FY 2016 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) 2016.

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

- Accounted for $231.9 million in program integrity efforts (fraud detection, cost savings and disqualifications).
- Performed 37,386 public assistance application investigations resulting in cost avoidance of more than $116.7 million.
- Identified $37.6 million of public assistance program fraud.
- Established $24.7 million in Medicaid provider receivables and cost savings.
- Completed 10,769 public assistance fraud investigations.
- Established $12.2 million in cost savings from disqualifications of public assistance recipients for intentional program violations.
- Referred 39 Medicaid provider fraud cases to the Michigan Department of Attorney General for prosecution review.

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

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

Sincerely,

Alan Kimichik
Inspector General

Executive Summary

FRAUD DETECTION AND PREVENTION

Enforcement Division
In FY 2016, the Office of Inspector General – Enforcement Division agents:

- Determined $153.3 million of fraud, cost savings and established program disqualifications, a 13 percent increase over FY 2015.
- Completed 10,769 fraud investigative dispositions.
- Completed 37,386 Front End Eligibility (FEE)[1] investigations.
- Identified $116.7 million in cost avoidance in FEE investigations, a nine percent increase over FY 2015.
- Established an additional $12.2 million in cost savings from intentional program violation (IPV) disqualifications.
- Identified $24.2 million of program fraud.

Integrity Division
In FY 2016, the Office of Inspector General – Integrity Division agents:

- Sanctioned 108 providers, establishing $3.1 million in fee for service and $5.5 million in managed care encounter payment cost savings.
- Identified $12.9 million in inappropriate Medicaid expenditures, recovering $7.5 million.
- Performed program integrity oversight of Michigan Medicaid's 11 Managed Care Organizations (MCO). These MCOs performed a total of 2,172 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $36.6 million.
- Referred 39 Medicaid providers to the Attorney General's Health Care Fraud Division for credible allegation of fraud investigations.
- Completed 1,616 fraud investigation dispositions.

Operations Division
In FY 2016, the Office of Inspector General – Operations Division:

- Established claims for over $19 million from Food Assistance Program (FAP) resulting from client or agency error and fraud.

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

Executive Summary
(Continued)

Enforcement Division
Specialized Investigative Units:

In FY 2016, the Special Investigations Unit (SIU) agents:

- Completed 356 investigations.
- Determined $4.8 million of provider, contractor, recipient and employee fraud.

In FY 2016, the Benefit Trafficking Unit (BTU) agents:

- Completed 2,034 benefit trafficking investigations, a 13 percent increase over FY 2015.
- Determined $3.5 million in fraud from trafficking, an 84 percent increase over FY 2015.
- Established an additional $1.8 million in cost savings from IPV disqualifications.

In FY 2016, the Cooperative Disability Investigation Unit (CDI) agents:

- Completed 115 cooperative disability investigations.
- Established $11.8 million in cost savings.

COST EFFECTIVENESS AND PRODUCTIVITY

In FY 2016:

- Every dollar spent on fraud prevention resulted in $33 of cost avoidance and savings for taxpayers.
- For every hour spent on an investigation, $340 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.

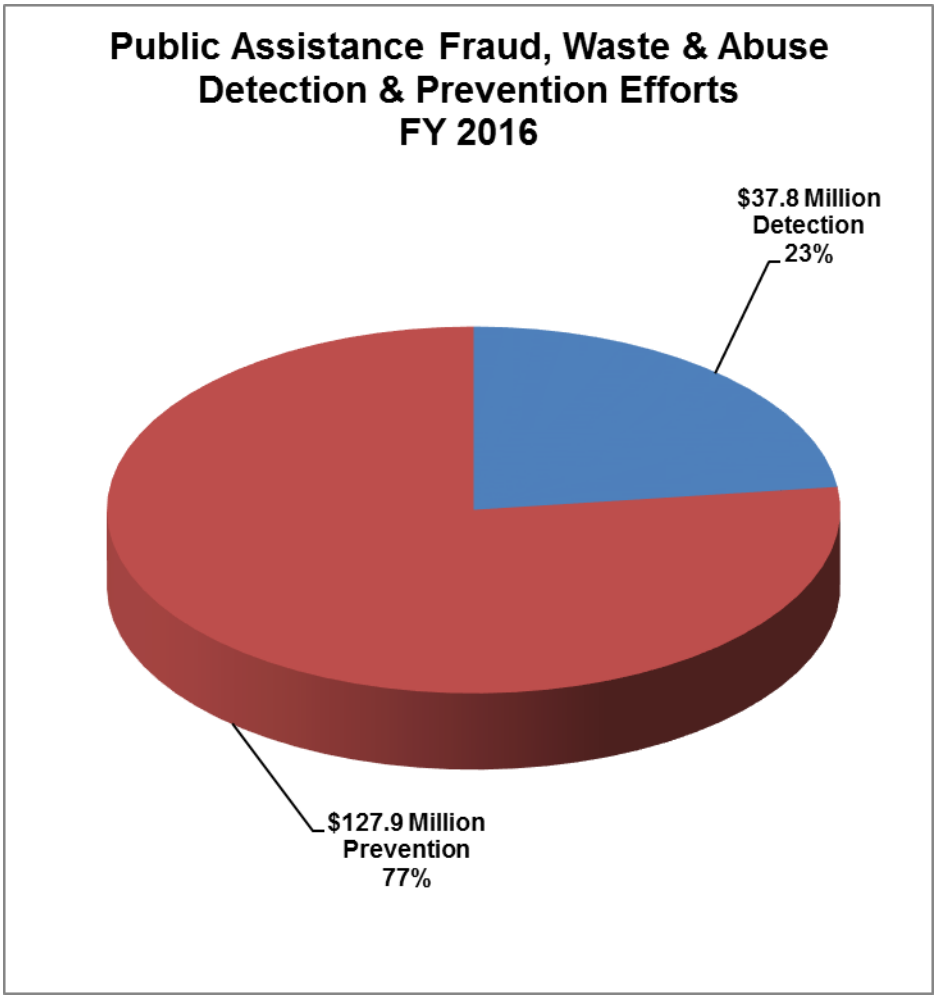
- Responsibility - OIG employees shall dedicate themselves to treating all people with respect, fairness and compassion.
- Excellence - OIG employees shall know the laws, rules and policies that will aid them in performing their duties and serving the public.
- Integrity - OIG employees shall recognize 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

