FY 2019 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) 2019 Annual Report.

The OIG's primary role is to investigate fraud, waste and abuse in programs administered by MDHHS and to increase program integrity and accountability. Now, more than ever, citizens expect accountability and integrity in state government, and OIG takes this to heart. As Inspector General of OIG, I am proud of the dedication, hard work and innovation my staff exhibit in the pursuit to reduce fraud, waste and abuse in public assistance programs. The landscape of fraud is constantly changing as new schemes are developed, and my staff continue to innovate to identify these schemes and ensure appropriate action is taken. As a result of my staff's dedication, the following accomplishments were achieved in FY 2019:

- Accounted for approximately $188 million in program integrity efforts (fraud detection, cost savings and disqualifications).
- Performed 24,712 public assistance application investigations resulting in cost avoidance of more than $85.3 million.
- Identified $11.8 million of public assistance program fraud.
- Completed 7,134 public assistance fraud investigations.
- Established $6 million in cost savings from disqualifications of public assistance recipients for intentional program violations.
- Established $37.8 million in Medicaid provider receivables and cost savings.

OIG's actions benefit all citizens by helping ensure that funds for public assistance programs are available to the residents that truly need them, and that taxpayer's money is spent on its intended purpose. I want to thank the OIG's dedicated employees, fellow state employees and all Michiganders who reported suspected fraud, waste, abuse, and misconduct in FY 2019 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 2019, the Office of Inspector General – Enforcement Division agents:

- Determined $110.4 million of fraud, cost savings and established program disqualifications.
- Completed 7,134 fraud investigation dispositions.
- Completed 24,712 Front End Eligibility (FEE)[1] investigations.
- Identified $85.3 million in cost avoidance in FEE investigations.
- Established an additional $6 million in cost savings from intentional program violation (IPV) disqualifications.
- Identified $11.8 million of program fraud.

"For every hour spent on an investigation, $201 of receivables and disqualifications were established."

Integrity Division
In FY 2019, the Office of Inspector General – Integrity Division agents:

- Sanctioned 102 providers, establishing $9.2 million in fee for service and $12.3 million in managed care encounter payment cost savings.
- Identified $6.6 million in inappropriate Medicaid expenditures, recovering $4.3 million.
- Performed program integrity oversight of Michigan Medicaid's 43 Managed Care Organizations (MCO). These MCOs performed a total of 28,024 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $27.5 million.
- Referred two Medicaid providers to the Attorney General's Health Care Fraud Division for credible allegation of fraud investigations.
- Completed 650 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 2019, the Special Investigations Unit (SIU) agents:

- Completed 245 investigations.
- Determined $1.4 million of provider, contractor, recipient and employee fraud.

In FY 2019, the Benefit Trafficking Unit (BTU) agents:

- Completed 1,983 benefit trafficking investigations.
- Determined $3.07 million in fraud from trafficking.
- Established an additional $1.8 million in cost savings from IPV disqualifications.

In FY 2019, the Cooperative Disability Investigation Unit (CDI) agents:

- Completed 71 cooperative disability investigations.
- Established $7.3 million in cost savings.

"Every dollar spent on fraud prevention resulted in $29 of cost avoidance and savings for taxpayers."

COST EFFECTIVENESS AND PRODUCTIVITY

In FY 2019:

- Every dollar spent on fraud prevention resulted in $29 of cost avoidance and savings for taxpayers.
- For every hour spent on an investigation, $201 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.

