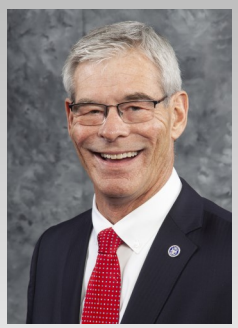
FY 2020 ANNUAL REPORT

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) 2020 Annual Report.

In an unprecedented year, our talented and committed staff deserve the credit for the accomplishments reflected in this annual report, especially during a period that required such adaptability, innovation and flexibility to new working conditions. I am privileged to lead such a dedicated team and am proud of our ongoing work to improving program integrity in the programs administered by the MDHHS.

The OIG's primary role is to investigate fraud, waste and abuse in programs administered by MDHHS and to increase program integrity and accountability. Now, more than ever, citizens expect accountability and integrity in state government, and OIG takes this to heart. The landscape of fraud is constantly changing as new schemes are developed, and my staff continue to innovate to identify these schemes and ensure appropriate action is taken. As a result of my staff's hard work, the following accomplishments were achieved in FY 2020:

- Accounted for approximately $157 million in program integrity efforts (fraud detection, cost savings and disqualifications).
- Performed 19,445 public assistance application investigations resulting in cost avoidance of more than $57.4 million.
- Established $52.7 million in Medicaid provider overpayment receivables and cost savings.
- Completed 5,177 public assistance fraud investigations.
- Identified $8.6 million of public assistance program fraud.
- Established $3.2 million in cost savings from disqualifications of public assistance recipients for intentional program violations.

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

As we move onward, our priority is to keep the OIG staff safe while utilizing forward thinking approaches, and being responsive to fighting fraud, waste and abuse in taxpayer-funded assistance programs.

I want to thank the OIG's staff, fellow state employees and all Michiganders who reported suspected fraud, waste, abuse and misconduct in FY 2020 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 2020, the Office of Inspector General – Enforcement Division agents:

- Determined $74.2 million of fraud, cost savings and established program disqualifications.
- Completed 5,177 fraud investigation dispositions.
- Completed 19,445 Front End Eligibility (FEE)[1] investigations.
- Identified $57.4 million in cost avoidance in FEE investigations.
- Established an additional $3.2 million in cost savings from intentional program violation (IPV) disqualifications.
- Identified $8.6 million of program fraud.

"For every hour spent on an investigation, $124 of receivables and disqualifications were established."

Integrity Division
In FY 2020, the Office of Inspector General – Integrity Division agents:

- Sanctioned 113 providers, establishing $40.3 million in fee for service and $15 million in managed care encounter payment cost savings.
- Identified $12.4 million in inappropriate Medicaid expenditures, recovering $10 million.
- Performed program integrity oversight of Michigan Medicaid's 43 Managed Care Organizations (MCO). These MCOs performed a total of 6,263 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $15.1 million.
- Referred 61 Medicaid providers to the Attorney General's Health Care Fraud Division for credible allegation of fraud investigations.
- Completed 1,046 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 2020, the Special Investigations Unit (SIU) agents:

- Completed 145 investigations.
- Determined $1 million of provider, contractor, recipient, and employee fraud.

In FY 2020, the Benefit Trafficking Unit (BTU) agents:

- Completed 1,303 benefit trafficking investigations.
- Investigated 43 identity theft criminal entities utilizing over 1,000 stolen and fraudulent identities to illegally obtain and traffic Food Assistance Program (FAP) benefits.
- Determined $1.6 million in fraud from trafficking.
- Established an additional $828,000 in cost savings from IPV disqualifications.

In FY 2020, the High Risk Medicaid Unit (HRMU) agents:

- Completed 1,467 high-risk Medicaid investigations.
- HRMU investigations resulted in 644 beneficiaries being locked into a specified pharmacy and/or health care provider.
- Investigations resulted in $9.5 million in Medicaid cost savings.

In FY 2020, the Cooperative Disability Investigation Unit (CDI) agents:

- Completed 53 cooperative disability investigations.
- Established $5 million in cost savings.

COST EFFECTIVENESS AND PRODUCTIVITY

In FY 2020:

- Every dollar spent on fraud prevention resulted in $15 of cost avoidance and savings for taxpayers.
- For every hour spent on an investigation, $124 of receivables and disqualifications were established.

OIG Authority

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

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

OIG Mission Statement

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

OIG VALUES

The Office of Inspector General (OIG) is accountable to the people of the State of Michigan for maintaining the highest standards of integrity and good moral character.

As members of the OIG, we must work together as a team to plan and strive for excellence, realizing that the daily decisions that are made will reflect on the future of the people we investigate as well as our organization as a whole.