The Office of Inspector General (OIG) is the criminal justice agency within the Michigan Department of Health and Human Services (MDHHS) providing program integrity services. OIG agents provide investigation and advisory services to ensure appropriate and efficient use of available public resources in the State of Michigan. Within the OIG there are three divisions: Integrity (Medicaid providers), Enforcement (recipients/vendors and non-Medicaid providers) and Operations (Administrative, Investigative Analytics and Field Recoupment). 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 - $37.8 million
Fraud prevention in public assistance - $127.9 million



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.

ENFORCEMENT DIVISION

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

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

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

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

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

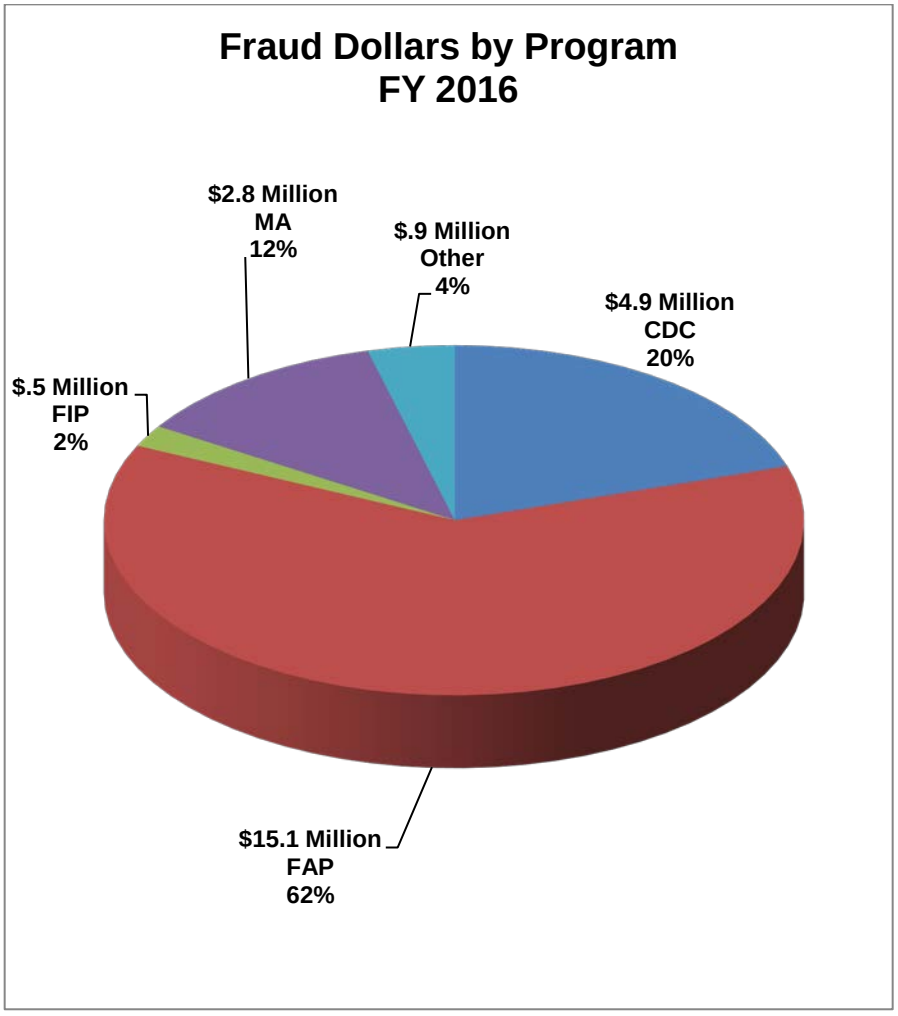
- Cooperative Disability Investigations (CDI) Unit: The CDI unit combats fraud by investigating questionable statements and activities of claimants, medical providers, interpreters or other service providers who facilitate or promote disability fraud. The unit investigates individual disability claims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

PROGRAM INTEGRITY IMPACTS

OIG's Enforcement Division determined over $24 million in fraud during FY 2016 within multiple Michigan public assistance program areas. As a result of the Enforcement Division efforts, during FY 2016, 276 felony warrants were authorized by county, state and federal prosecutors. Investigations by Enforcement Division agents have uncovered over $75.6 million in fraud during the last three years.