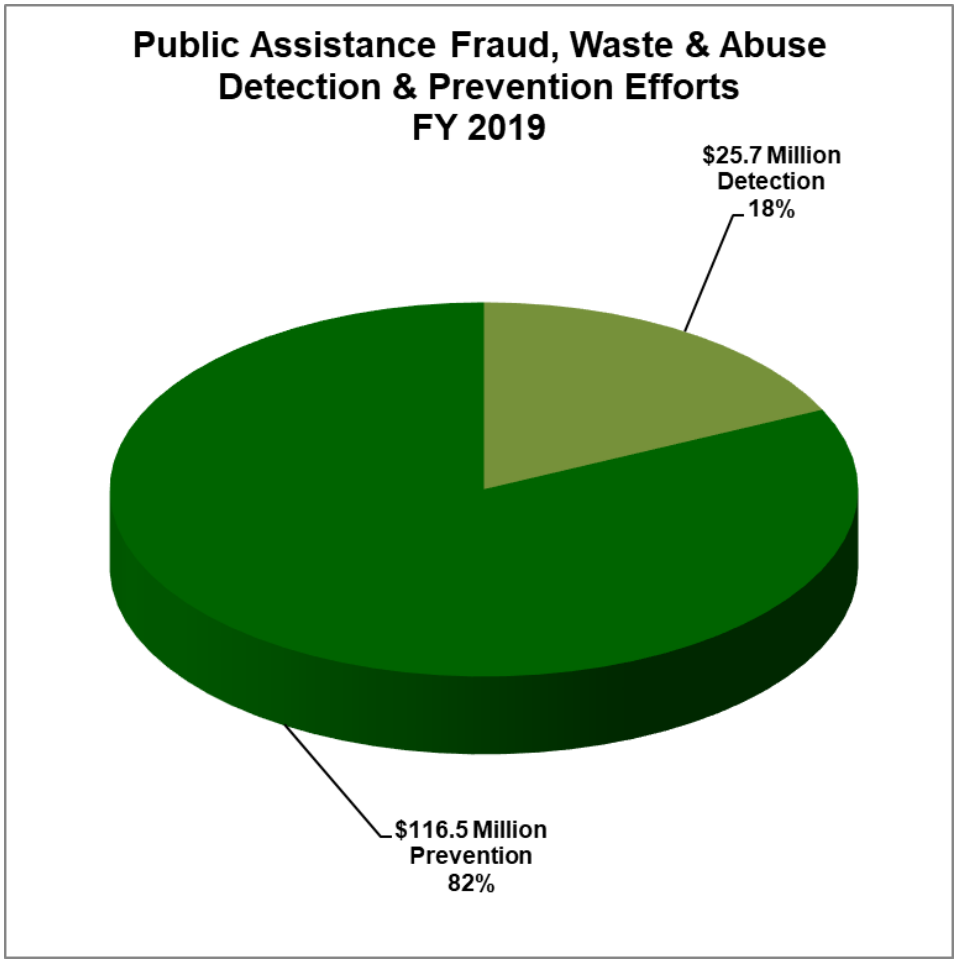
INSPECTOR GENERAL OVERVIEW

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 - $25.7 million
Fraud prevention in public assistance - $116.5 million



Notes: Represents FIP (Family Independence Program), FAP (Food Assistance Program), SDA (State Disability Assistance), SER (State Emergency Relief), and Fee-For-Service Medicaid.

ENFORCEMENT DIVISION

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

FRAUD INVESTIGATIONS

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

Fraud Investigation Highlights

Dual Assistance
A referral was received by the Office of Inspector General alleging that a public assistance recipient was simultaneously receiving benefits in Michigan and South Carolina. The investigation determined the recipient fraudulently received $61,545 in Food Assistance Program and $56,404 in Medicaid benefits. The recipient pled guilty to felony Welfare Fraud and was sentenced to restitution of $117,949, two years of probation and two days in jail (credit for time served).

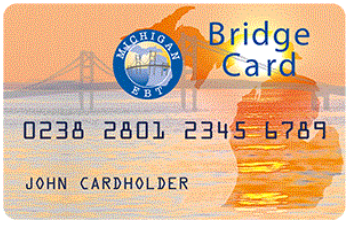
Employed Spouse in the Household
OIG identified a recipient that filed fraudulent applications with MDHHS. The recipient failed to report that their spouse was employed and residing in the household, which resulted in the recipient improperly receiving Medicaid benefits in the amount of $31,843 and Food Assistance Program benefits in the amount of $31,724. The recipient pled guilty to felony Welfare Fraud and was sentenced to restitution of $63,567, fines and costs of $1,458, two days in jail, and five years of probation.

Group Composition
An Office of Inspector General investigation identified a recipient that intentionally failed to report accurate group composition and household income resulting in an over payment of Food Assistance Program benefits of $17,952 and Medicaid benefits of $12,798. The recipient was charged and pled guilty to felony Welfare Fraud and was sentenced to full restitution, fines and costs, one day in jail, five years of probation, and 250 hours of community service to be served within six months or serve 125 days in jail.

ENFORCEMENT DIVISION

Failure to Report Correct Household Income

An Office of Inspector General investigation determined that a public assistance recipient's adjusted gross income was over four times the amount that the recipient reported, resulting in the fraudulent receipt of $13,390 of Food Assistance Program benefits and $45,800 of Medicaid benefits. The recipient pled guilty to felony Welfare Fraud and was ordered to pay fines and costs and restitution to the Michigan Department of Health and Human Services in the amount of $62,551.



Self-Employment Income

An investigation of a public assistance recipient by the Office of Inspector General determined the recipient owned a home maintenance service and underreported their self-employment income to the Michigan Department of Health and Human Services. This resulted in the recipient fraudulently receiving Food Assistance Program benefits in the amount of $21,646. The recipient was criminally convicted of Welfare Fraud and was sentenced to restitution in the amount of $21,646, a term of probation with 90 days suspended jail time and a 12-month Food Assistance Program disqualification.

