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Missouri State Auditor

SOCIAL SERVICES

MO HealthNet Division

Program Integrity Unit

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Thomas A. Schweich
Missouri State Auditor

CITIZENS SUMMARY

Findings in the audit of the Department of Social Services (DSS), MO HealthNet Division, Program Integrity Unit (PIU)

Background	<p>The Program Integrity Unit (PIU) monitors MO HealthNet program compliance of providers and participants by conducting post payment reviews to determine the propriety of claims reimbursed by the Medicaid program. The PIU also reviews allegations of MO HealthNet participant fraud or abuse. Potential fraud or abuse by MO HealthNet providers is referred to the Attorney General's Medicaid Fraud Control Unit for further investigation.</p> <p>State law (Section 191.909.2, RSMo) requires the DSS to report annually on certain activities related to the PIU and requires the state auditor to conduct an audit of the PIU.</p>
Annual Reports	<p>Annual reports did not include some information required by state law and included some inaccurate amounts and unverified data. In addition, supervisors did not conduct reviews of the information entered into the reporting subsystem to ensure the information was entered correctly. Similar findings were noted in prior audit reports.</p>
Payment of Performance Review Costs	<p>The DSS spent approximately \$139,000 on employees' salaries and travel costs during fiscal years 2010 and 2011 for a performance review of the PIU. The DSS paid the costs of these employees even though the employees did not perform PIU functions and reported to the Office of Administration, Division of Budget and Planning Director, not to DSS personnel.</p>

In the areas audited, the overall performance of this entity was **Good**.*

American Recovery and Reinvestment Act 2009 (Federal Stimulus)	<p>The MO HealthNet Division, Program Integrity Unit did not receive any federal stimulus monies during the audited time period.</p>
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*The rating(s) cover only audited areas and do not reflect an opinion on the overall operation of the entity. Within that context, the rating scale indicates the following:

- Excellent:** The audit results indicate this entity is very well managed. The report contains no findings. In addition, if applicable, prior recommendations have been implemented.
- Good:** The audit results indicate this entity is well managed. The report contains few findings, and the entity has indicated most or all recommendations have already been, or will be, implemented. In addition, if applicable, many of the prior recommendations have been implemented.
- Fair:** The audit results indicate this entity needs to improve operations in several areas. The report contains several findings, or one or more findings that require management's immediate attention, and/or the entity has indicated several recommendations will not be implemented. In addition, if applicable, several prior recommendations have not been implemented.
- Poor:** The audit results indicate this entity needs to significantly improve operations. The report contains numerous findings that require management's immediate attention, and/or the entity has indicated most recommendations will not be implemented. In addition, if applicable, most prior recommendations have not been implemented.

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THOMAS A. SCHWEICH

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Honorable Jeremiah W. (Jay) Nixon, Governor
and
Members of the General Assembly
and
Brian Kinkade, Interim Director
Department of Social Services
and
Dr. Ian McCaslin, Director
MO HealthNet Division
Jefferson City, Missouri

We have audited certain operations of the Department of Social Services, MO HealthNet Division, Program Integrity Unit, as required by Section 191.909.2, RSMo. The objectives of our audit were to:

1. Determine the amount of money recovered by the unit.
2. Determine the amount of money invested in the unit.
3. Evaluate the unit's compliance with certain legal provisions.

Our audit determined the amount of money recovered by and invested in the unit, and reported those amounts in Appendixes A and B. In addition, for the areas audited, we identified noncompliance with legal provisions.

We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides such a basis.

The accompanying Organization and Statistical Information is presented for informational purposes. This information was obtained from the department's management and, other than Appendixes A and B, was not subjected to the procedures applied in our audit of the Program Integrity Unit.

A handwritten signature in black ink that reads "Thomas A. Schweich". The signature is written in a cursive style with a large, sweeping initial 'T'.

Thomas A. Schweich
State Auditor

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Department of Social Services, MO HealthNet Division,

Program Integrity Unit

Introduction

Background

Starting in 2008, pursuant to Section 191.909.2, RSMo, the Department of Social Services (DSS) is to report annually, by January 1 of each year, the following activities related to the Program Integrity Unit (PIU):

- "(1) The number of MO HealthNet provider and participant investigations and audits relating to allegations of violations under sections 191.900 to 191.910 completed within the reporting year, including the age and type of cases;
- (2) The number of MO HealthNet long-term care facility reviews;
- (3) The number of MO HealthNet provider and participant utilization reviews;
- (4) The number of referrals sent by the department to the attorney general's office;
- (5) The total amount of overpayments identified as the result of completed investigations, reviews, or audits;
- (6) The amount of fines and restitutions ordered to be reimbursed, with a delineation between amounts the provider has been ordered to repay, including whether or not such repayment will be completed in a lump sum payment or installment payments, and any adjustments or deductions of future provider payments;
- (7) The total amount of monetary recovery as the result of completed investigation, reviews, or audits;
- (8) The number of administrative sanctions against MO HealthNet providers, including the number of providers excluded from the program."