Program Highlights

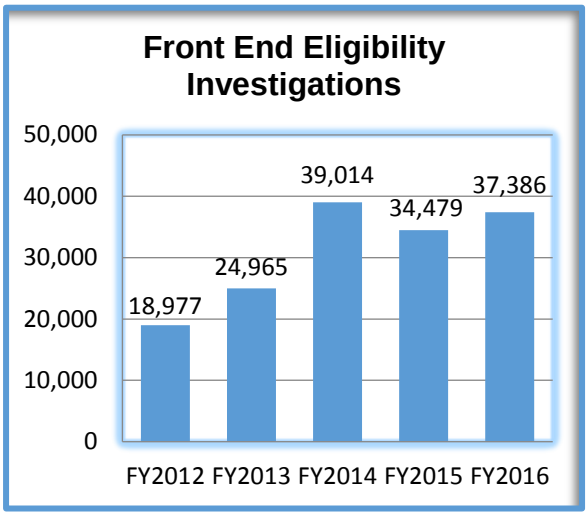
- FAP accounted for 62 percent of Michigan's public assistance fraud during FY 2016.
- OIG investigated 9,609 fraud cases in the FAP program, with 5,451 fraud investigative dispositions and 255 criminal warrants issued for a fiscal year total of over $15.1 million in fraud found.
- OIG completed 449 CDC cases resulting in $4.9 million in fraud found for the Michigan Department of Education (MDE).
- OIG completed 669 investigations of Medicaid beneficiary fraud resulting in $2.8 million in fraud found.

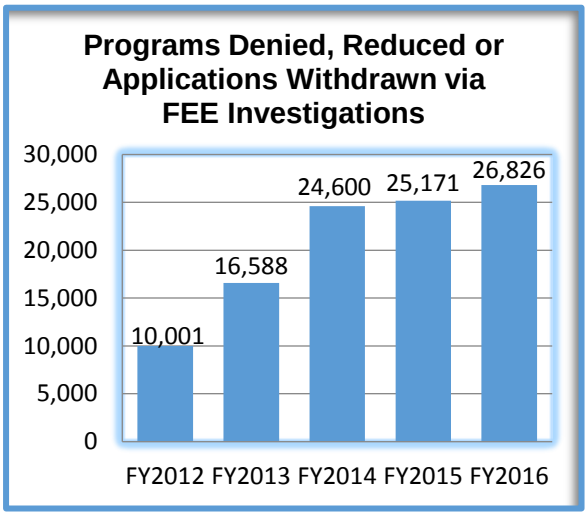


CDC = Child Development and Care Program
FAP = Food Assistance Program
FIP = Family Independence Program
MA = Medicaid Program
Other = Adult/Children's Services, State Disability, State Emergency Relief

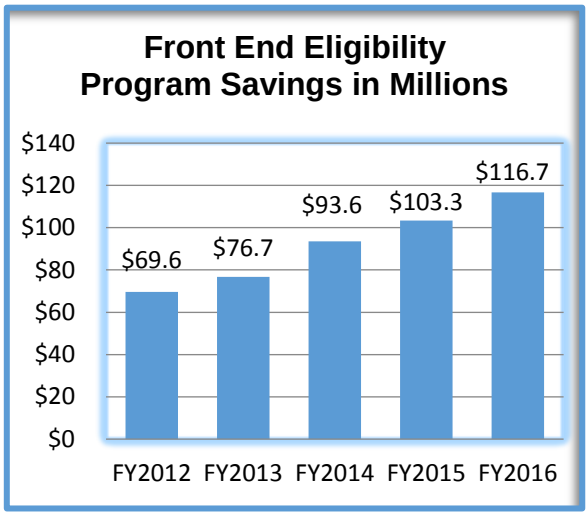
FEE: EARLY FRAUD DETECTION AND PREVENTION

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 37,386 investigations in FY 2016 and identified over $116.7 million in cost savings. Investigations by these agents have resulted in over $313 million in program savings for taxpayers over the last three-year period.



2016 ENFORCEMENT DIVISION FRAUD DETECTION AND PREVENTION INVESTIGATION HIGHLIGHTS

Unreported Business Ownership

OIG initiated a FEE investigation based on a data analytics match that identified recipients of Medicaid who also received payments as a Medicaid provider. The client applied for MA and reported self-employment as a dentist earning $20,000 per year. The subsequent OIG investigation found that the client owned the dental practice and the building in which it was housed. It was also confirmed that the client owned a 2015 Mercedes Benz. In response to a request for vehicle purchase information, the Mercedes Benz dealership disclosed that the client reported he earned $150,000 per year as a dentist. As a result of the FEE investigation, Medicaid for the entire family closed, resulting in an annual cost savings of over $285,000. The case remains under investigation in regards to past issued medical benefits.

Multi-Agency Fraud

A client, who was also a landlord, failed to report that she illegally kept her tenants' social security benefits each month. When interviewed by OIG, the client admitted stealing over $4,000 per month in social security benefits intended for her disabled tenants. Based on the improper receipt of the Social Security benefits, the client was completely ineligible for the food assistance and Medicaid she received under her own public assistance case. In addition, the investigation revealed that the client used the food assistance benefits of two of her former tenants after they became hospitalized and later died. The client pled guilty to several fraud charges and was ordered to pay $260,000 in Social Security Administration benefits and $25,185 in restitution to MDHHS. The client was subsequently sentenced to 24-60 months in prison.