Use of an Alias and Fake Children to Obtain Benefits

The Office of Inspector General initiated an investigation after receiving a hotline referral indicating that a recipient claimed a larger household composition than was accurate. It was determined that the recipient had two open cases. One utilized a legal name. The second utilized an alias as well as fake birth certificates and social security cards for three children (that did not exist) to obtain Child Development and Care, Food Assistance Program, Family Independence Program, and Medicaid benefits. The recipient was convicted of felony Welfare Fraud and was ordered to pay back $40,582 in restitution to the State of Michigan and sentenced to one day in jail and 36 months of probation.

Two Social Security Numbers

A joint investigation with the Social Security Administration (SSA) identified a recipient that applied for and received federal and state benefits under two different social security numbers. The recipient pled guilty to Theft of Government Funds and was sentenced to one month of house arrest followed by 35 months of probation and ordered to pay restitution of $63,576 to the SSA and $10,232 to the Michigan Department of Health and Human Services in Food Assistance and Medicaid benefits.

Joint Investigation

The Office of Inspector General and the Social Security Administration conducted a joint investigation and identified a recipient that failed to report that their employed spouse lived in the same household. The investigation determined the recipient was over-issued Food Assistance Program benefits. In addition, the Social Security Administration determined the recipient was not eligible for Supplemental Security Income (SSI) benefits, resulting in ineligibility for Medicaid and State SSI cash payments. The recipient pled guilty to False Statements Relating to SSI and was sentenced to two years supervised release and ordered to pay restitution of $76,440 to MDHHS and $73,769 to the Social Security Administration.

ENFORCEMENT DIVISION

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.

FEE Investigation Highlight

Unreported Assets
As the result of a Front End Eligibility (FEE) referral, an Office of Inspector General investigation confirmed that a recipient and their partner lived in one residence and failed to disclose to the department that they owned two additional residences. The undisclosed assets made the recipient ineligible to receive Food Assistance Program benefits and resulted in an overpayment of $17,112. The case has been forwarded to the county prosecutor for criminal charges along with a 12-month Food Assistance Program disqualification.

BENEFIT TRAFFICKING UNIT (BTU)

The Benefit Trafficking Unit agents investigate the unauthorized acquisition or trafficking of public assistance benefits, including the use of stolen or fraudulent identities in benefit applications. Trafficking is buying, selling or trading public assistance benefits for cash or other ineligible items, including tobacco, alcohol, firearms, drugs, and gambling. The unit also investigates allegations of Medicaid fraud, which includes prescription forgery, prescription theft, and narcotics “shopping” with multiple prescribers and/or pharmacies. In addition, the unit investigates the sale of a person’s Medicaid card to obtain health services.

Trafficking Investigation Highlights

Identity Theft Investigation
An OIG investigation discovered that numerous fraudulent benefit applications were submitted by an individual using stolen or manufactured identities to illegally receive FAP benefits. The investigation identified the perpetrator and determined that nearly $75,000 in fraudulent benefits were obtained by the suspect. A warrant request has been submitted to the prosecutor for food stamp fraud over $1000, a 10-year felony. The investigation also determined that several of the fraudulent FAP benefits were trafficked to owners of a bar that used the benefits to buy food for resale at the bar. In addition, the business owners failed to report assets and income to MDHHS while also receiving public assistance benefits. The couple was criminally charged and convicted and ordered to pay $71,356 in restitution.

ENFORCEMENT DIVISION

Identity Theft and Food Assistance Program Trafficking
An individual was involved in an elaborate welfare fraud scheme by stealing the identities of others and trafficking Food Assistance Program (FAP) benefits on numerous occasions. The offender was captured on store surveillance videos using the Electronic Benefit Transfer (EBT) cards of several individuals without their knowledge or permission. The offender was found guilty of three felony counts: Welfare Fraud, Identity Theft and Financial Transaction Device, with a habitual offender – second offense notice; and was sentenced to full restitution of $66,232 and five years of probation.

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.

SIU Investigation Highlights

Adoption Subsidy Fraud
A married couple failed to notify the Adoption Subsidy Unit when their adopted child was no longer residing in the household. The couple continued to receive monthly subsidy checks intended for the financial support of the child. The couple pled guilty to misdemeanor larceny and were ordered to pay full restitution of $21,175.

Employee Fraud
A MDHHS employee was investigated by OIG when it was discovered that approximately 89 percent of the clients on the employee's caseload were receiving services from the same Adult Home Help business. It was determined that the employee had possible ownership in the business and had received kickbacks from the provider agency for the referrals. Checks from the agency's business bank account were written and cashed by the employee or deposited into the employee's personal bank accounts. OIG determined that the employee also referred clients on their caseload to another adult home help agency while receiving a kickback as well. The employee was charged by the Michigan Attorney General Medicaid Fraud Control Unit with three felony charges: Conspiracy to Commit Medicaid Fraud and two counts of Medicaid Fraud Kickbacks. The employee pled guilty to all three charges, agreed to $196,831 in restitution and agreed to cooperate and give statements against the co-defendants' role in the kickback scheme.