Recognition

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

Dignity

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

Innovation

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

Teamwork

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

Integrity

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

Excellence

- OIG employees are expected to meet the responsibilities of their assigned job duties, be responsible for their actions and be accountable to their supervisors, co-workers and to the citizens they serve.
- Perform the duties of the OIG Mission to their utmost ability.
- Know the laws, rules and policies that will aid them in performing their duties. Be aware of and meticulously adhere to all legal requirements on the release and dissemination of information.
- Understand that when trust and confidence are established within our organization, our stakeholders and the public will support us in fulfilling our duties.
- Take pride in themselves and their organization, take ownership of their work and be leaders in their areas of responsibility.

INSPECTOR GENERAL OVERVIEW

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

Within the OIG there are three divisions: Integrity (Medicaid providers), Enforcement (recipients/vendors and non-Medicaid providers) and Operations (Administrative, Investigative Analytics and Policy & Training). OIG agents and their managers are strategically located throughout Michigan to assist MDHHS in maintaining integrity and accountability in the administration of all its programs.

OIG IMPACT ON PUBLIC ASSISTANCE PROGRAMS

Fraud detection in public assistance - $26 million
Fraud prevention in public assistance - $97.7 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 fraud detection and prevention:

FRAUD INVESTIGATIONS

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

Fraud Investigation Highlights

Unreported Income
An OIG investigation determined that a public assistance recipient withheld information concerning their employment status, resulting in an overpayment of Family Independence Program, Food Assistance Program and Medicaid benefits. The income from employment made the household ineligible for all program benefits. The recipient pled guilty to welfare fraud and was sentenced to restitution of $37,375 and probation.

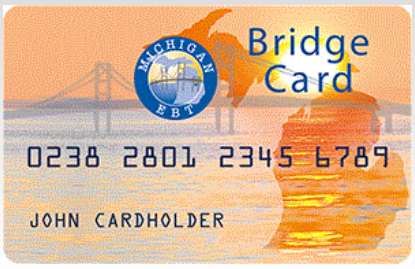
Employed Spouse in the Household
A joint criminal investigation between OIG and the Social Security Administration identified a recipient that failed to report their employed spouse was living in the household. The recipient pled guilty to criminal charges and was ordered to pay restitution of $36,793 in disability benefits and $9,035 in Food Assistance Program benefits.

Unreported Self-Employment
An OIG investigation revealed that a recipient failed to report ownership of a grocery store and the income from that business to the department. As a result of the recipient's failure to report their self-employment, they received $17,921 in Food Assistance Program benefits they were not entitled to. The investigation has been referred to the Attorney General's office for criminal prosecution review.

Dual Assistance
An OIG investigation revealed that a recipient had established a residence in Alabama and continued to submit multiple applications in Michigan for Medicaid benefits, receiving benefits in both states. OIG submitted the investigation for an Administrative Hearing. The Administrative

ENFORCEMENT DIVISION

Law Judge ruled for the department and ordered the recipient to repay $16,735 in Medicaid benefits fraudulently obtained from Michigan.



FRONT END ELIGIBILITY (FEE)

In focusing on fraud prevention, the FEE program provides for pre-eligibility investigations when applications or recertifications for public assistance contain suspicious or error prone information. OIG agents investigate, substantiate or refute discrepancies and suspicious activities. Agents complete the investigation within 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.

FEE Investigation Highlight

Misrepresentation of Children in the Home
A recipient applied for Food Assistance Program and Medicaid benefits for five children. OIG's investigation revealed that the children did not reside with the recipient, but instead resided with their other parent. This FEE investigation resulted in annual program cost savings of $27,780 in Medicaid and $8,640 in Food Assistance Program benefits.

BENEFIT TRAFFICKING UNIT (BTU)

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 the sale of a person's Medicaid card to obtain health services.

Identity theft is a vital concern for the OIG and the focus of extensive investigative resources. The BTU is currently investigating over 40 criminal entities utilizing over 1,000 stolen and fraudulent identities to obtain assistance benefits. These schemes have increased during the COVID-19 pandemic.

Trafficking Investigation Highlights

Welfare Fraud
During a Medicaid provider fraud investigation, the OIG uncovered evidence that the provider's spouse failed to fully report income and assets when applying for assistance benefits on multiple occasions over several years. The investigation determined that the individual fraudulently reported that they were separated from their spouse in order to qualify for benefits when in fact the couple lived together and had substantial income and assets, including multiple residential and business properties. The investigation determined that the recipient illegally obtained over $159,000 in Food Assistance Program and Medicaid benefits. The offender pled guilty to welfare fraud and repaid full restitution to the

ENFORCEMENT DIVISION

Michigan Department of Health and Human Services.

Identity Theft and FAP Trafficking
An OIG investigation revealed that stolen identities of three victims were being used to illegally obtain and traffic Food Assistance Program benefits. The investigation uncovered the identity of the perpetrator, who was also on parole for a previous crime. The person was convicted of welfare fraud and was sentenced to jail and to pay full restitution of $36,524.14 to the MDHHS.