Unreported Income

An OIG initiated data mining project identified a client who failed to report her employment to MDHHS. The OIG investigation verified that from March 2013 through February 2016, the client received over $15,000 in FAP benefits which she was completely ineligible for. The client reported $660 to $1,400 in monthly income to MDHHS. Her actual monthly gross income ranged from $4,000 to $8,000. The employer verified that the paystubs provided to MDHHS to establish eligibility were altered to reflect lower than actual earned income amounts. The client also failed to report another employer where she had monthly gross income ranging from $3,900 to $8,600. The client pled guilty to welfare fraud and was ordered to pay restitution of $15,622 and serve probation.

Group Composition

Over the course of several years, a client failed to report several eligibility factors to MDHHS which resulted in her receiving more public assistance than she was entitled to. The client failed to report that her husband, who received annuity payments of $8,500 per month, resided with her and that she also operated a beauty supply business with another person. The client also failed to report that her son, who she was collecting public assistance for, was incarcerated. During the period of October 2014 through July 2016 the client improperly received $29,256 in FAP and Medicaid. After a lengthy investigation, the client pled guilty to welfare fraud.

False Reporting of Employment

For several years, a client reported to MDHHS that she had multiple employers to show she was working and meeting CDC program requirements. The client claimed she was paid cash "under the table." The OIG investigation revealed that the clients' employment with the various businesses did not occur during the CDC eligibility period. Hand-written receipts submitted to MDHHS were determined to be fabricated by the client. An administrative hearing found that the client was in violation of MDHHS policy and ordered her to repay $32,326 in CDC benefits.

Child Development and Care Program Fraud

A complaint alleged that a client was not working, but claimed to be so she could receive CDC benefits. The OIG investigation revealed that the client was not employed and that the employment verification form she provided MDHHS was fabricated. OIG interviewed the client who, after a brief discussion, refused to provide further details of the alleged employment and subsequent CDC benefits being issued to her mother who was listed as her child care provider. After the OIG interview, the client agreed to repay the CDC benefits in the amount of $66,812.

Unreported Business Ownership

A FEE referral was received regarding a client's unreported self-employment income. During the investigation, OIG obtained bank records and identified several large deposits. Further investigation revealed the client's self-employment and the large deposits represented payments for contracted services. When interviewed by the OIG agent, the client admitted he did not report his self-employment to MDHHS. The agent obtained further evidence that another company owned by the client grossed over $110,000 in income during 2015. The client submitted a signed confession and requested FAP and MA case closure. This resulted in cost avoidance of $28,428 for both programs. A fraud investigation is being conducted.

BENEFIT TRAFFICKING UNIT (BTU)

The BTU investigates allegations of Food Assistance Program (FAP) trafficking. Trafficking is the buying and selling of benefits for cash or other ineligible items including tobacco, alcohol, firearms, drugs and gambling. Violations 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.

The BTU also investigates allegations of Medicaid (MA) fraud which includes prescription forgery, prescription theft and narcotics "shopping" with multiple prescribers and/or pharmacies. In addition, the BTU investigates the sale of a person's MA card to obtain health services.

FY 2016 BTU HIGHLIGHTS

OIG has an investigative partnership with Michigan State Police's (MSP) Bridge Card Enforcement Team (BCET). The Bridge Card is MDHHS' debit card used to issue FAP and cash benefits. OIG and MSP actively work to identify and prosecute retailors and public assistance recipients who traffic FAP benefits and commit identity theft. In two separate investigations, BTU and BCET successfully prosecuted store owners and recovered over $84,000 in court ordered restitution. BTU agents are pursuing disqualification and benefit recovery from over 200 MDHHS recipients based on evidence of FAP trafficking from the store investigations.

Convenience Store Trafficking

A trafficking investigation involving a small convenience store using multiple Bridge Cards to make purchases was initiated with the assistance of store associates at a Michigan big box retailer. Store employees noticed several inappropriate FAP transactions were made using MDHHS recipient's Bridge Cards. The purchases were suspicious to the store associates as the food items purchased are not normally associated with household consumption. After investigation, several MDHHS recipients agreed to repay over $3,600 in benefits and were each disqualified from participation in the FAP for 12 months.

Vending Machines

A retail store employee observed a vending machine owner using another person's Bridge Card to pay for his purchases. The BTU investigation determined that the vending machine owner was in possession of another recipient's Bridge Card. The vending machine owner admitted that he paid another person for the use of the Bridge Card to stock his own vending machines. The BTU successfully collected $1,100 from the vending machine owner, who was also receiving FAP, and the other recipient in this short-lived fraud. Both individuals were disqualified from FAP for 12 months.

Joint BTU and the United States Department of Agriculture (USDA)-OIG Investigation

The BTU and USDA-OIG agents initiated a joint investigation involving a Michigan convenience store. The owner of the store also owned two homes, one of which he was renting and not reporting the income to MDHHS. The store owner was active in numerous MDHHS programs including FAP, cash assistance, CDC and MA. During the period of 2004 to 2015, the store owner reported minimal income to MDHHS in a fraudulent attempt to continue receiving public assistance benefits. The BTU and USDA agents collected evidence that ultimately resulted in the subject being convicted of FAP trafficking and welfare fraud. In federal court the store owner was ordered to repay over $225,000 in public assistance benefits and disqualified from FAP for life.

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 2016 SIU HIGHLIGHTS

MDHHS Employee Fraud

OIG received a fraud hotline complaint alleging a MDHHS employee was fraudulently assisting her family members in obtaining welfare benefits including FAP and MA. The employee was the case worker for the family members and approved applications for assistance knowing that the information provided on the applications was fraudulent. The investigation confirmed that the employee was assisting her brother, the father of her children and his mother in obtaining public assistance benefits they were not entitled to. The employee was subsequently convicted of welfare fraud and ordered to pay $11,025 in restitution. The employee resigned from her state position in lieu of termination. The employee's brother was also charged and convicted separately, based on this investigation.