Child Development and Care Fraud
An Office of Inspector General investigation determined that a Child Development and Care provider overbilled the State of Michigan for childcare hours. The provider was criminally charged with felony Welfare Fraud and was sentenced to one day in jail, 60 months of probation and $58,829 in restitution to the State of Michigan.

Child Development and Care Fraud
The Office of Inspector General investigated a Child Development and Care provider who billed the State of Michigan for more childcare hours than were provided.

2019 ENFORCEMENT DIVISION HIGHLIGHTS

Examination of the provider's billing records found that the provider was unable to substantiate the number of hours charged to the Michigan Department of Health and Human Services for the care of the children. The provider pled to misdemeanor False Pretenses and was sentenced to pay full restitution of $37,097 and to serve 45 days in jail, suspended.

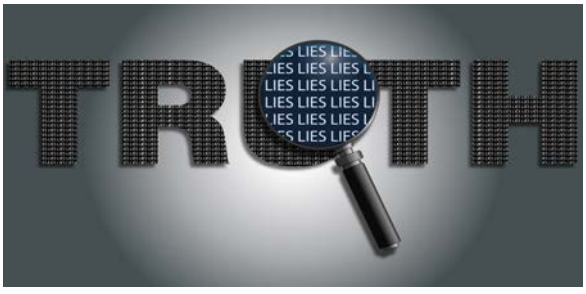
COOPERATIVE DISABILITY INVESTIGATIONS (CDI) UNIT

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 $7.3 million.

CDI Unit Investigation Highlight

Disability Fraud
An OIG agent in the Social Security Administration Office of Inspector General Cooperative Disability Investigations (CDI) Unit investigated a recipient that had suspicious medical evidence and conflicting statements regarding employment. Based on the investigation, the Disability Determination Service rescinded the initial medical approval and denied the recipient's disability benefits. The denial resulted in SSA savings of over $47,000 and Medicaid savings of over $74,000.

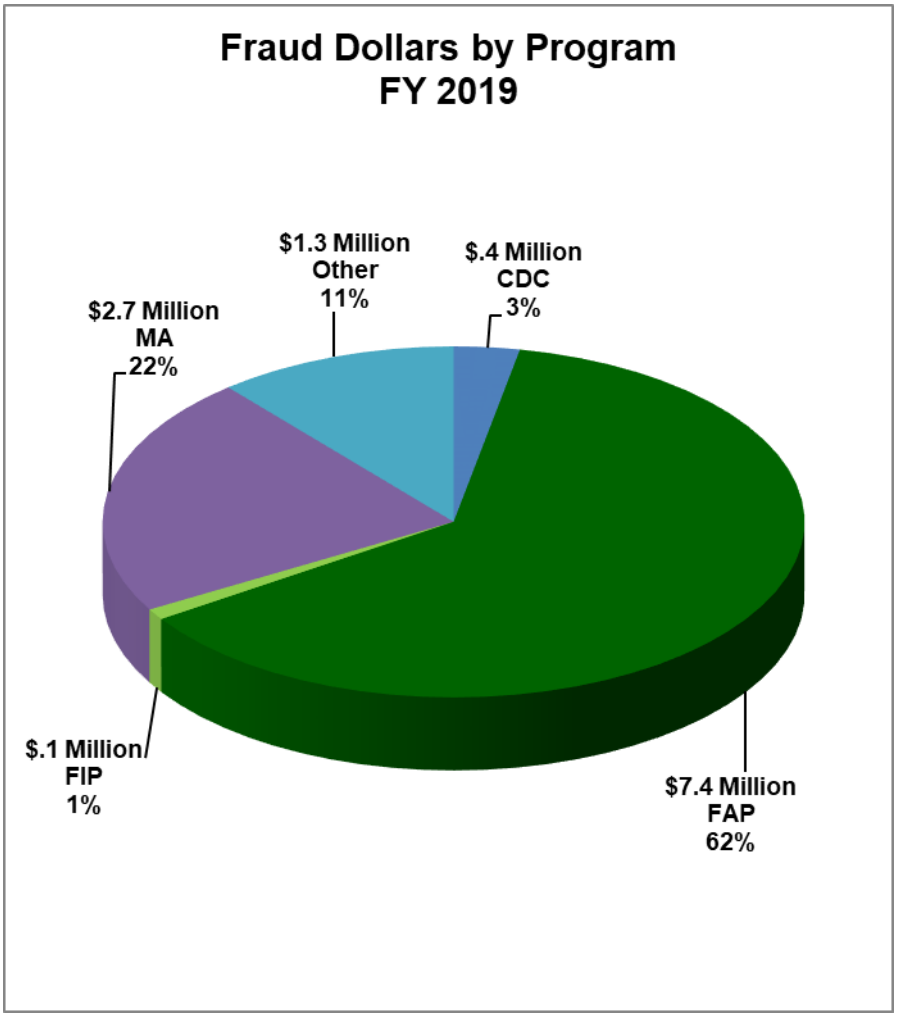


PROGRAM INTEGRITY IMPACTS

OIG's Enforcement Division determined over $11.8 million in fraud during FY 2019 within multiple Michigan public assistance program areas. Because of the Enforcement Division efforts, during FY 2019, 472 felony warrants were authorized by county, state and federal prosecutors. Investigations by Enforcement Division agents have uncovered $45 million in fraud during the last three years.