Food Stamp Trafficking
OIG received an anonymous tip that a local party store owner was buying Food Assistance Program benefits to stock their business inventory and resell the items for profit. The OIG investigation revealed that the store owner used over $7,700 in benefits to funnel EBT eligible food items through their party store to increase business revenue from 2017 to 2020. The investigation was referred to the United States Department of Agriculture's Food and Nutrition Service and the MDHHS Women, Infant and Children Program for further review. The case was authorized for criminal prosecution.

SPECIAL INVESTIGATION UNIT (SIU)

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

SIU Investigation Highlights

Employee Fraud
OIG investigated allegations that an employee could not account for disbursements from a State Emergency Relief fund designed to assist needy recipients with emergency expenditures. An OIG investigation determined that the employee diverted over $30,000 in funds for personal use. A warrant request was submitted to the Office of Attorney General for Embezzlement and is pending criminal charges.

Child Development and Care Fraud
OIG investigated allegations that a Child Development and Care provider improperly billed for child care hours. It was determined that the provider failed to maintain proper records and illegally overbilled the department. The provider pled guilty to misdemeanor larceny and paid full restitution of $93,679.

ENFORCEMENT DIVISION

HIGH RISK MEDICAID UNIT (HRMU)

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

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

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

In addition, HRMU agents identify criminal schemes and report activities to the proper authorities to include State and Local Drug Task Force Teams, prosecutors and the Medicaid Fraud Control Unit.

HRMU Investigation Highlights

Multiple Doctors and Prescriptions
An OIG investigation determined that a beneficiary received more than six controlled substance prescriptions, had more than two controlled substance providers and utilized more than four pharmacies during the first quarter of 2020. During the previous two years, the beneficiary was written 20 controlled substance prescriptions by 10 different providers, utilized numerous physicians in different practices to obtain duplicate or similar services for the same or similar health conditions and utilized four different pharmacies to obtain their prescriptions. In addition, the beneficiary had a total of 23 emergency department visits during the two-year review period. BMP locked the beneficiary into a specified provider and pharmacy for two years resulting in Medicaid cost savings of approximately $13,339.

Multiple Controlled Prescriptions
An OIG investigation revealed that a beneficiary had been utilizing a provider whose office was approximately 97 miles away from their home to obtain prescriptions for controlled substances. In addition, the investigation revealed that the beneficiary received 53 prescriptions for controlled substances and utilized seven doctors from separate practices to obtain prescriptions for controlled substances. BMP locked the beneficiary into a specified provider and pharmacy resulting in Medicaid cost savings of approximately $13,339.

COOPERATIVE DISABILITY INVESTIGATIONS (CDI) UNIT

Since 2014, OIG has partnered with the Social Security Administration Office of Inspector General (SSA-OIG) through a Cooperative Disability Investigations (CDI) program in Michigan. CDI combats fraud by investigating questionable claims, statements and activities of claimants, medical providers, interpreters or other service providers who are suspected of

ENFORCEMENT DIVISION

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.

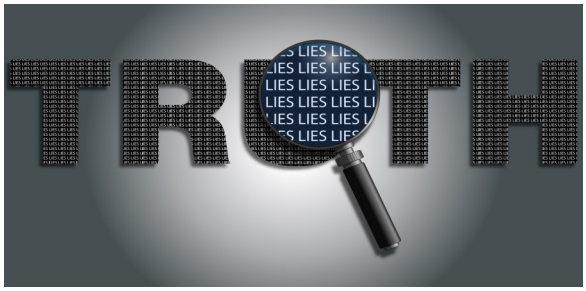
The two OIG agents, working in partnership with SSA-OIG, produced a total cost savings of $5 million.

CDI Unit Investigation Highlight

Disability Fraud
The Detroit CDI Unit investigated a 25-year-old person who applied for Title II and Title XVI disability benefits in August 2019, alleging a gunshot wound which resulted in back pain and Post-Traumatic Stress Disorder. The Michigan DDS, after examining hospital records regarding treatment of an August 2014 gunshot wound, reviewed public prisoner records and learned the person was convicted of a robbery that occurred in August 2014. Concerned about SSA policy that mandates the exclusion of any impairments connected to felony activity and conviction from consideration in the disability determination process, DDS referred the claim for investigation.

The CDI investigation revealed the person was a suspect in a series of Craigslist armed robberies in 2014, and that they were shot trying to sell items that were presumably stolen. Because the person's felony conviction was for the robbery, not the sale of the stolen goods, Michigan DDS was not required to exclude their impairments when determining their disability. However, the Detroit CDI Unit obtained videos and photographs from social media sites that appeared to contradict the person's alleged limitations. Subsequently, CDI investigators interviewed the person and confronted them with the videos and photographs. The person acknowledged feeling better on some days than others.

As a result of the investigation, Michigan DDS denied the person's application for disability benefits resulting in a projected SSA savings of $47,814, and non-SSA savings of $74,835.

