizing a Bridge Card with no name on it. The cashier provided the card number and a receipt of the transaction. OIG determined that the Bridge Card was issued to a neighbor of the employee and that there was no authorized representative assigned to the account. Video surveillance footage was obtained for several local stores in the area where the Bridge Card in question was utilized, showing the employee using the Bridge Card to purchase items on several occasions. The MDHHS employee was interviewed by OIG and acknowledged she used the Bridge Card along with another one issued to a different neighbor. The total amount of the unauthorized usage was $676. The investigation was presented to the Michigan Department of Attorney General to review for criminal charges. The employee was convicted of a misdemeanor charge of welfare fraud, unauthorized use of food assistance. The employee was fired by the MDHHS Office of Labor Relations after her conviction.

COOPERATIVE DISABILITY INVESTIGATIONS (CDI) UNIT

In August 2014, OIG partnered with Social Security Administration (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 SSA cost savings of $1.9 million and non-SSA cost savings (Medicare and Medicaid) of $2.4 million.

CDI UNIT HIGHLIGHTS

SSI Eligibility Denied
The CDI Unit investigated an 18-year-old woman who was receiving SSI for speech and language delays, learning disorder, back condition, and asthma. According to the referral, the woman, who appeared with her mother at a consultative examination, apparently exaggerated her disability functions at the examination. Further, the DDS obtained her high school records that noted that she was no longer eligible for special education services as of 2011 and that she graduated in 2014 from regular education classes. In addition, she achieved high grades in subjects such as English and geometry.

The CDI Unit investigators interviewed the woman's neighbor, who said the woman displayed normal speech and helped the neighbor with fixing computer problems. The neighbor's children also received assistance with their homework from the woman. The investigators also interviewed the owner of a pet store where the woman worked as an unpaid volunteer. The owner said that he liked the woman very much and would hire her immediately if there was an opening. The owner had no problem with the woman operating the cash register, as well as other duties with the business. The CDI Unit

investigators also confirmed that the woman recently applied to the U.S. Air Force.

The CDI Unit investigators conducted a ruse interview of the subject who indicated that she worked at a pet store for $5.00 an hour in cash "under the table." She further acknowledged that she was very good with computers and technology and that she graduated from high school with a 4.0 grade point average. She admitted that she has met with an U.S. Army recruiter; however, she was leaning towards joining the Air Force. No evidence of mental or physical impairments was found from the interview.

As a result of the CDI Unit investigation, the DDS found that the woman's medical condition had improved. Subsequently, the SSA ceased her SSI payments.

Disability Unsubstantiated
The CDI Unit investigated a 57-year-old man who applied for Disability Insurance Benefits by claiming depression, a damaged heart, and damaged hips. He claimed that he worked at a shop that made trophies and plaques for a maximum of 10 hours per week (a shop owned by his wife). The same man was recently convicted in a federal court for SSA fraud for

working at that business full-time, while collecting Disability Insurance Benefits. The conviction and administrative cessation of benefits followed an investigation by the Grand Rapids SSA-OIG office. The CDI Unit investigators interviewed a United Parcel Service driver, who acknowledged that the man worked at the business four or five days a week. An interview with a FedEx driver also confirmed the subject worked there alone. The investigators also interviewed the man at the business during which he claimed that he worked at the business about one to two hours per day to give his wife a break. He said that he would also work at the business on some Sundays to get away from his wife. Surveillance by the investigators found the subject at the business additional times and hours.

The investigators interviewed the man's wife at the business. She acknowledged that the man does work there every day for a couple hours a day and that he can do anything in the business, including the engraving of the trophies and waiting on customers. She said that he could do a lot more work at the business; however, he chose not to because of laziness. She said that he had some physical problems; however, he could still work. Despite recently applying for some jobs in their geographic area, he chooses to sit around their house all day watching television, which required the wife to work at the business.

As a result of the CDI Unit investigation, the Michigan DDS denied the man's claim. He currently is paying restitution as a result of the criminal conviction.