Program Highlights

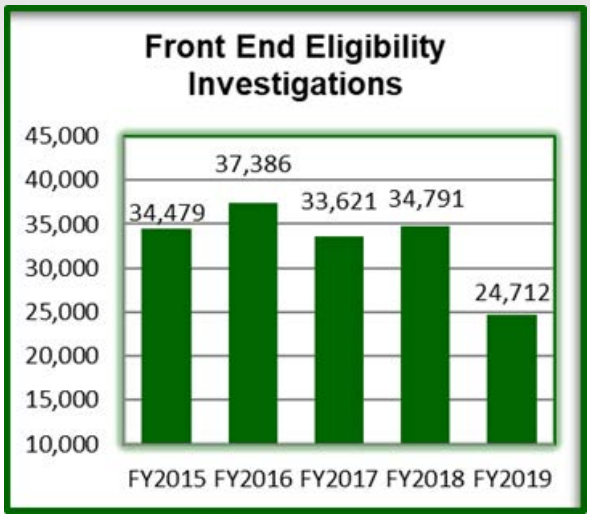
- FAP accounted for 62 percent of Michigan's public assistance fraud during FY 2019.
- OIG investigated 5,878 fraud cases in the FAP program, with 3,201 fraud investigative dispositions and 417 criminal warrants issued for a fiscal year total of $7.4 million in fraud found.
- OIG completed 85 CDC cases resulting in $373,472 in fraud found for the Michigan Department of Education (MDE).
- OIG completed 1,097 investigations of Medicaid program fraud resulting in $2.7 million in fraud found.

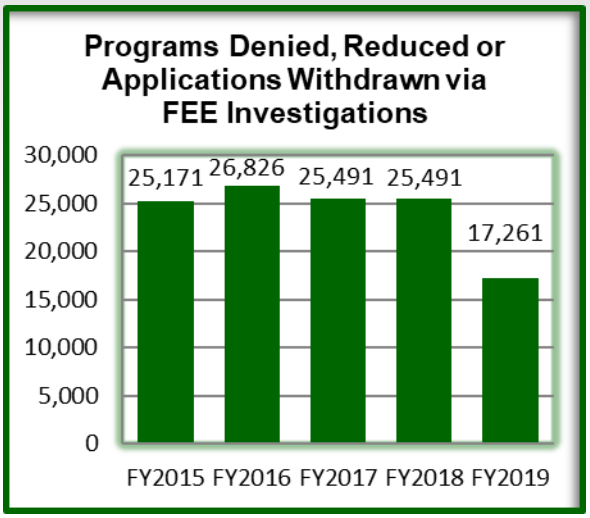


CDC = Child Development and Care Program
FAP = Food Assistance Program
FIP = Family Independence Program
MA = Medicaid Program
Other = Adult/Children's Services, State Disability, State Emergency Relief

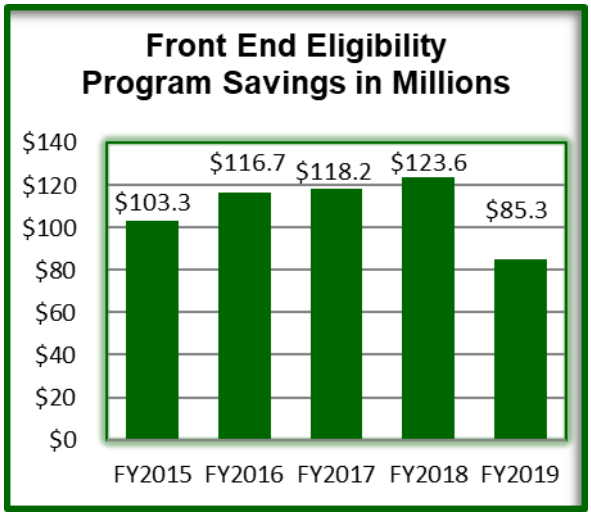
FEE: EARLY FRAUD DETECTION AND PREVENTION

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 24,712 investigations in FY 2019 and identified $85.3 million in cost savings. Investigations by these agents have resulted in $327 million in program savings for taxpayers over the last three-year period.



