

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #2
Allowing the Inspector General to Keep a Portion of the Money Recovered from
Persons Committing Medicaid Fraud**

Background

On July 9, 2008, the Legislative Coordinating Council (LCC) approved a number of studies be conducted in the Interim by the Kansas Health Policy Authority (KHPA). Identification of these studies was in response to a May 2008 request made by the Conference Committee on H. Sub. for SB 81. One of the studies requested was reporting on the experiences of other states using incentive payments in the Office of Inspector General (OIG) programs.

Introduction

The evolution of state Medicaid Offices of Inspector Generals is a relatively recent event. In 1987, Congress gave the U.S. Department of Health and Human Services, Office of Inspector General (HHS/OIG) authority to enforce fraud and abuse laws including anti-kickback statutes. In FY 2003, The Centers for Medicare and Medicaid Services, (CMS) started receiving funds from the Health Care Fraud and Abuse Control (HCFAC) program to help improve Medicaid Financial Management.¹ In 2006, Congress enacted the Medicaid Integrity Program, a new federal effort within CMS created under the Deficit Reduction Act to ensure program integrity in the Medicaid program. There are few comprehensive analyses of the overall program integrity challenges that Medicaid faces.² Coordination on both the state and federal level is imperative to protect and ensure efficient use of taxpayer dollars committed to the Medicaid program. Literature and data about the success of offering incentive payments for reporting Medicaid fraud and abuse is limited. Such incentive payments are not widely utilized.

Over the past 10 years, some states have combined their Medicaid Fraud and Abuse Control (MFCU) units with their Program Integrity Units, both of which are federally mandated programs states are required to establish. In some states these combined programs have become the Medicaid Office of Inspector General.

Not every state has an OIG dedicated solely to Medicaid/Medicare fraud and abuse. For example, some OIG's may focus primarily on criminal or fraudulent activities that are turned over to the MFCU. Others may choose to focus heavily on program administration, making sure publicly funded programs use funds efficiently, and ensure that program integrity and quality remain high. Some states use a combined approach. In some states, the OIG is a statewide law enforcement entity that may house an office dedicated to Medicaid fraud as part of a larger enforcement agency contained in the State's Attorney General's office.

¹ Medicaid Financial Management: *Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Effort*, United States Government Accountability Office, June 2006.

² *The New Medicaid Integrity Program: Issues and Challenges in Ensuring Program Integrity in Medicaid*, Wachino, Victoria. The Kaiser Commission on Medicaid and the Uninsured. June, 2007

Historically, efforts that focus on criminal activity are less likely to result in money coming back to the state programs or general fund. If the provider is successfully prosecuted, they are out of business and a negotiated settlement to return funds evaporates. Additionally, Health and Human Services/Centers for Medicare and Medicaid Services (HHS CMS) also enforces a rule that requires any state that identifies misappropriated funds to return the federal share of those funds back to the federal government within 60 days, regardless of the states status in collecting those funds. These funds are included on the state's quarterly CMS 64 Report. The CMS 64 report is used by CMS to assist states in reporting federal funds collected and expended for their Medicaid programs.

If the focus of an OIG is administrative oversight of state agencies and programs to ensure efficiency, to limit fraud and abuse, and ensure quality, policies that promote program integrity should be established. Stricter oversight of provider policies, procedures, and billing activities can result in savings to the Medicaid program by acting as a deterrent to fraudulent activity. However, without some additional funding source, neither criminal nor administrative activities may be sufficient to solely support an OIG budget. If funding for an OIG is solely contingent upon incentives, or a return of a portion of misappropriated funds, a return on investment should be calculated to ensure appropriate levels of funding are available to operate the office.

Current Practice in Kansas

The Kansas Medicaid program follows a number of program integrity procedures including internal and external auditing, and reporting measures required by the federal government. The agencies providing oversight and the processes in place at KHPA to ensure program integrity are detailed below:

- CMS Federal Reporting Requirements
 - Medicaid Eligibility Quality Control (MEQC) is federally mandated to monitor and improve the administration of state Medicaid programs. The MEQC unit performs reviews of Medicaid beneficiaries identified through a statistically reliable statewide sample of cases selected from eligibility files.
 - Payment Error Rate Measurement (PERM) runs parallel to MEQC, is federally mandated and designed to comply with the Improper Payments Information Act of 2002. PERM performs reviews of eligibility determinations and works closely with CMS contractors who review accuracy of claims and measure improper payments in the Medicaid and State Children's Health Insurance Programs
- U.S. Health and Human Services Office Of Inspector General Audits
 - Internal Audit Unit monitors external audits of KHPA, and provides assistance to external auditors, conducts audits and targeted reviews of KHPA operations, program and procedures, conducts consultation engagements to improve internal processes, and leads the enterprise risk management program.
- Other related activities include KHPA's Management's Medicaid program reviews for 2008 and 2009.
 - Medicaid Management's Information System (MMIS) edits and audits; SAS70 Report on MMIS controls
 - Legal Unit counsel related to the collection of third party claims (medical subrogation) and recoupment of long-term care costs from the estates of deceased Medicaid recipients.

- Fair Hearing Unit acts as the agency representative in disputes with providers or consumers relating to cases involving Surveillance and Utilization Review Subsystem (SURS) recoupment, claims processing, prior authorizations, provider enrollment and any area where an adverse action has been rendered, refers potentially fraudulent cases to SURS for review.
- Other State Agencies
 - Attorney General's Medicaid Fraud and Control Unit (MFCU), federal oversight provided by the HHS OIG. Investigates and prosecutes Medicaid provider fraud which includes false claims, false statements, kickbacks, bribes, illegal rebates, negligent and intentional failure to maintain records, and destruction of records. Prosecutes abuse and neglect of residents in residential health care facilities that are Medicaid providers, based on referrals from KHPA.
 - Legislative Division of Post Audit conducts performance audits, compliance and control audits, and financial compliance audits of Kansas government agencies, programs and activities.
- KHPA Activities
 - Surveillance and Utilization Review Subsystem (SURS) is federally mandated to monitor providers and consumers of Medicaid services.
 - SURS performs post-payment provider reviews. Consumer reviews, fraud analysis, and data analysis to safe guard against unnecessary or inappropriate use of services and against excess payments. Assess quality of services and provides control of the utilization of all services provided. SURS may impose provider sanctions such as education, recoupment, pre-pay review, withholding of payments, termination of provider agreement, and federal exclusion. Refers potentially fraudulent cases to MFCU.
 - Program Integrity Manager oversees the Kansas Medicaid state plan amendments and regulations and interagency agreements. Serves as a liaison to Social and Rehabilitation Services and Kansas Department of Aging.
- Office of Inspector General, an independent oversight body created by the Kansas Legislature in 2007.
 - Investigates fraud, waste, abuse and illegal acts committed by the KHPA and its agents, employees, vendors, contractors, consumers, clients and health care providers or other providers.
 - Performs reviews or audits of the KHPA, its employees, contractors, vendors, and health care providers to ensure that appropriate payments are made for services rendered, and to recover overpayments.
 - Monitors adherence to contract terms between KHPA and claims payment organization.
 - Networks with MFCU, SURS, the Medicaid Integrity Group (MIG), the regional health care fraud working group, KDOA, and other related groups.
 - Refers potentially fraudulent cases to MFCU.

National Survey

To report on the experiences of other states and incentive funding, six states with Inspectors General were surveyed by KHPA. New York, Florida, Kentucky, and Illinois are four states that responded to the survey. Their responses are listed below.

New York

The Office of Medicaid Inspector General was established by statute as an independent entity within the New York State Department of Health to improve and preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste and abuse control activities for all State agencies responsible for services funded by Medicaid. The State of New York does not utilize incentive funding. James Sheehan, Medicaid Inspector General, voiced some concerns over the practice. The concerns he identified were based upon his experience in health care investigations and his experience with federal health care and asset forfeiture programs. His concerns are as follows:

- Incentive payments may open up an area of cross-examination for investigators and auditors by defense counsel. The Inspector General's strength is relative objectivity as state employees; this type of funding gives the defense a foothold to show bias;
- Incentive payments may give outside counsel for healthcare organizations a device to whip up hostility toward the program among their clients and state legislators. The first time the Inspector General is unsuccessful in a case, it will be heard that the agency is a "bounty hunter" just out to increase its own funding;
- The Inspector General may receive requests for documents and information about how much (incentive) is received, what is done with it, how staff are paid and promoted, whether goals or quotas are set for individuals or groups (to identify fraud and therefore collect incentive monies) which can mean increased administrative activities and costs.
- Finally, incentive payments may lead to increased media requests and scrutiny.