Provider Fraud

Information derived from a data mining project revealed billing irregularities regarding a provider in the CDC program. Attendance records maintained by the provider did not match the provider's CDC Billing/Attendance Invoices submitted to MDHHS for payment. Evidence was gathered verifying the dates and times the parents required day care. The provider was unable to substantiate the number of hours charged to MDHHS for the care of the children. The child care provider was charged and convicted of fraud by false pretenses. The provider was incarcerated for three days, ordered to pay $55,499 in restitution to MDHHS and received 12 months' probation.

Adoption Subsidy Fraud

Based on a referral from the MDHHS Adoption Subsidy Unit (ASU), OIG investigated allegations that a client failed to report changes in her household group composition. The OIG investigation revealed that the adopted mother collected adoption subsidy funds for a child after the child had moved out of the home and the client failed to inform MDHHS. The client signed a repayment agreement to reimburse the state over $6,721 in adoption subsidy payments.

COOPERATIVE DISABILITY INVESTIGATIONS (CDI) UNIT

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

The two OIG agents, working in partnership with SSA-OIG, produced a total cost savings of $11.8 million.

CDI Investigation Highlight:

Since 2010, the subject was receiving SSA Disability Insurance Benefits. Following the commencement of a routine continuing disability review, the subject informed DDS that her mental impairment continued, she was schizophrenic, that she heard voices and imagined she was in the Army. The subject's sister completed SSA forms stating the subject had the mental capacity of a child and never went outside the house alone. She also claimed the subject needed assistance with dressing and bathing. DDS believed the subject was exaggerating her symptoms and referred this to the CDI Unit.

The OIG agent initiated contact with the subject's neighbors who indicated that the subject had no apparent mental or physical problems, that they often observe the subject outside and that the subject had no problems in conversing. The agent confirmed with a local fitness facility that the subject worked out at the gym. During a subsequent interview with OIG, the subject acknowledged that she left the home often and that she was employed as a test driver for a local automotive company (she was hired two months prior to the interview). OIG obtained records from the employer, which confirmed the employment. The subject stated that she was planning to obtain her CDL driver's license endorsement to earn more money. The agent video recorded the interview, which provided further evidence that the subject had the ability to converse and act in a normal manner.

Due to the investigation, the DDS discontinued the subject's disability benefits. The case resulted in a SSA savings of over $90,000 and a Medicaid savings of over $60,000. Additionally, the case was referred for civil monetary penalties due to the sister's false statements on the SSA forms.

INTEGRITY DIVISION

In FY 2016, Michigan's health services programs had a combined budget of approximately $17.9 billion and paid approximately 100,000 providers for goods and services provided to beneficiaries covered under the programs. OIG's Integrity Division (OIG-ID) fulfills the program integrity functions required by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR §455.13-17, 42 CFR §455.21-23 and 42 CFR §455.500-518.

The Integrity Division is responsible for conducting and supervising activities to prevent, detect and investigate provider fraud, waste and abuse in Michigan's health services programs, including Michigan's Medicaid Program, Mental Health Program, MI Child Program and Children's Special Health Care Services Program (for the purposes of this report, these health services programs will be described using the general term "Medicaid"). Through its audits and investigations, the Integrity Division works to ensure that the money spent on health services is used for the best care of the beneficiaries.

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

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

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

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

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

HEALTH SERVICES PROGRAMS IMPACTS

In FY 2016, OIG-ID had an overall impact to direct Medicaid spending (i.e., fee-for-service (FFS)) totaling $24.7 million through the following activities:

- Identified a total of $12.9 million in overpayments made to Medicaid providers. To date, $7.5 million has been recovered while the remaining $5.4 million is being repaid over time.

- In FY 2016, OIG-ID:

    - Received 501 allegations of potential fraudulent activity from various sources (e.g., 156 tips from beneficiaries, 135 tips from the public (55 anonymous), 134 referrals from inside MDHHS, 27 referrals from MCOs, 23 tips from beneficiary family members/friends, 11 referrals from law enforcement agencies, nine tips from providers).
    - Identified 576 audit targets through data analytics.
    - Completed 1,616 fraud investigation dispositions.

- Prevented an estimated $4.7 million in future payments, through reduced billing activities as a result of Medicaid provider audits and investigations.

- Sanctioned 108 Medicaid providers, preventing an estimated $3.1 million in future payments.

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

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

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

- Referred 39 Medicaid providers to the Medicaid Fraud Control Unit (MFCU) for criminal investigation.