INVESTIGATIVE ANALYTICS UNIT (IAU)

OIG-REB's IAU is responsible for providing system and analytic support for ongoing investigations and fraud referrals. Examples of IAU functions and responsibilities include:

- Management Reports for Performance Measurement
- OIG's Case Management System (MIGS) Maintenance and Enhancement
- Executive Office Reports: Scheduled and Upon Demand
- Michigan's Enterprise Fraud Detection System
- Out-of-State Bridge Card Transaction Project
- Internet Protocol (IP) Address Locator Project

- Public Assistance Reporting Information System (PARIS) Match Analysis
- County Jail Match Analysis
- Multiple Bridge Card Replacement Analysis
- Food Assistance Program (FAP) Trafficking Data Mining
- Medicaid Fraud, Waste and Abuse Data Mining
- Social Media Analysis
- MDHHS Policy Analysis

- USDA-FNS Client Integrity Referral Analysis
- USDA-FNS Management Evaluation Analysis/Liaison
- Identity Theft/Application Fraud
- OIG's Designated Staff Person for IRS Data
- Office of Auditor General (OAG) Audit Liaison
- Law Enforcement Liaison for Trafficking Investigations

Public Assistance Reporting Information System (PARIS)

OIG-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 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 2015, PARIS matches also resulted in $10.1 million in annual cost avoidance. The investigations also identified over $680,000 in fraud.

PARIS Match Highlight

OIG received a PARIS match indicating that a MDHHS client was receiving welfare benefits in both Oklahoma and Michigan. An OIG investigation confirmed this, as well as uncovered that the client had also trafficked her benefits. As a result of this investigation, the client was disqualified from FAP for 10 years,

and agreed to repay the $19,912 in benefits that had been fraudulently received.

Michigan's Enterprise Fraud Detection System (EFDS)

During FY 2015 OIG Investigative Analytics Unit continued working with contractors and Michigan Department of Technology, Management and Budget (DTMB) on the design and development of the FAP segment of the Enterprise Fraud Detection System (EFDS). The FAP segment was put into production and rolled out to OIG staff during FY 2015. Investigations initiated by leads generated from the EFDS have led to $13.2 million in annualized cost avoidance and determined over $440,000 in fraud.

EFDS Project Highlight

OIG received an alert from EFDS indicating that a client had two drug related felony convictions after August 1996. Per MDHHS policy, recipients are not eligible for FAP if they have two drug-related felony convictions after August 1996. Upon further investigation the OIG agent determined that the client was not eligible for FAP benefits for over three years. The client signed an agreement acknowledging the program disqualification and agreeing to repay $8,619 in benefits.
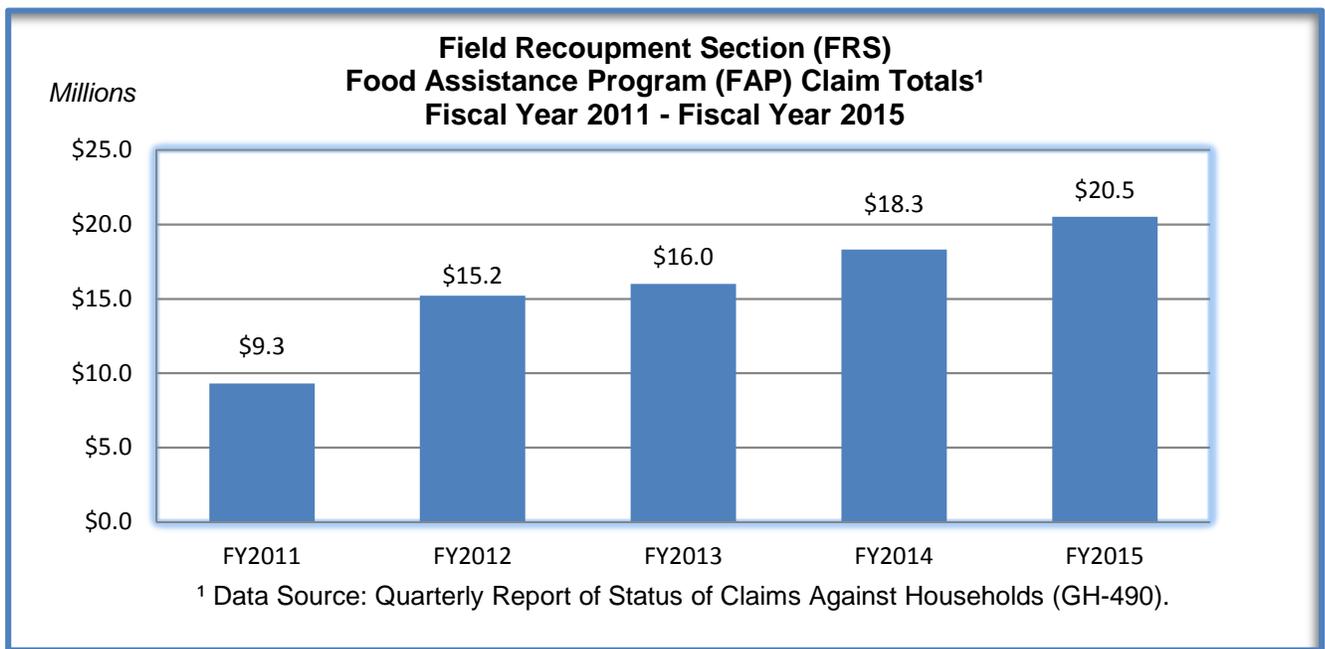
RECOUPMENT AND DEBT RECONCILIATION