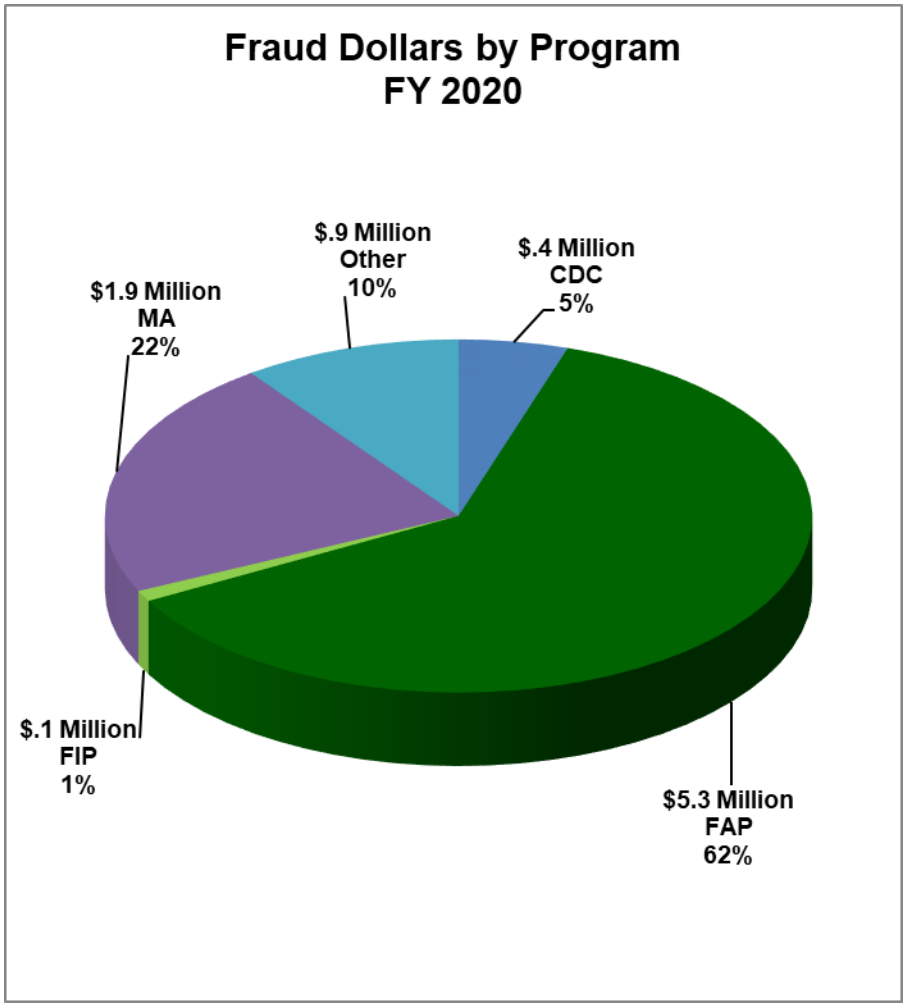


PROGRAM INTEGRITY IMPACTS

OIG's Enforcement Division determined over $8.6 million in fraud during FY 2020 within multiple Michigan public assistance program areas. Because of the Enforcement Division efforts, during FY 2020, 171 felony warrants were authorized by county, state and federal prosecutors. Investigations by Enforcement Division agents have uncovered $33.5 million in fraud during the last three years.

Program Highlights

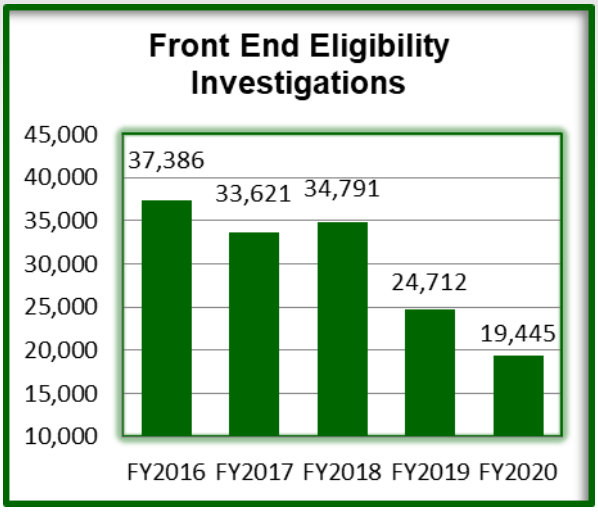
- FAP accounted for 62 percent of Michigan's public assistance fraud during FY 2020.
- OIG investigated 3,845 fraud cases in the FAP program, with 2,413 fraud investigative dispositions and 140 criminal warrants issued for a fiscal year total of $5.3 million in fraud found.
- OIG completed 45 CDC cases resulting in $421,376 in fraud found for the Michigan Department of Education (MDE).
- OIG completed 842 investigations of Medicaid program fraud resulting in $1.9 million in fraud found.