Additionally, the state auditor is required to conduct an audit of the PIU ". . . to quantitatively determine the amount of money invested in the unit and the amount of money actually recovered by such office."

When preparing the 2010 and 2009 annual reports, the DSS interpreted Section 191.909.2, RSMo, to require all recovery activity of the MO HealthNet Division (MHD) be reported, including PIU recoveries. In addition, although not required, the DSS also reported in both the 2010 and 2009 annual reports 1) cost avoidance amounts for various MHD units for the current year, 2) cost recovery and cost avoidance amounts for the 5 previous years for the PIU and various other MHD units, and 3) recoveries of MHD monies by the DSS Division of Legal Services.



Department of Social Services, MO HealthNet Division,
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Introduction

PIU personnel obtain information from other DSS units, including the Cost Recovery Unit, MO HealthNet Investigations Unit (MHIU), Welfare Investigations Unit (WIU), Institutional Reimbursement Unit, and the Pharmacy and Clinical Unit, for inclusion in the annual report. Both the MHIU and WIU are units within the DSS Division of Legal Services. The MHIU investigates fraud and abuse committed by recipients against MO HealthNet providers, such as use of multiple physicians and pharmacies, forged prescriptions, or the payment of covered medication with cash. The WIU investigates fraud and abuse committed by public assistance recipients based on eligibility issues, such as inaccurately reporting income or household composition.

The Attorney General's Medicaid Fraud Control Unit (MFCU), not the DSS, is responsible for provider investigations related to fraud and abuse. The MFCU notifies the PIU of the outcome of all investigations completed on referrals from the DSS.

Scope and Methodology

The scope of our audit included, but was not necessarily limited to, the 2 years ended June 30, 2010.

Our methodology included conducting interviews with appropriate DSS personnel; reviewing written policies and procedures; obtaining and reviewing the PIU annual reports for the years ended June 30, 2010 and 2009; reviewing applicable state law and DSS and PIU records; and testing selected transactions.

We obtained an understanding of internal controls that were significant within the context of the audit objectives and assessed whether such controls had been properly designed and placed in operation. We tested certain of those controls to obtain evidence regarding the effectiveness of their design and operation. We also obtained an understanding of legal provisions that were significant within the context of the audit objectives, and we assessed the risk that illegal acts, including fraud, and violations of legal provisions could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting instances of noncompliance significant to those provisions.

To determine the amount of monies recovered by and invested in the unit, we compared the annual report information to the revenues and expenditures recorded in the state accounting system (SAM II) and to supporting documentation. We reviewed the annual report to determine whether all amounts and information required by Section 191.909.2, RSMo, were included, and compared the amounts and information to supporting documentation to determine the completeness and accuracy of the report. We also tested the amounts and information in the case files to determine the completeness and accuracy of PIU supporting documentation.

Department of Social Services, MO HealthNet Division, Program Integrity Unit Management Advisory Report - State Auditor's Findings

1. Annual Reports

The Department of Social Services (DSS), MO HealthNet Division (MHD), Program Integrity Unit's (PIU) annual reports for fiscal years 2010 and 2009 did not include some information required by state law. In addition, due to inadequate internal controls and procedures, some amounts in the annual reports were inaccurate, data obtained from other sources was not verified for accuracy, and supervisory reviews were not performed.

State law requires specific information be included in the annual reports (see the Background section). For these reports to be useful to the General Assembly, the required information needs to be included and its accuracy needs to be ensured.

1.1 Participant and provider investigations

Some participant and provider investigations were not included in the annual reports, as required by Section 191.909.2(1), RSMo.

WIU and MHIU participant investigations

The annual reports did not include some participant investigations completed related to allegations of violations under Sections 191.900 to 191.910, RSMo. Although the reports included the investigations completed by the Welfare Investigations Unit (WIU), the investigations completed by the MO HealthNet Investigations Unit (MHIU) were not reported. In addition, the age and type of participant investigations completed by the WIU and MHIU were not reported.