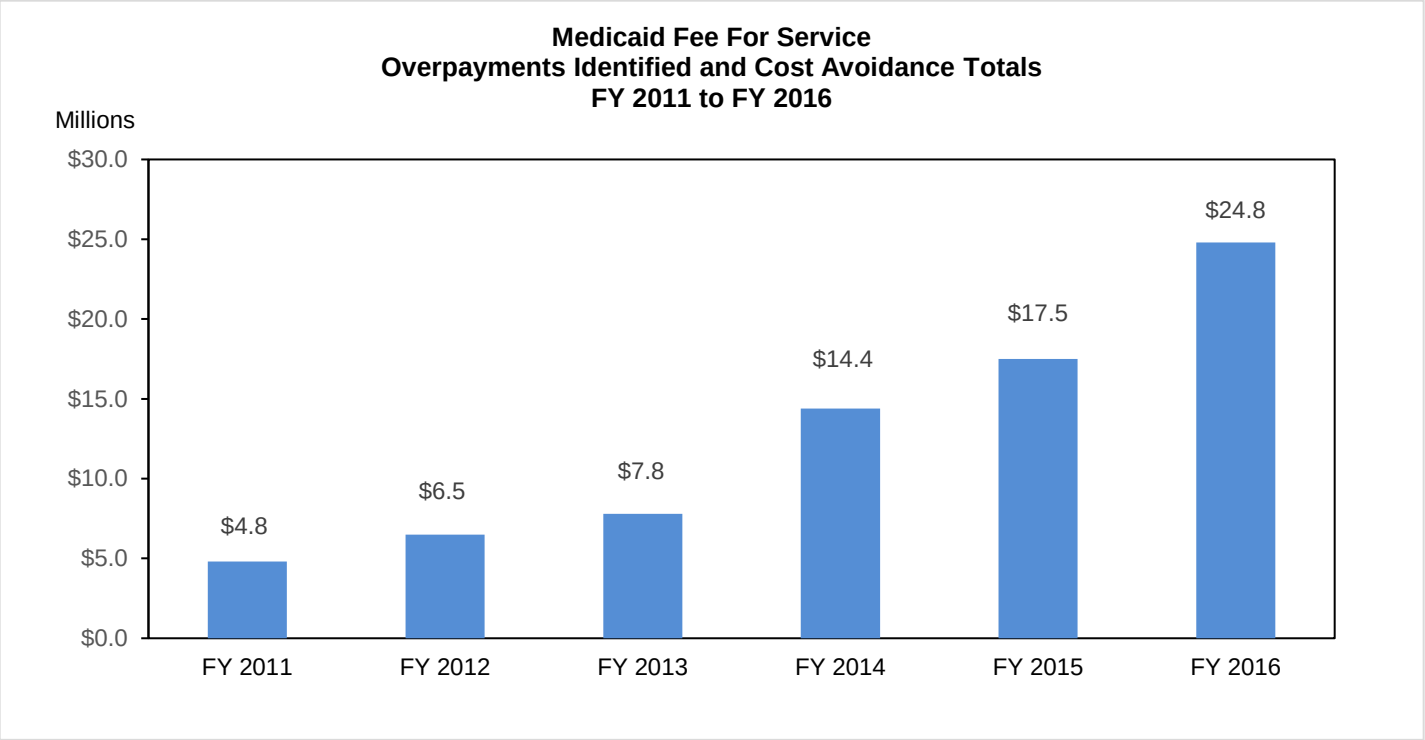
    - In accordance with federal regulation (42 CFR §455.21), the MFCU is the first referral destination for all cases of suspected Medicaid provider fraud.
    - 11 previously referred providers were convicted and required to pay a total of $547,473 in restitution.

In FY 2016, OIG-ID had an overall impact to indirect Medicaid spending (i.e., Managed Care Organization (MCO) encounter claims) totaling $42.1 million through the following activities:

- $36.6 million in identified overpayments through program integrity related oversight of the Michigan Medicaid MCOs.

    - An increase of $31.8 million from FY 2015.

- Sanctioned 108 Medicaid providers, preventing an estimated $5.5 million in future MCO encounter payments.



FIELD INVESTIGATION SECTIONS OVERVIEW

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

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

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

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

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

2016 FIELD INVESTIGATION SECTIONS HIGHLIGHTS

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

In FY 2016, 18 pharmacy providers agreed to repay the Medicaid program a total of $3.3 million as a result of pharmaceutical inventory audits.

Home Help
In FY 2016, receivables were established for 474 home help providers totaling $1.3 million for payments made while their beneficiaries were hospitalized and/or after their death or while the provider was incarcerated.

Dental
In FY 2016, 16 dental providers agreed to repay the Medicaid program a total of $178,687 that they received as a result of billing for services that violated Medicaid Dental Policy.

Long Term Care
A nursing home repaid the Medicaid program $31,975 as a result of peer review results indicating that two patients did not meet the level of care eligibility requirements to qualify for long term care services.

Vision
In FY 2016, 28 vision providers agreed to repay the Medicaid program a total of $181,127 that they received as a result of billing for services that violated Medicaid Vision Policy.

Maternal Infant Health Program (MIHP)
In FY 2016, 19 MIHP providers agreed to repay the Medicaid program a total of $139,420 that they received as a result of billing for services that violated Medicaid MIHP Policy.

Transportation
In FY 2016, three ambulance providers agreed to repay the Medicaid program a total of $126,093 that they received as a result of billing for advanced life support, when basic life support was more appropriate.

Home Health
In FY 2016, 10 home health providers agreed to repay the Medicaid program a total of $47,081 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.