DIVISION OVERVIEW

The Recoupment and Debt Reconciliation Division (R&DR) is responsible for the establishment, recovery and reconciliation of payments received for over-issued benefits to clients and overpayments to service providers. Recovery of over-issued benefits helps to maintain the integrity of the programs and specifically for Food Assistance is required under Federal Code 7 CFR 273.18. The division's work results in the recovery of millions of dollars per year of over-issued state and federal funds and provides a source of revenue for the State of Michigan due to the retention percentage allowable from the recovery of over-issued federal benefits.

FIELD RECOUPMENT SECTION

- When a household receives more benefits than it is entitled to receive, MDHHS must attempt to recoup the over-issued benefits. When field staff suspect that an over-issuance has taken place due to late processing of case information, a client error or an intentional program violation (IPV), they make a claim referral to a Recoupment Specialist (RS). The RS must then determine the validity of those claim referrals where a benefit over-issuance has been identified.
- RS staff are responsible for analyzing the claim referrals, determining the validity of the referral, and the gathering of additional information to be used in establishing the claim. If valid, the RS establishes the over-issuance period, over-issuance amount and the type of claim; agency error, client error, or possible IPV error.
- If necessary, RS route suspected IPV claims to OIG investigators as appropriate. RS enter all claims and associated client penalties into the Bridge system. The recoupment unit is the primary source for the determination, investigation, establishment and entrance of over-issuance claims and any resulting penalties into the Bridges system.

Field Recoupment Section (FRS)
Food Assistance Program (FAP) Claim Totals[1]
Fiscal Year 2011 - Fiscal Year 2015

Millions

FY2011	FY2012	FY2013	FY2014	FY2015
$9.3	$15.2	$16.0	$18.3	$20.5

[1] Data Source: Quarterly Report of Status of Claims Against Households (GH-490).

RECONCILIATION AND RECOUPMENT SECTION

The Reconciliation and Recoupment Section is primarily responsible for:

- Resolution of debtor inquiries (client and provider) and disputes in satisfaction of due process afforded, and pertaining to collection of delinquent claims.
- Posting of payments received by debtors.
- Reconciliation of collection data, and thereby validating continued legal collectability through constant, timely and accurate claim adjustments needed to keep balances in sync with outside collection agencies.
- Reporting to the U.S.D.A. Food and Nutrition Service (FNS) through annual certification of continuing legal collectability and assurance of required due process consideration and submission of pertinent collection data for MDHHS participation in the Treasury Offset Program (TOP).
- Referral of defaulted claims to the Department of Attorney General for debt collection.

WELFARE DEBT UNIT

The Welfare Debt Unit, housed under the Reconciliation and Recoupment Section, is responsible for claim monitoring and collection of over-issued client FIP, FAP, CDC and SDA benefits. This unit:

- Collects client overpayments utilizing the Welfare Debt Collection System, Bridges, Michigan Department of Treasury Collections (per agreement), and the Federal Tax Offset Process.
- Interacts closely with the OIG agents and with RS in the resolution of client debtor disputes.
- Performs routine reconciliation processes that are essential to keeping debt balances and claim coding correct and current.