INTEGRITY DIVISION

In FY 2019, Michigan's health services programs had a combined budget of approximately $17.3 billion and paid 230,873 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 CONTRACTORS

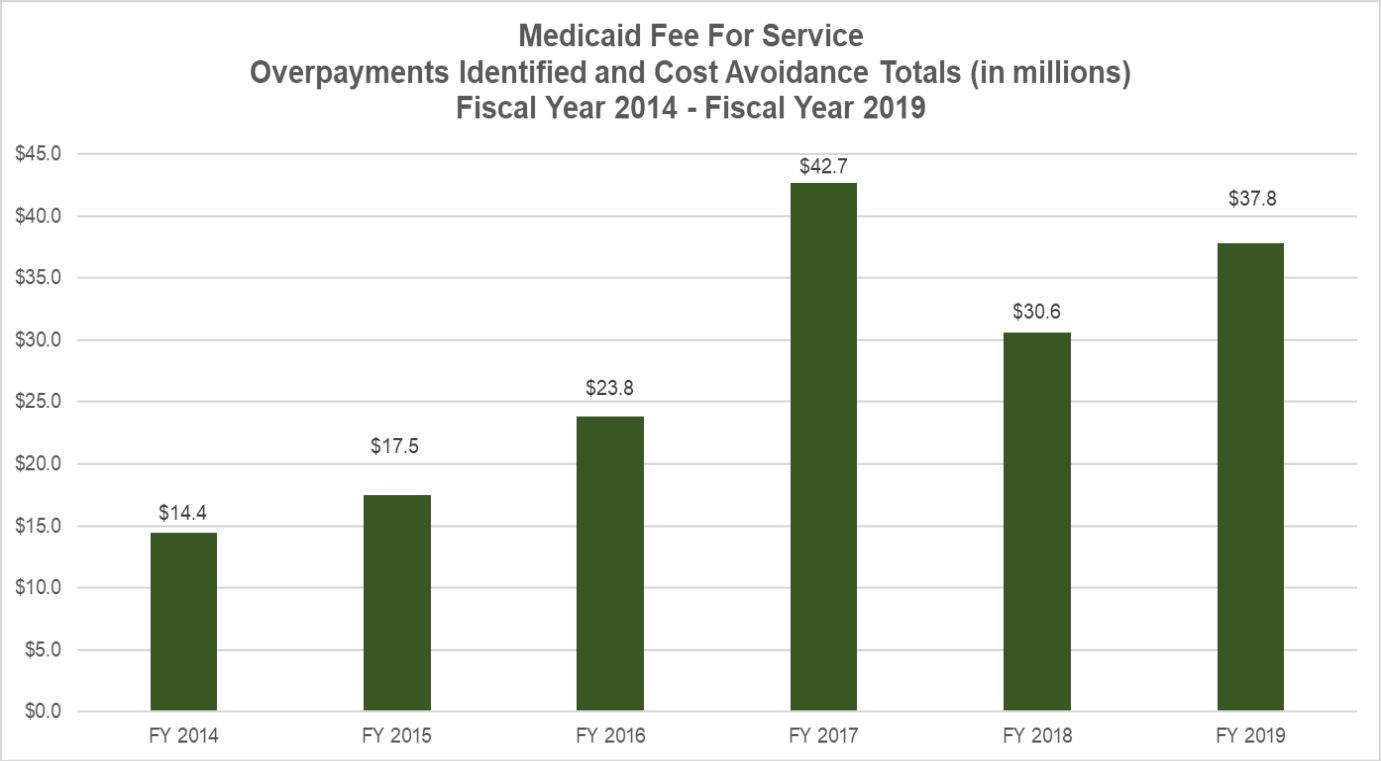
The Integrity Division has contracted with one vendor to perform audits and recover overpayments from Medicaid providers.

MANAGED CARE OVERSIGHT

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

Examples of health services provider fraud, waste and abuse:

* Billing for medical services not actually performed.
* Billing for unnecessary services.
* Billing for more expensive services than actually performed.
* Billing for services separately that should legitimately be one billing.
* Billing more than once for the same medical service.
* Dispensing generic drugs but billing for brand-name drugs.
* Billing for supplies/medication not dispensed.



NOTE – Approximately $12 million in FY 2019 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 2019, OIG-ID had an overall impact to direct Medicaid spending (i.e., fee-for-service (FFS)) totaling $37.8 million through the following activities:

- Identified a total of $6.6 million in overpayments made to Medicaid providers. To date, $4.3 million has been recovered while the remaining $2.3 million is being repaid over time.
- In FY 2019, OIG-ID:
    - Received 243 allegations of potentially fraudulent activity from various sources (e.g., 34 tips from beneficiaries, 55 tips from the public (21 anonymous), 132 referrals from inside MDHHS, three tips from providers).
    - Identified 548 audit targets through data analytics.
    - Completed 650 fraud investigation dispositions.
- Prevented an estimated $13.8 million in future payments, through reduced billing activities as a result of Medicaid provider audits and investigations.