Florida

The Office of Inspector General is a part of Florida's Agency for Health Care Administration. The OIG oversees three areas; Internal Audits, Investigations and Medicaid Program Integrity. The State of Florida did not indicate whether the Inspector General utilizes incentive funding. However, Kenneth Yon, Bureau Chief, provided some options that may be useful to states weighing the use of incentives. These options are related to incentive funding when contracting with an independent vendor to conduct recovery efforts and identifies advantages and disadvantages of each:

- Use of time and material contracts: Contracts based upon the actual time and material used. These contracts are uncapped and may be difficult to budget for, but allows for vendor flexibility to complete the work;
- Use of flat fee contracts: Contracts based upon a flat fee regardless of the outcomes. Flat fee contracts are predictable in price, but there is less vendor flexibility to complete work;
- Contingency contracts: Contingency contracts are contingent upon vendor outcomes. In this case, payment is based on the Medicaid overpayments identified and the overpayments recovered. Contingency is much like incentive funding practices, in that it may promote vendors to pursue easy to recover "low

hanging fruit” and discourage pursuit of overpayments more difficult to recover, unless the state addresses audit specifics in the contract.

Kentucky

The Cabinet for Health and Family Services houses most of Kentucky’s human services and health care programs, including Medicaid. The Office of Inspector General, a division within the Cabinet, is Kentucky’s regulatory agency for licensing all health care, day care and long-term care facilities, and child adoption/child-placing agencies in the Commonwealth. They are responsible for the prevention, detection and investigation of fraud, abuse, waste, mismanagement and misconduct by the cabinet’s clients, employees, medical providers, vendors, contractors and subcontractors.

Kentucky Revised Statute 205.8467 addresses penalties for Medicaid providers who received Medicaid payments to which they were not entitled. Those penalties include paying for legal fees and the costs of investigation and enforcement of civil payments. Kentucky has not enforced the statute consistently, in part because the statute requires that the provider be found by a preponderance of the evidence in an administrative process to have “knowingly submitted or caused claims to be submitted for payment for furnishing treatment, services or goods....” The majority of the cases that would qualify under this statute are referred for prosecution. The state is currently reviewing the statute to see if it may be modified to make it more appropriate for those cases in which administrative action is the preferred course of action.

Illinois

The State of Illinois does not currently utilize any incentive funding programs.

Fiscal Impact and Cost Recovery Efforts across States

States report to CMS annually on OIG activities. These reports reflect agencies as varied as each state’s Medicaid program. No two states use the same methods to collect funds, collect the same data, nor do they have the same staffing configurations. For example, some state’s OIG have vast enforcement authority that is integrated into their State’s Attorney General’s office. Some have much fewer staff which may include only Medicaid Program Integrity staff, who works in conjunction with Medicaid Fraud and Control Unit (MFCU) staff located in a separate Attorney General’s office. Consequently, comparing Medicaid Fraud and Abuse cost savings, cost avoidance or effects of deterrence to measure one state’s recoupment success or audit methodology against another in a meaningful manner is difficult. Below are methods that some selected states utilize to identify and collect funding lost through fraud and abuse in Medicaid programs.

Maryland

Located in the Department of Health and Mental Hygiene, the OIG works to protect the integrity of the Department and promote standards that benefit the citizens of Maryland and program beneficiaries.

For FY 2008, the External Audits unit completed 28 audit reports of health care providers and audited 910 grants administered by the Department of Health and Mental Hygiene (DHMH) units totaling over \$274 million. These audits rendered 115 audit findings and recommendations. These findings ranged from inadequate controls over the cash receipts to untimely deposit of collections. As a result of its reviews the net amount due to the State was \$735,855.

In addition to calls made to its referral hotline, the Program Integrity Unit develops cases through data analysis provided by the SURS unit. When a unit receives a report of provider fraud, waste or abuse, the unit conducts a billing review of the provider. At the conclusion of the review the unit issues a report to the DHMH program that paid the claims under review. If appropriate, the report recommends to the paying program that it recover inappropriately paid funds from the provider. The Program Integrity Unit also refers certain cases to the Medicaid Fraud Control Unit of the Office of the Inspector General for prosecutorial review. In FY 2008, the Program Integrity Unit activities reflected a cost savings of \$20,952,007.³

Texas

The Health and Human Services Office of Inspector General was created by the Texas Legislature and works to prevent and reduce waste, abuse and fraud within the Texas health and human services system.