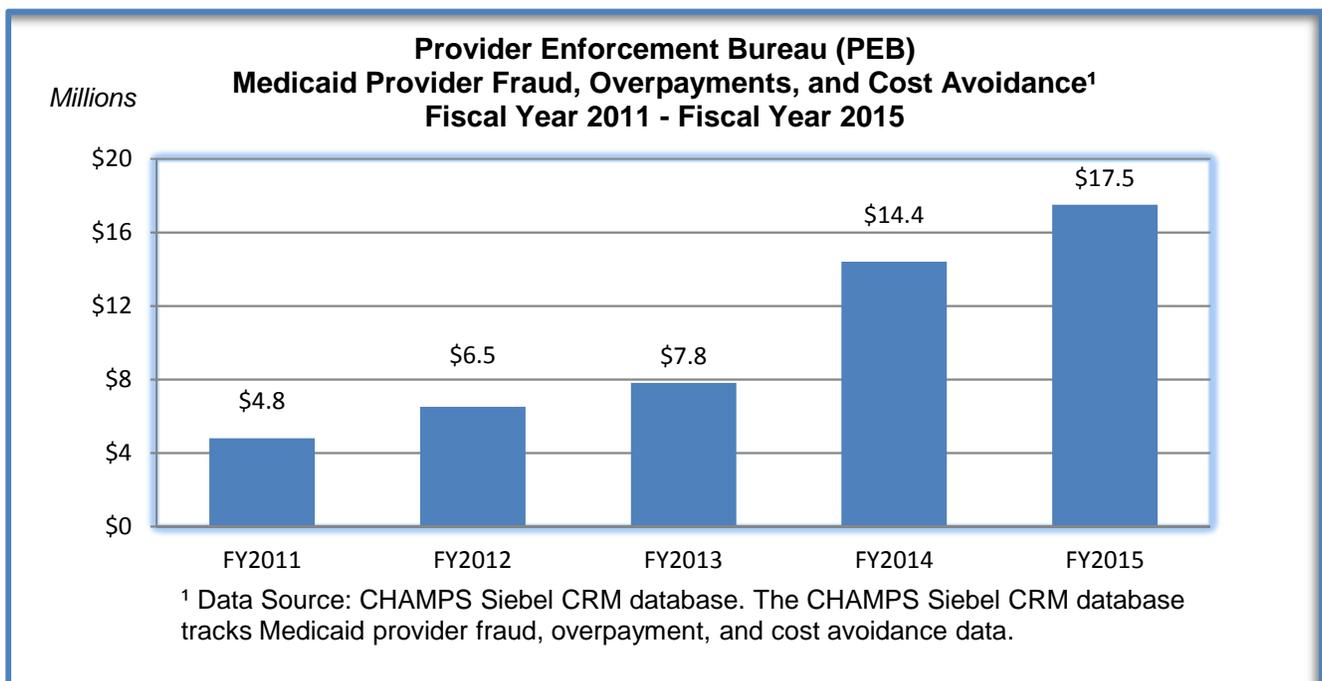# RECOUPMENT AND DEBT RECONCILIATION DIVISION PRODUCTIVITY

During FY 2015, the R&DR:

- Increased recoupment claims established by 14 percent and total dollars retained by 13 percent.
- Recovered over $11.9 million from the FAP, FIP, CDC and SDA programs.
- Increased the FAP debt recovery through the Federal TOP by 19.1 percent, resulting in an average annual increase of $2 million, and FY 2015 collections totaling $5.1 million.
- Increased total active claims in TOP by over 12,000 carrying receivables balance of $18.6 million.
- Increased civil collections derived through concerted efforts using the Michigan Department of Attorney General by 85 percent. Efforts comprised of 83 cases fully litigated and 258 cases established without litigation, resulting in overall collections totaling $418,000.

PROVIDER ENFORCEMENT BUREAU (PEB)

HEALTH SERVICES PROGRAMS IMPACTS

In FY 2015, the Provider Enforcement Bureau (PEB) agents had an overall impact to direct Medicaid spending (i.e., fee-for-service (FFS)) totaling $17.5 million through the following activities:

- Identified a total of $7.3 million in overpayments made to Medicaid providers. To date, $6.3 million has been recovered while the remaining $1 million is being repaid over time.
    - In FY 2015, PEB received 899 allegations of potential fraudulent activity from various sources (e.g., 351 tips from the public (101 anonymous), 226 tips from beneficiaries, 162 referrals from inside MDHHS, 74 referrals from MCOs, 43 tips from beneficiary family members/friends, 34 tips from providers, etc.).
- Sanctioned 46 Medicaid providers, preventing an estimated $8.4 million in future payments.
    - PEB is responsible for making the determination to sanction a provider based on the grounds specified by MCL 400.11e and 42 CFR §455.23.
- Made three formal recommendations to the Medical Services Administration (MSA) to prevent an estimated $1.7 million in future claims from being paid.
    - When PEB agents identify vulnerabilities where a more robust Medicaid policy and/or system edits would have prevented an identified fraud, waste or abuse; PEB makes formal recommendations to prevent future claims from being paid.
- Referred 41 Medicaid providers to the Medicaid Fraud Control Unit (MFCU).
    - In FY 2015, 16 previously referred providers were convicted and required to pay a total of $150,217 in restitution.
    - In accordance with federal regulation (42 CFR §455.21), the MFCU is the first referral destination for all cases of suspected Medicaid provider fraud.

Provider Enforcement Bureau (PEB)
Medicaid Provider Fraud, Overpayments, and Cost Avoidance[1]
Fiscal Year 2011 - Fiscal Year 2015

[1] Data Source: CHAMPS Siebel CRM database. The CHAMPS Siebel CRM database tracks Medicaid provider fraud, overpayment, and cost avoidance data.

RESULTS REPRESENT FEE FOR SERVICE (FFS) MEDICAID IMPACT ONLY

FIELD INVESTIGATION SECTIONS OVERVIEW

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

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

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

PEB's Field Investigation Sections are primarily responsible for:

- Identifying vulnerabilities where a more robust Medicaid policy and/or system edit would have prevented an identified 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.

2015 PEB INVESTIGATION SECTION HIGHLIGHTS

Home Help
In FY 2015, receivables were established for 481 home help providers totaling $959,578 for payments made while their beneficiaries were hospitalized and/or after their death or while the provider was incarcerated. To date, $144,971 has been repaid.

Long Term Care
As a result of submitting an altered freedom of choice form, a nursing home agreed to repay the Medicaid program $144,513, all of which has been repaid.

Dental
In FY 2015, 17 dental providers agreed to repay the Medicaid program a total of $111,494 that they received as a result of billing for services that violated Medicaid Dental Policy. To date, $110,000 has been repaid.

Home Health
In FY 2015, 22 home health providers agreed to repay the Medicaid program a total of $85,014 that they received as a result of billing for home health services while the beneficiaries were also receiving private duty nursing services or were hospitalized. To date, $53,189 has been repaid.

Pharmacy
In FY 2015, two pharmacy providers agreed to repay the Medicaid program a total of $80,973 as a result of pharmaceutical inventory audits. To date, $50,703 has been repaid.

Private Duty Nursing
In FY 2015, six private duty nursing providers agreed to repay the Medicaid program a total of $22,674 that they received as a result of billing for home health services while the beneficiaries were hospitalized or receiving home health services, all of which has been repaid.

DATA ANALYTICS SECTION OVERVIEW

PEB uses analytical tools and techniques, as well as knowledge of Medicaid program rules, to mine Medicaid claims data and identify improper claim conditions. Data analytics allows for detection and identification of patterns of fraudulent behavior not otherwise readily apparent and are the critical first steps in the investigative process. PEB's staff investigators use information from data analytics to focus their efforts and resources to areas of the greatest risk and return, leading to greater recoveries, and discouraging future abuse.

The Data Analytics Section is primarily responsible for:

- Providing system and analytic support for ongoing investigations and fraud referrals.
- Identifying patterns of suspicious Medicaid provider behavior based on historical data, including the following examples:
  - Peer billing comparison (e.g., outlier detection, provider ranking, etc.).
  - Impossibility scenarios (e.g., provider and beneficiary death match, incarceration match, institution match, etc.).
  - Upcoding scenarios (i.e., overcharging the Medicaid program for services rendered).
  - Unbundling scenarios (i.e., using multiple billing codes instead of a single billing code in order to increase the reimbursement amount).
- Implementing Michigan's Enterprise Fraud Detection System (EFDS) for Medicaid provider fraud.

2015 PEB DATA ANALYTICS HIGHLIGHTS

Medicaid Provider Overpayment Detection
In FY 2015, approximately half of the Medicaid provider overpayment recoveries and fraud referrals were generated as a part of data analytics/data mining.

In FY 2015, PEB cases generated from data analytics/data mining resulted in a total of $966,446 in overpayments identified.