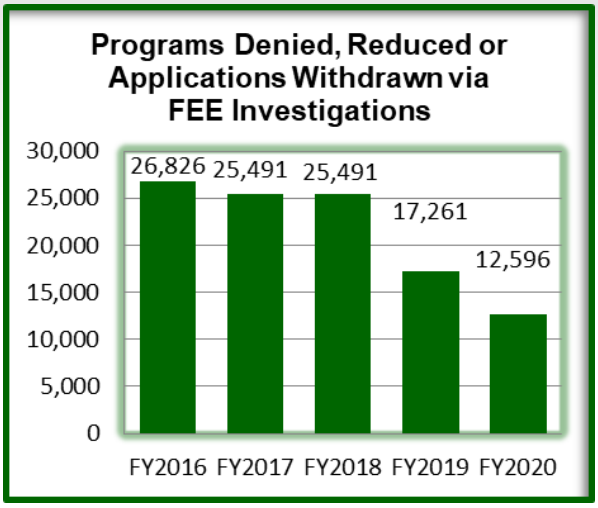


CDC = Child Development and Care Program
FAP = Food Assistance Program
FIP = Family Independence Program
MA = Medicaid Program
Other = Adult/Children's Services, State Disability, State Emergency Relief

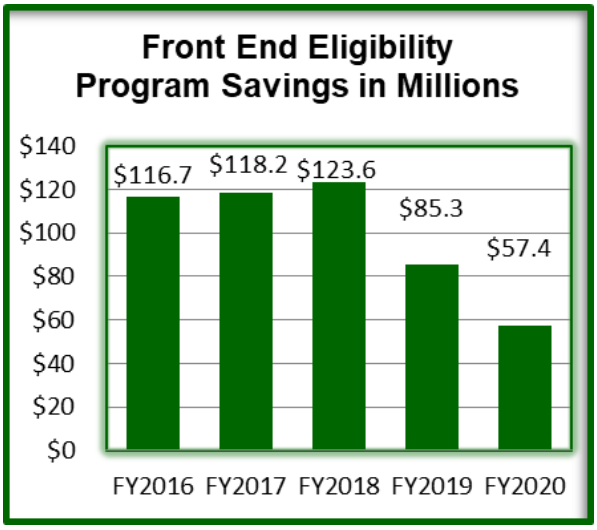
FEE: EARLY FRAUD DETECTION AND PREVENTION

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





Working toward fraud prevention, Enforcement Division agents conducted 19,445 investigations in FY 2020 and identified $57.4 million in cost savings. Investigations by these agents have resulted in $266 million in program savings for taxpayers over the last three-year period.



INTEGRITY DIVISION

In FY 2020, Michigan's health services programs had a combined budget of approximately $18.7 billion and paid 242,606 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 investigations, the Integrity Division works to ensure that the money spent on health services is used for the best care of the beneficiaries. There are several unique programs and units that focus on important aspects of investigation and fraud detection and prevention.

INVESTIGATIONS

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

RECOVERY AUDIT CONTRACTOR

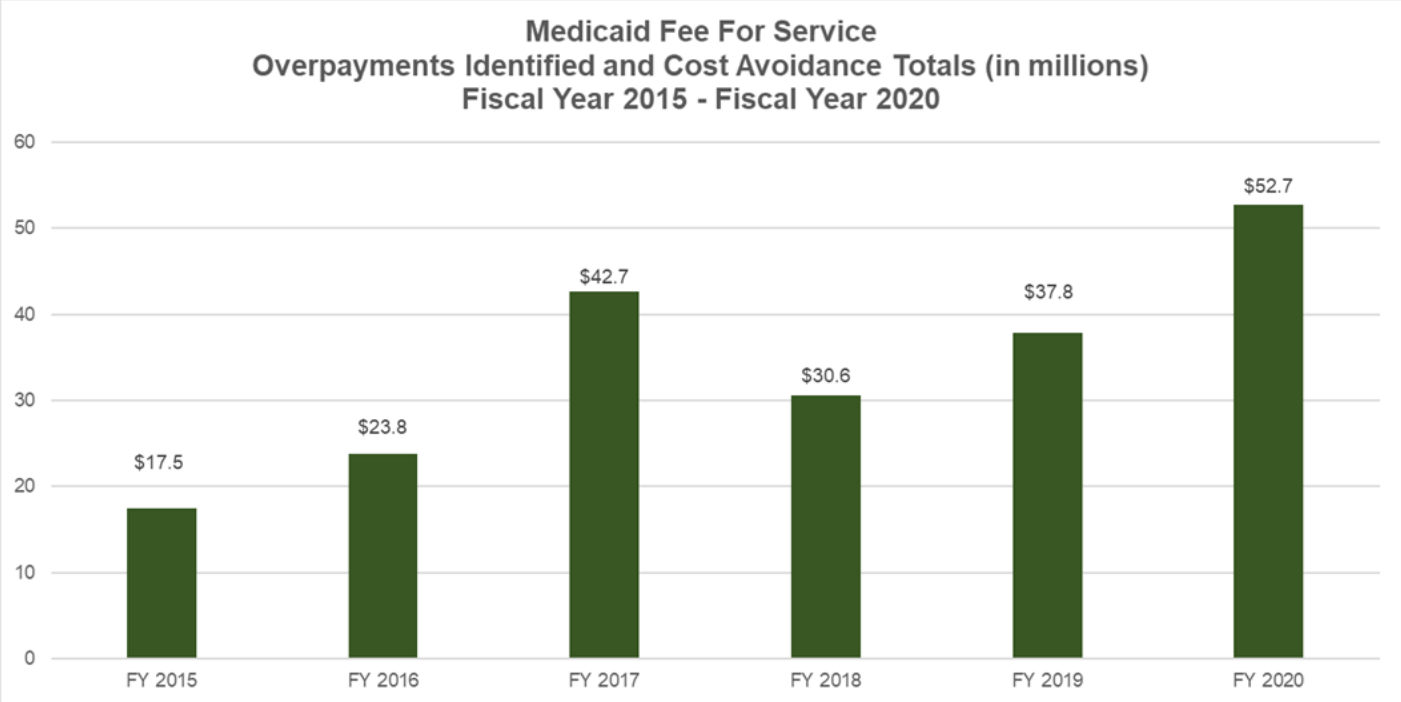
The Integrity Division has contracted with a vendor to perform audits and recover overpayments from Medicaid providers.