CONTRACT OVERSIGHT SECTION OVERVIEW

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

MCO OVERSIGHT UNIT

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

- In coordination with the Managed Care Plan Division, OIG-ID requires each of Michigan Medicaid's physical health MCOs to complete section six of the Managed Care Compliance Review tool.
    - Section six requires each MCO to report to OIG-ID their program integrity activities performed each quarter. Program integrity activities include information relating to tips/grievances received (including explanation of benefits), data mining activities, audits performed and provider dis-enrollments.
    - As MCOs submit their quarterly reports, OIG-ID's MCO Oversight Unit analysts review each report for compliance. An MCO's report can receive a pass, incomplete or failure. MCOs who receive an incomplete or fail must submit a Corrective Action Plan (CAP).
    - Corrective Action Plan submissions are reviewed by the MCO Oversight Unit analysts to ensure the CAP meets contract requirements.
- MCOs are required to refer all credible allegations of fraud to the MCO Oversight Unit.
    - An OIG-ID analyst is assigned to each MCO fraud referral to evaluate the referral and determine if the allegation was credible and if the fraudulent activity occurred system wide among other health plans and Medicaid fee-for-service.
    - If the allegation is deemed to be credible, a formal referral is made to the Attorney General's Medicaid Fraud Control Unit (MFCU).

2016 MCO OVERSIGHT UNIT HIGHLIGHTS

Provider Audits/Reviews
In FY 2016, Michigan Medicaid's 11 MCOs performed a total of 2,172 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $36,601,604.

Provider Sanctions
In FY 2016, OIG-ID agents prevented an estimated $5.5 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-IDs Vendor Audit Program. OIG-ID financial recovery activities include third party audit contractors to improve program integrity.

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

2016 VENDOR OVERSIGHT UNIT HIGHLIGHTS

Inpatient Hospital

In FY 2016, HMS performed a data mining scenario identifying beneficiaries with short lengths of stay for inpatient hospital claims. Medicaid beneficiary medical records were requested and reviewed by HMS to determine if the hospital stays were medically necessary (i.e., services could have been provided in an outpatient hospital or observation environment).

A total of 128 inpatient hospitals repaid $4.7 million back to Medicaid for those inpatient stays that were determined not to be medically necessary hospital stays.

Inpatient Hospital

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

In FY 2016, a total of 54 inpatient hospitals repaid $285,589 back to Medicaid for claims where the medical records did not validate the billing of the DRG code paid by Medicaid.

Hospice

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

In FY 2016, a total of 11 hospice providers repaid $251,648 back to Medicaid for those hospice stays that were determined to be uncompliant with Medicaid eligibility, service coverage and/or documentation requirements.

Inpatient Hospital

In FY 2016, HMS performed a data mining scenario, which identified incorrect DRG codes related to newborn claims.

A total of 47 inpatient hospitals repaid $152,332 back to Medicaid for claims where the medical records did not validate the billing of the DRG code paid by Medicaid.

OPERATIONS DIVISION

OIG's Operations Division (OIG-OD) is comprised of three sections: Administrative Services, Investigative Analytics and Field Recoupment. OIG-OD Administrative Services is responsible for overall administrative support of the office. It manages budget development and monitoring, system security, fraud hotlines, OIG policy, investigative process support as well as overseeing of the day-to-day business operations. In FY 2016, OIG's Administrative Services provided extensive quality control reviews on over 3,800 investigative packets referred to the Michigan Administrative Hearing System for debt collection and disqualification requests.

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

Thirdly, OIG-OD has responsibility for financial recoupment of monies owed to MDHHS. OIG-OD's Field Recoupment Section is responsible for the establishment of public assistance over-issuance claims owed by clients and service providers. Recovery of over-issued benefits helps to maintain the integrity of the programs. The section's work results in the establishment 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.

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 not otherwise readily apparent and are the critical first steps in the investigative process. OIG 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. IAU regularly mines Medicaid claims data to identify improper claim conditions. Examples include:

- Identifying patterns of suspicious Medicaid provider behavior based on historical data, including:
    - 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 to increase the reimbursement amount).

Examples of additional IAU functions and responsibilities include:

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

2016 IAU HIGHLIGHTS

Medicaid Provider Overpayment Detection In FY 2016, approximately 48 percent of the Medicaid provider overpayments identified by OIG and 26 percent of the fraud referrals were generated as a part of IAU data analytics/data mining.

Public Assistance Program Fraud Detection In FY 2016, approximately 53 percent of the public assistance program fraud investigations conducted by OIG were generated as a part of IAU data analytics/data mining.

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 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 2016, PARIS matches also resulted in $32.3 million in annual cost avoidance. The investigations also identified over $916,000 in fraud. OIG has representation on the national PARIS Board of Directors, providing guidance to all 50 states and territories utilizing the program.

PARIS Match Highlight

OIG received a PARIS match indicating that an MDHHS client was receiving welfare benefits in both Georgia and Michigan. Due to this investigation, the client was disqualified from the Food Assistance Program for 10 years, and ordered to repay $10,545 in benefits that had been fraudulently received.

Unbundling & Double Billing Algorithms

IAU developed standardized reports that use rules to identify overpayments related to the following: medical procedure code overlaps, medical procedure code unbundling, and medical procedure code double billing. The streamlined reporting tool allows investigators to quickly query on groups of procedures, date ranges, and other fields that may identify billing violations for investigation.

Billing Frequency Algorithms
Several new and modified sets of rules which identify billing violations related to medical procedures occurring too soon were created as standardized reports that can be ran by OIG staff. Investigators can now easily identify instances of a provider billing too frequently for new patient office visits, durable medical equipment, and dental services through the reporting tool.

Internet Protocol (IP) Locator Project
The Internet Protocol (IP) Locator Project was created to give OIG the capability to identify the physical location of individuals using MI Bridges to apply for Michigan public assistance benefits online. This capability increases the chances of catching potential and current clients who are residing outside Michigan and are improperly applying for public assistance benefits in Michigan. In FY 2016, the IP Locator Project resulted in $1.4 million in annualized cost avoidance, and $1.13 million in fraud found.