HEALTH SERVICES PROGRAMS IMPACTS

- Prevented an estimated $5.4 million in future payments, through a provider education campaign aimed at increasing pharmacy compliance with voiding claims for no show prescriptions.

- Sanctioned 102 Medicaid providers, preventing an estimated $9.2 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 $2.8 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 two Medicaid providers to the Medicaid Fraud Control Unit (MFCU) for criminal investigation.

    * In accordance with federal regulation (42 CFR §455.21), the MFCU is the first referral destination for all cases of suspected Medicaid provider fraud.
    * Five previously referred providers were convicted and/or signed civil settlement agreements. These five providers were required to pay a total of $66,790 in restitution.

In FY 2019, OIG-ID had an overall impact to indirect Medicaid spending (i.e., MCO encounter claims) totaling $39.7 million through the following activities:

- $27.5 million in identified overpayments through program integrity related oversight of the Michigan Medicaid MCOs.

- Sanctioned 102 Medicaid providers, preventing an estimated $12.3 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 three specialized investigative units, each unit primarily investigates cases dealing with the following provider types in their assigned region:

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

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

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

- Identifying vulnerabilities where a more robust Medicaid policy and/or system edit would have prevented fraud, waste or abuse and making formal recommendations to prevent future claims from being paid.
- Investigating allegations of Medicaid provider fraud, waste and abuse, leading to the following outcomes:
    - Referring Medicaid provider fraud to the Attorney General's Health Care Fraud Division.
    - Suspending payments to Medicaid providers when it is determined there is a credible allegation of fraud for which an investigation is pending.
    - Identifying and recovering non-fraud overpayments from Medicaid providers.

In FY 2019, OIG-ID had an overall impact to direct Medicaid spending (i.e., fee-for-service (FFS)) totaling $37.8 million.

2019 FIELD INVESTIGATION SECTION HIGHLIGHTS

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

In FY 2019, 10 pharmacy providers agreed to repay the Medicaid program a total of approximately $1.1 million as a result of pharmaceutical inventory audits.

An additional 14 pharmacy provider cases are pending appeal decisions, litigation or repayment terms negotiation. These cases represent approximately $9.1 million.

Home Help
In FY 2019, receivables were established for 578 home help providers totaling approximately $2 million for payments made while their beneficiaries were hospitalized, after their death, while the provider was incarcerated or for other noncompliance with Medicaid policy.

An additional 43 home help provider cases are pending appeal decisions, litigation or repayment terms negotiation. These cases represent over $2.5 million.

Hospitals
In FY 2019, 12 hospitals agreed to repay the Medicaid program a total of $72,160 that they received as a result of improperly billing when their physician spends more than 30 minutes with a patient during discharge.

Durable Medical Equipment (DME)
In FY 2019, 11 DME providers agreed to repay the Medicaid program a total of $152,863 that they received as a result of billing for oxygen and oxygen supplies for patients who did not meet the Medicaid requirements for oxygen saturation.

Pharmacy
In FY 2019, five pharmacy providers agreed to repay the Medicaid program a total of $383,245 as a result of billing for pharmaceuticals using the wrong unit of measurement (i.e., mg instead of ml).

Dental
In FY 2019, 17 dental providers agreed to repay the Medicaid program a total of $363,145 that they received as a result of billing for services that violated Medicaid Dental Policy.

Maternal Infant Health Program (MIHP)
In FY 2019, 13 MIHP providers agreed to repay the Medicaid program a total of $128,838 that they received as a result of billing for services that violated Medicaid MIHP Policy.

Pediatric Clinics
In FY 2019, 12 pediatric clinics agreed to repay a total of $107,634 due to improperly billing the Medicaid program when they did not maintain documentation to support performing developmental screening on their patients.

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 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 dis-enrollments.
    - 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).

2019 MCO OVERSIGHT UNIT HIGHLIGHTS

Provider Audits/Reviews
In FY 2019, Michigan Medicaid's 43 MCOs performed a total of 28,024 provider audits and/or reviews, resulting in a total reduction of MCO encounter payments of $27.5 million.

Provider Sanctions
In FY 2019, OIG-ID agents prevented an estimated $12.3 million in Medicaid MCO encounter payments as a result of provider suspensions.

VENDOR OVERSIGHT UNIT

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

- The Affordable Care Act (ACA) requires Medicaid agencies to contract with a Recovery Audit Contractor (RAC) to identify and recover overpayments.
    - In FY 2018, CMS approved a waiver to allow OIG to utilize their Unified Program Integrity Contractor (UPIC) as the Michigan Medicaid RAC.
    - The UPIC performs data mining algorithms on the Medicaid database to identify potential areas of recovery. These scenarios are preapproved by the Vendor Oversight Unit analysts.
    - Vendor Oversight Unit analysts also review and pre-approve each proposed UPIC audit target as well as their sample selection prior to record review.