MANAGED CARE OVERSIGHT

The Integrity Division is responsible for monitoring the program integrity activities of Michigan Medicaid's Managed Care Organizations (MCO). Quarterly, MCOs are required to report 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.



NOTE – Approximately $15.4 million in FY 2020 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

HEALTH SERVICES PROGRAMS IMPACTS

In FY 2020, OIG-ID had an overall impact to direct Medicaid spending (i.e., fee-for-service (FFS)) totaling $52.7 million through the following activities:

- Identified a total of $12.4 million in overpayments made to Medicaid providers. To date, over $10 million has been recovered while the remaining $2.3 million is being repaid over time.

- In FY 2020, OIG-ID:

    * Received 290 allegations of potentially fraudulent activity from various sources (e.g., 34 tips from beneficiaries, 77 tips from the public (17 anonymous), 163 referrals from inside MDHHS, seven tips from providers).
    * Identified 954 audit targets through data analytics.
    * Completed 1,046 fraud investigation dispositions.

- Prevented an estimated $17.8 million in future payments, through reduced billing activities as a result of Medicaid provider audits and investigations.

HEALTH SERVICES PROGRAMS IMPACTS

- Prevented an estimated $6 million in future payments, through a provider education campaign aimed at increasing pharmacy compliance with voiding claims for no show prescriptions.

- Sanctioned 113 Medicaid providers, preventing an estimated $13.3 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 $3.2 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 61 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.
    * Three previously referred providers were convicted and/or signed civil settlement agreements. These three providers were required to pay a total of $84,129 in restitution.

In FY 2020, OIG-ID had an overall impact to indirect Medicaid spending (i.e., MCO encounter claims) totaling $30.1 million through the following activities:

- $15.1 million in identified overpayments through program integrity related oversight of the Michigan Medicaid MCOs.

- Sanctioned 113 Medicaid providers, preventing an estimated $15 million in future MCO encounter payments.

FIELD INVESTIGATION SECTION OVERVIEW

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

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

These 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 Michigan Department of Attorney General's Health Care Fraud Division.
    - Suspending payments to Medicaid providers when it is determined there is a credible allegation of fraud for which an investigation is pending.
    - Identifying and recovering non-fraud overpayments from Medicaid providers.

Field Investigation Section Highlights

Home Help
In FY 2020, receivables were established for 973 home help providers totaling approximately $5.3 million for payments made while their beneficiaries were hospitalized, after their death, while the provider was incarcerated, or for other noncompliance with Medicaid policy.

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

As a result of OIG efforts, in FY 2020, seven ICOs repaid Michigan Medicaid $2.9 million in capitation payments that were paid on behalf of Medicaid beneficiaries who were not enrolled in the ICO program at the time of the capitation payment.

Additionally, in FY 2020, 78 long term care facilities agreed to repay a total of $1.6 million due to improperly being paid by the Medicaid program directly for service periods when their beneficiaries were enrolled in the ICO program and the ICO received capitation payments for those same service periods. These 78 long term care facilities were to be reimbursed by the ICO for those services.

In FY 2020, OIG-ID had an overall impact to direct Medicaid spending (i.e., fee-for-service (FFS)) totaling $52.7 million.