IP Locator Project Highlight
IAU unveiled a large identity theft scheme as a result of its IP Locator Project. This identity theft scheme consisted of the usage of more than 300 stolen identities which were used to apply for and/or receive fraudulent public assistance benefits. Through collaborative effort with OIG's Benefits Trafficking Unit (BTU), United States Department of Agriculture-Office of Inspector General (USDA-OIG), Michigan State Police and the Dearborn Police Department, the responsible subject plead guilty to Identity Theft and Theft of Public Money. The subject was sentenced to 70 months in prison, three years of probation, full restitution of over $518,000, and a lifetime disqualification from the Food Assistance Program.

FIELD RECOUPMENT

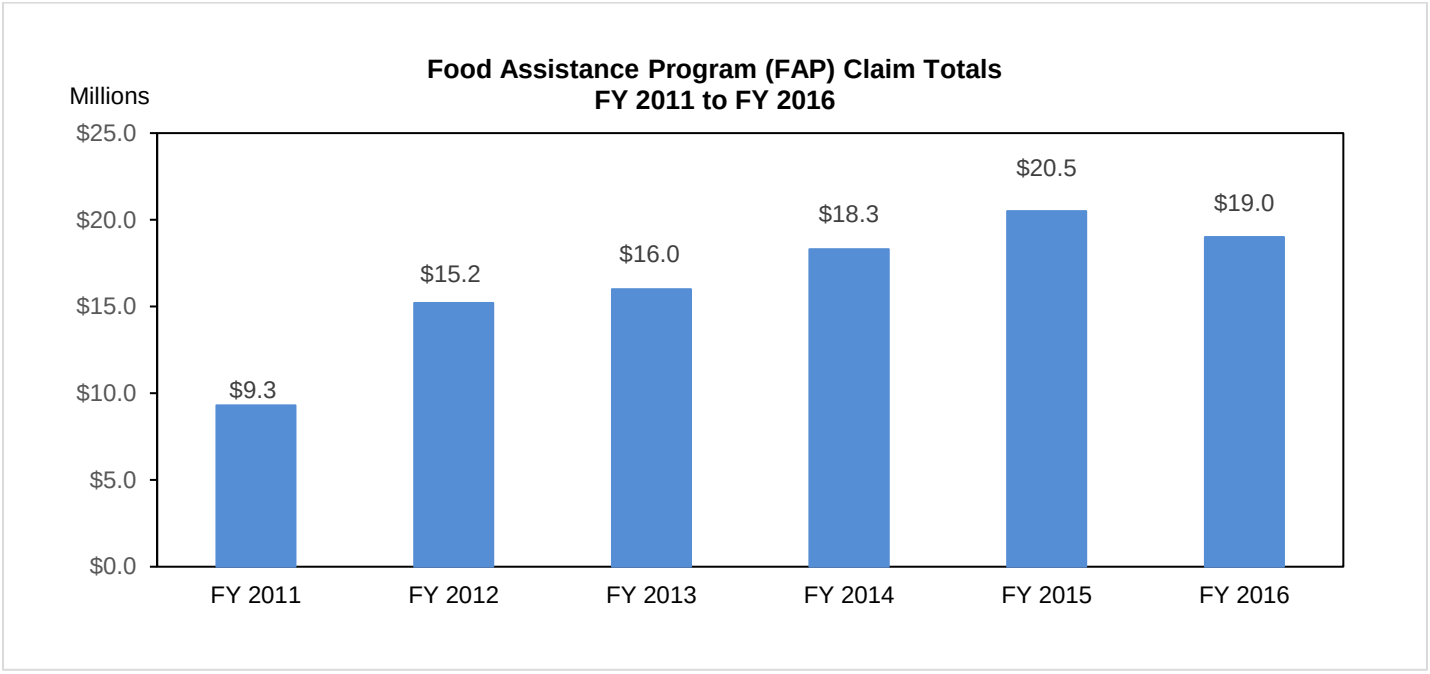
The Field Recoupment Section is responsible for the analysis, determination, establishment and administrative recoupment of benefits received for over-issued program benefits to clients. Recovery of over-issued benefits helps to maintain the integrity of the public assistance programs administered by the department. Field Recoupment efforts satisfy federal requirements under 7 CFR §273.18. The section'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. Recoupment staff are responsible for:

- Analyzing and determining the validity of over-issuance referrals, as well as gathering additional information to be used in establishing a claim. If valid, the Recoupment Specialist (RS) establishes the over-issuance period, amount and the type of claim; agency error, client error, or possible Intentional Program Violation (IPV). RS route suspected IPV claims to OIG investigators as appropriate.

- Providing assistance in the resolution of debtor inquiries and disputes pertaining to collection of delinquent claims.

- Representing the agency in Administrative Hearings for collection of debt due to over-issued benefits.

- Entering penalties and sanctions into the Bridges system and handling inquiries from other states pertaining to sanctions found on USDA-FNS' eDRS (disqualified recipient reporting system).



OIG ACTIVITIES

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

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

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

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

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

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

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

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

IP Locator Project: The Internet Protocol (IP) Locator Project was created to give the Enforcement Division 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.

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

Action Plan (CAP).

Policy Recommendations: OIG provides a leadership role in recommendations for policy changes to enhance prevention and detection of fraud by the continuous review of proposed and current department policy.

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

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

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

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

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.

The Michigan Department of Health and Human Services (MDHHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a MDHHS office in your area.