EFDS Project Highlight
The PEB Data Analytics Section has been working with Michigan's Department of Technology, Management and Budget (DTMB), as well as its vendors, to utilize Michigan's Enterprise Fraud Detection System (EFDS) for fraud detection. This DTMB system utilizes and leverages state owned data to identify potential fraud.

MANAGED CARE AND AUDIT VENDOR OVERSIGHT SECTION OVERVIEW

The Managed Care and Audit Vendor Oversight Section is comprised of two units, the Managed Care Oversight Unit and the Audit Vendor Oversight Unit.

MANAGED CARE OVERSIGHT UNIT

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

- In coordination with the Managed Care Plan Division, PEB 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 PEB 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, PEB's Managed Care 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 Managed Care Oversight Unit.
  - A PEB 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).

2015 MANAGED CARE OVERSIGHT UNIT HIGHLIGHTS

Provider Audits/Reviews
In FY 2015, Michigan Medicaid's 13 MCOs performed a total of 2,649 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $4,801,630.

Provider Sanctions
In FY 2015, PEB agents prevented an estimated $6 million in Medicaid MCO encounter payments as a result of provider suspensions.

AUDIT VENDOR OVERSIGHT UNIT

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

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

- Michigan Peer Review Organization (MPRO) is contracted to perform audits of hospitals.
    - MPRO performs data mining algorithms on the Medicaid database to identify potential areas of recovery. These scenarios are preapproved by the Audit Vendor Oversight Unit.
    - Audit Vendor Oversight Unit analysts review and approve each MPRO data scenario prior to implementation as well as their sample selection prior to record review.

2015 AUDIT VENDOR OVERSIGHT UNIT HIGHLIGHTS

Inpatient Hospital
In FY 2015, HMS and MPRO each performed a *short stay* data mining scenario, which identified beneficiaries with short lengths of stay for inpatient hospital claims. Medicaid beneficiary medical records were requested and reviewed by HMS and MPRO to determine if the hospital stays were medically necessary (i.e., services could have been provided in an outpatient hospital or observation environment).

A total of 211 inpatient hospitals paid over $4 million back to Medicaid for those inpatient stays that were determined not to be medically necessary hospital stays.

Durable Medical Equipment (DME)
In FY 2015, HMS performed a *DME capped* data mining scenario, which identified DME rental payments past the 10-month rental period. Specific medical equipment is rented for a 10-month period and then, per Medicaid policy, it is considered to have been purchased for that beneficiary. As a result, $18,806 was recovered from 19 DME providers.

Inpatient Hospital
In FY 2015, MPRO performed a *mechanical vent* data mining scenario, which identified Medicaid beneficiaries with inpatient hospital claims that resulted in receiving payment for mechanical vent related codes. Beneficiary medical records were requested and reviewed by MPRO to validate the number of hours of mechanical ventilation (i.e., from intubation of the patient until the endotracheal tube was removed).

A total of 26 inpatient hospitals paid $921,710 back to Medicaid for those claims that were deemed to have been billed with more hours of mechanical ventilation than were actually provided.

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.

Debt Collections/Dispute Resolution: OIG's Welfare Debt Unit is responsible for collecting client overpayments through multiple methods, including direct collections, Michigan Treasury and federal tax offset programs. Debtor disputes are also investigated and resolved.

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

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

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

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

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

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

IP Locator Project: The Internet Protocol (IP) Locator Project was created to give REB 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.

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.

Lottery Match: Through a partnership with the Michigan Bureau of Lottery, MDHHS matches known lottery winners with active public

assistance recipients/clients. When lottery winnings and active clients are identified, appropriate case action is taken regarding the continued eligibility of the client. Unreported lottery winnings affecting eligibility may be investigated by OIG.

MCO Program Integrity Activities: Each MCO reports their program integrity activities performed each quarter to PEB. As MCOs submit their quarterly reports, PEB staff review each of the 13 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: PEB uses an investigative process to detect and deter potential instances of fraud, waste and abuse in health services programs. Provider fraud may include giving or receiving bribes or kickbacks, unacceptable medical and/or billing practices, misusing or abusing Medicaid services, falsifying records or giving false information. Cases involving credible allegations of fraud or other illegal activities are forwarded to the Attorney General's Health Care Fraud Division for pursuit of appropriate civil or criminal prosecution.

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

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

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

Recoupment: Recoupment Specialists (RS) are responsible for validating worker generated claim referrals and establishing client and agency error, as well as referring potential IPV referrals for OIG agent investigation.

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.