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 2020, two pharmacy providers agreed to repay the Medicaid program a total of approximately $936,739 as a result of pharmaceutical inventory audits.

Additionally, in FY 2020, eight pharmacy providers agreed to repay the Medicaid program a total of $891,681 as a result of billing for pharmaceuticals using the wrong unit of measurement (i.e., mg instead of ml).

Dental
In FY 2020, 21 dental providers agreed to repay the Medicaid program a total of $232,671 that they received as a result of billing for services that violated Medicaid Dental Policy.

Pediatric Clinics
In FY 2020, six pediatric clinics agreed to repay a total of $75,311 due to improperly billing the Medicaid program when they did not maintain documentation to support performing developmental screening on their patients.

Maternal Infant Health Program (MIHP)
In FY 2020, 11 MIHP providers agreed to repay the Medicaid program a total of $62,297 that they received as a result of billing for services that violated Medicaid MIHP Policy.

Durable Medical Equipment (DME)
In FY 2020, nine DME providers agreed to repay the Medicaid program a total of $47,322 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.

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 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 and dental MCOs to complete section six of the Managed Care Compliance Review tool.
    - Section six requires each MCO to report to OIG-ID their program integrity activities performed each quarter. Program integrity activities include information relating to tips/grievances received (including explanation of benefits), data mining activities, audits performed, and provider disenrollments.
    - MiChoice Waiver Agencies and Prepaid Inpatient Health Plans (PIHP) are also required to submit these program integrity activity reports quarterly.
    - As MCOs submit their quarterly reports, OIG-ID's MCO Oversight Unit analysts review each report for compliance. An MCO's report can receive a pass, incomplete or failure. MCOs who receive an incomplete or fail must submit a Corrective Action Plan (CAP).
    - 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).

MCO Oversight Unit Highlights

Provider Audits/Reviews
In FY 2020, Michigan Medicaid's 43 MCOs performed a total of 6,263 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $15.1 million.

Provider Sanctions
In FY 2020, OIG-ID agents prevented an estimated $15 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.
- In FY 2020, the UPIC identified $168,133 in overpayments made to Medicaid providers.

OPERATIONS DIVISION

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

OIG-OD's Administrative Services is responsible for overall administrative support of the administration. It manages budget development and monitoring, system security, fraud hotlines, investigative process support as well as overseeing of the day-to-day business operations. For example, in FY 2020, OIG's Administrative Services provided extensive quality control reviews on over 1,850 investigative packets referred to the Michigan Office of Administrative Hearings and Rules 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, predictive analytics 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-OD's Policy & Training Unit is responsible for ensuring accurate and timely policy review, development and implementation. The unit reviews, researches and analyzes current and proposed department policy, state laws, federal legislation, and associated MDHHS and OIG policy changes. It is responsible for developing and delivering training to OIG staff as the need develops. This includes planning, coordinating and facilitating both internal and external training events.

2020 Administrative Services Highlight

COVID-19 Staff Support
At the onset of COVID-19, OIG's Administrative Services shifted into high gear to obtain and equip staff so they may work remotely and safely. In addition to personal protection equipment, they quickly secured and disbursed laptop computers, headphones, microphones, VPN's, and shared email boxes to keep the workflow intact and productive. The team took on additional printing, scanning and mail handling responsibilities to assist remote staff who lost access to these tools.

POLICY & TRAINING UNIT (P&T)

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

OPERATIONS DIVISION

2020 Policy and Training Unit Highlights

OIG's Training Institute

This fiscal year, OIG started developing a new comprehensive training program, OIG's Training Institute (OTI). OTI will provide a solid foundation for new employees through formal instruction followed by on-the-job training. This is designed to develop professional habits, judgement and critical skills that will prepare them for a successful career with OIG. OTI will also provide trainings for current OIG staff that may need a refresher on a particular tool, topic or investigation type. OIG's Quality Assurance Specialist and Policy Analyst have played key roles in successfully initiating, designing, planning, and managing this undertaking that will have infinite benefits for our administration. At this time, there are over 100 modules in development for OTI, using the knowledge of subject matter experts within OIG.

Soft Skills Training

In FY 2020, P&T increased focus on soft skills trainings for staff. While the importance of relevant education, training and job experience cannot be refuted, less tangible abilities like emotional intelligence and soft skills must not be overlooked. Soft skills deal more with interpersonal relationships and involve things like conflict resolution, communication, listening and problem solving. The unit provided nine online trainings that covered a wide range of soft skills to further develop staff's skill sets.

Training Events

The unit developed and delivered (facilitated) 11 training events for OIG staff.

Final Department Reviews

The unit reviewed and analyzed 60 proposed department polices associated with MDHHS.

Instructional Guides and Resource Tools

In FY 2020, the unit developed and published 34 instructional guides and resource tools for investigators to use to improve the quality and accuracy of their investigations.