OPERATIONS DIVISION

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

OIG-OD's Administrative Services is responsible for overall administrative support of the office. It manages budget development and monitoring, system security, fraud hotlines, OIG policy, investigative process support as well as overseeing of the day-to-day business operations. For example, in FY 2019, OIG's Administrative Services provided extensive quality control reviews on over 2,337 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.

POLICY & TRAINING UNIT (P&T)

In FY 2019 the Policy & Training Unit was responsible for streamlining 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 continuously improves the program to ensure employees are educated on the 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. In FY 2019 the unit developed and published 20 instructional guides and resource tools for the investigators to use to improve the quality and accuracy of their investigations. In FY 2019 the unit also reviewed and analyzed 56 proposed department policies associated with MDHHS to ensure program integrity and offer recommendations as needed. The unit analyzed the impact of those proposed policies and the effect it could potentially have on OIG business processes as well as the potential global impact on the department.

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

2019 INVESTIGATIVE ANALYTICS UNIT HIGHLIGHTS

In-House Investigative Algorithms

Over the course of FY 2019, the IAU devised or refined over 20 algorithms used in the generation of investigative leads. One new algorithm identified fee-for-service claims for beneficiaries who were enrolled in an integrated care organization (ICO) where the ICO received a full capitation payment for the same month of service. To date, several investigations have been completed with an associated overpayment identified of $2.3 million. A second algorithm matched self-reported income from public assistance applications with AGI reported on State of Michigan Income taxes. 232 cases were created on anomalies. So far, completed investigations have resulted in $114,138 of fraud found and $534,996 in cost avoidance.

USDA-FNS Supplemental Nutrition Assistance Program – Fraud Framework Grant

IAU applied for and was awarded a grant from USDA-FNS in the amount of $738,000 to assist in the implementation of components of their Fraud Framework. The framework is a collection of recently formulated procedures, innovative ideas and best practices designed to improve efforts by state agencies to more effectively detect, investigate and prevent fraud in SNAP/FAP.

With this grant, OIG will secure new data sources and acquire advanced analytics capabilities such as machine learning and link analysis for use in the SNAP/FAP fraud identification process.

2019 INVESTIGATIVE ANALYTICS UNIT HIGHLIGHTS

Medicaid Provider Overpayment Detection
In FY 2019, approximately 84 percent of OIG's Medicaid provider recoupment cases were generated as a part of IAU assisted data analytics/data mining.

Public Assistance Program Fraud Detection
In FY 2019, approximately 61 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
OIG established a plan with IHPI to leverage their experience with advanced predictive models and machine learning in health care to identify aberrant or excessive billing patterns in Medicaid claims data. This partnership seeks to leverage the unparalleled clinical and statistical expertise of a leading university to combat fraud, waste and abuse in the Medicaid program. The first collaboration will target suspicious behavior related to prescriptions and will explore machine learning approaches that include penalized logistic regression, XGBOOST and random forest methods of classification.

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 2019, PARIS matches resulted in $24.7 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

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 2019, the out-of-state spending project resulted in $22.3 million in annualized cost avoidance.

Internet Protocol Locator Project
The Internet Protocol Locator Project was created to give OIG the capability to identify the physical location of individuals using MI Bridges to apply for Michigan public assistance benefits online. This capability increases the chances of catching potential and current clients who are residing outside Michigan and are improperly applying for public assistance benefits in Michigan. This project is also an instrumental tool in the identification, tracking and management of large-scale identity theft cases. In FY 2019, the IP Locator Project resulted in $360,804 in annualized cost avoidance.

OIG ACTIVITIES

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

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

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

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

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

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

Hotline – Health Services: The public and other state/federal entities report allegations of 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 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 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.

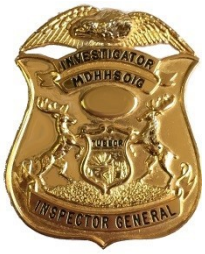
Provider Fraud – Health Services: OIG uses an investigative process to detect and deter potential instances of fraud, waste and abuse in health services programs. Provider fraud may include giving or receiving bribes or kickbacks, unacceptable medical and/or billing practices, misusing or abusing Medicaid 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 your food benefits or Bridge Card.
- Purchasing beverage(s) that require a bottle deposit, dumping/discarding beverage(s) and then returning the container(s) to obtain the cash deposit refund.
- Accepting food benefits/Bridge Card for unauthorized items (retailers only).

Report Welfare Fraud at:
www.michigan.gov/reportwelfarefraud or 800-222-8558

Examples of Medicaid Provider Fraud:

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

Report Medicaid Provider Fraud at:
www.michigan.gov/fraud or 855-643-7283

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