Total recoveries for State Fiscal Year (SFY) 2007 were \$418,079,369 (all funds). Recovery dollars are defined as actual collections recoupments, or hard dollars saved by OIG. Recoveries, as reported by OIG, do not include any other type of “soft money” or future settlement payments.

The state utilizes cost avoidance methods. Cost avoidance is a reduction to a state expenditure that would have occurred or was anticipated to occur, without OIG intervention. Cost avoidance dollars are calculated differently by business function. OIG takes a conservative approach in reporting these dollars. Some of the methodologies by business function used to calculate cost avoidance include:

- Sanctions - cost avoidance dollars are estimated savings to the state Medicaid program, which result in administrative action and/or imposing a sanction against a Medicaid provider.
- Third Party Resources - these are actual claim denials in which the provider was identified as having other insurance for which the provider was required to bill prior to billing Medicaid.
- Audit - cost avoidance results for four types of audit activities.
 - ✓ Cost report review through desk reviews and performance audits
 - ✓ Contract audit
 - ✓ Medicaid/CHIP audit through oversight and consulting
 - ✓ Outpatient Hospital/MCO Audit through desk review and performance audit⁴

Illinois

In December 2003, the Governor signed into law a bill which officially created the Office of Executive Inspector General for the Agencies of the Illinois Governor (OEIG). The OEIG powers and duties were expanded to include jurisdiction over all State agencies, including the state public universities and community colleges, except the Attorney General, Secretary of State, and Treasurer.

³ Maryland Department of Health and Mental Hygiene, Annual Report FY 2008, Office of the Inspector General. Accessed December 10, 2008

⁴ The State of Texas, Health and Human Services Commission, Office of Inspector General Annual Report, FY 2007 – Released September 2008. Accessed December 10, 2008.

During calendar Year 2007, the OIG realized a savings of over \$78.6 million through collections and cost avoidances. The OIG used a range of enforcement and prevention strategies to realize the savings. Prevention activities, which account for 55% of the cost savings, were:

- Provider Sanctions Cost Avoidance
- Food Stamp Cost Avoidance
- Fraud Prevention Investigations
- Long Term Care – Asset Discovery Investigations
- Recipient Restrictions
- New Provider Verification

Enforcement activities which account for 45% of cost savings included:

- Provider Audit Collections
- Fraud Science Team Overpayments
- Restitution
- Global Settlements
- Provider Sanctions Cost Savings
- Client Overpayments
- Food Stamp Overpayments
- Child Care Overpayments⁵

Summary

The creation of Medicaid offices of Inspectors General has been a relatively recent event. States with OIG's have different missions, authority, staffing, and numbers of beneficiaries served. Research did not identify states that engage in returning a portion of recovered Medicaid funds as incentive funds to their OIG. It does not appear to be a common practice. States that did respond to inquiry indicated that any funds recovered were returned to the state's Medicaid or General Fund.

Kansas follows many of the practices that other states reported to protect the integrity of Medicaid funds for public health programs. In order to identify and deter fraud, waste, abuse and illegal acts in state funded medical programs, Kansas conducts Audits, Investigations and Program Reviews.

- Financial Audits include review of financial documents and internal processes
- Performance Audits examine program economy, effectiveness or efficiency
- Investigations assess specific circumstances surrounding an allegation or incident of fraud, waste, abuse or illegal acts committed by a specific individual
- Program reviews are conducted to review program elements that are alleged to have caused fraud, waste, abuse or illegal acts

The KHPA OIG partners with other agencies that have the same goal of promoting proper use of taxpayer dollars and preventing fraud and abuse. Two Federal mandates establish requirements for KHPA as the Single State Medicaid Agency (SSM) to work cooperatively with the state Medicaid Fraud and Control Unit (MFCU), and the Statewide Utilization and Control Program (SURS). The MFCU receive referrals from the OIG when potential evidence of fraud is identified and investigation is compulsory. MFCU is a division of the Kansas Attorney General's office.

⁵ Illinois Department of Healthcare and Family Services, 2007 OIG Annual Report. Accessed December 10, 2008.

The SURS unit acts as a safeguard against unnecessary or inappropriate use of, or excessive payments for services. SURS also provides for the control of the utilization for all services provided and assesses the quality of those services. Kansas contracts with the Medicaid Fiscal Agent, Electronic Data Systems (EDS) to fulfill this federal mandate. EDS also manages the Kansas Medicaid Management Information System (MMIS). KHPA and SURS cooperate and assist MFCU, and the U.S. Attorney's Office with investigations concerning Medicaid fraud or abuse.