COVID-19 Support

P&T offered COVID-19 support by creating innovative trainings and resources for staff working remotely during the pandemic. This included live demonstrations with software and tools that were new to staff. P&T not only supported staff working remotely but also shared mental and emotional wellness resources.

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:

- Food Assistance Program Trafficking Data Mining
- Medicaid Fraud, Waste and Abuse Data Mining
- Social Media Analysis
- Internet Protocol Locator Project
- Identity Theft/Application Fraud Analysis
- Asset Detection
- Public Assistance Reporting Information System (PARIS) Match Analysis
- USDA-FNS Client Integrity Referral Analysis
- County Jail Match Analysis
- Out-of-State Bridge Card Transaction Analysis
- Provider and Recipient Vital Records Match
- OIG's Case Management System Development, Maintenance and Enhancement
- In-house investigative data consolidation/ reporting tools
- Executive Office Reports: Scheduled and Upon Demand
- Standardized Medicaid Claims Activity Reports
- Ad-hoc Investigative Support Data Requests

Investigative Analytics Unit Highlights

In-House Investigative Algorithms

Over the course of FY 2020, the IAU devised or refined over 20 algorithms used in the generation of investigative leads. For example, an ever-evolving predictive model that identifies high risk pharmacies has resulted in the creation of numerous investigations. To date, those investigations have an associated overpayment identified of $1.6 million. A second algorithm uses a recipient's benefit type to identify incarcerated individuals, missed through other matching processes, who are still receiving food assistance. Three-hundred-four cases were created and so far, 268 completed investigations have resulted in $704,311 in cost avoidance.

Medicaid Provider Overpayment Detection

In FY 2020, approximately 85 percent of OIG's Medicaid provider recoupment cases were generated as a part of IAU assisted data analytics/data mining.

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 2020, the out-of-state spending project resulted in $14.5 million in annualized cost avoidance.

2020 INVESTIGATIVE ANALYTICS UNIT HIGHLIGHTS

Public Assistance Program Fraud Detection
In FY 2020, approximately 50 percent of the public assistance program fraud investigations conducted by OIG were generated as a part of IAU data analytics/ data mining efforts.

University of Michigan – Institute for Healthcare Policy and Innovation (IHPI) Collaboration
Partnering with and utilizing the estimable clinical and statistical expertise of facility and doctorial students at the University of Michigan, OIG was able to strengthen advanced analytics models that target suspicious behavior related to pharmacy prescriptions. Using techniques such as "non -ignorable missing logistic regression," IHPI helped refine leads that will increase the efficiency of investigative resources.

High Risk Medicaid Utilization Analytics
IAU leverages technical expertise and Medicaid program knowledge to identify recipients and associated providers that may be abusing the program's resources.

In one example, IAU identified a general practice doctor that was writing strong opioid prescriptions to over 90 percent of his patients with little to no support in the corresponding diagnosis. The doctor was also identified as the top prescriber, by a significant margin, of an atypical combination of drugs. OIG's investigation revealed many recipients were seeing him for office visits each month to get their prescriptions, many more were concurrently enrolled in a substance abuse program and some were driving over 100 miles just to see this doctor. As a result, dozens of recipients were locked into a Medicaid benefits monitoring program and the doctor changed his prescribing habits.

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 2020, PARIS matches resulted in $11.7 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.

PARIS
PUBLIC | ASSISTANCE | REPORTING | INFORMATION | SYSTEM

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 2020, the IP Locator Project resulted in $919,620 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 who have committed a criminal offense are referred to the Michigan Department of Attorney General for review of criminal charges.

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

Front End Eligibility (FEE): MDHHS caseworkers may request an investigation by an OIG agent when applications or 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 potentially fraudulent activity in the Medicaid program to OIG through a variety of methods including email, telephone and toll-free hotline.

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

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

MCO Program Integrity Activities: Each MCO reports their program integrity activities performed each quarter to OIG. As MCOs submit their quarterly reports, OIG-ID staff review each of the 43 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.

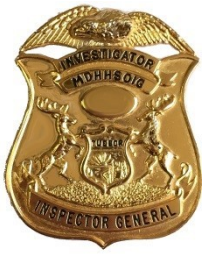
Provider Fraud – Health Services: OIG uses an investigative process to detect and deter potential instances of fraud, waste and abuse in health services programs. Provider fraud may include giving or receiving bribes or kickbacks, unacceptable medical and/or billing practices, misusing or abusing Medicaid 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.).

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 food benefits or Bridge Cards.
- Purchasing beverage(s) that require a bottle deposit, dumping/discarding beverage(s) and then returning the container(s) to obtain the cash deposit refund.
- Accepting food benefits/Bridge Card for unauthorized items (retailers only).

Report Welfare Fraud at:
Michigan.gov/Reportwelfarefraud 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:
Michigan.gov/Fraud or 855-643-7283

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person’s eligibility.

DHS-Pub-235 (Revised: 3-21)