A similar condition was noted in our prior two reports. At that time, the DSS indicated the MHIU investigations would be reported in the fiscal year 2009 annual report; however, this corrective action was not taken.

Medicaid Fraud Control Unit provider investigations

The number of provider investigations, with the applicable age and type of case, conducted by the Attorney General's Medicaid Fraud Control Unit (MFCU) based on referrals from the DSS is not reported. The MFCU notifies the PIU of the outcome of all investigations completed on referrals from the DSS; however, the PIU does not report it.

A similar condition was noted in our prior two reports. In response to both reports, the DSS did not agree it should report provider investigations completed by the MFCU, because that data is reported by the MFCU pursuant to Section 191.909.1, RSMo. However, while the MFCU reports the number of referrals received as well as the number of provider investigations conducted due to allegations of violations under Sections 191.900 to 191.910, RSMo, it does not specifically identify which investigations conducted were the result of DSS referrals.

1.2 Fines and restitution

Fines and restitution ordered to be reimbursed, as well as other required information on provider investigations closed by the MFCU, are not reported as required by Section 191.909.2(6), RSMo. The MFCU provides the PIU documentation regarding fines and restitution ordered to be



reimbursed on cases referred to the MFCU by the DSS; however, the PIU does not include this information in the annual reports.

A similar condition was noted in our prior two reports.

1.3 Information obtained from other DSS units

The PIU has not established adequate procedures to ensure the accuracy of amounts obtained from other DSS units included in the annual reports and some amounts were not accurately reported.

Welfare Investigations Unit participant cases investigated

The reported number of investigations into suspicion of participant health care fraud conducted by the WIU in the fiscal year 2010 annual report was not accurate. In addition, documentation supporting the number of WIU participant cases investigated and overpayments identified by the WIU based on those investigations was not obtained and reviewed by the PIU at that time and no longer exists.

In fiscal year 2010, the WIU reported its personnel investigated 403 participant cases with 431 associated claims; however, in the 2010 annual report, PIU personnel erroneously reported 431 participant cases were investigated by the WIU.

In addition, no supporting documentation was maintained to support the number of investigations or overpayments presented in the report. The PIU did not obtain documentation from the WIU supporting the number of cases and overpayments identified at the time the amounts were received from the WIU for inclusion in the annual reports. We attempted to obtain this documentation from the WIU during our audit. However, in October 2010 (prior to the start of our audit), the WIU converted its case database system, and Division of Legal Services (DLS) personnel indicated not all data converted correctly. In addition, DLS personnel indicated adjustments may have subsequently been made to overpayment amounts after the numbers were reported to the PIU due to additional claims received from providers.

Other DSS units

We also noted additional information obtained from other DSS units, including the WIU, the Institutional Reimbursement Unit, and Pharmacy and Clinical Unit, is not verified for accuracy by the PIU prior to inclusion in the annual reports.

A similar condition was noted in our prior report.

1.4 Adjustments to overpayments

Adjustments to PIU overpayment amounts identified and tracked were not reported in the fiscal year 2010 annual report; however, the annual report stated the overpayment amount included adjustments that occurred during the reporting year.



Adjustments to overpayment amounts may occur due to additional documentation received from the provider, an Administrative Hearing Commission decision, or other administrative actions. These adjustments are tracked by the PIU and were taken into consideration when reporting overpayments in the fiscal year 2009 annual report. However, due to changes in personnel, adjustments to PIU overpayments were not taken into consideration when compiling the fiscal year 2010 annual report, resulting in the overstatement of overpayments by approximately \$363,000.

A similar condition was noted in our prior two reports.

1.5 Supervisory reviews

Supervisory reviews of information included in the reports are not adequate. Information on MHD provider cases reviewed, such as number of claims examined and overpayment amounts identified, is entered into the Surveillance and Utilization Review Subsystem (SURS) by various DSS personnel from manual case cards in the case files. The SURS is a subsystem of the Medicaid Management Information System, which maintains and stores Medicaid claims data. The SURS is programmed to detect suspicious billing and service utilization patterns and is used to document MHD case reviews. Once information from the manual case cards is entered into the SURS, the PIU prints electronic SURS case cards to retain in case files. The PIU creates SURS reports containing provider case review information which are then entered in spreadsheets for the annual reports; however, there is no reconciliation between the manual and electronic case cards in the case files to ensure all information was entered correctly.

A similar condition was noted in our prior report.

Recommendations

The DSS:

- 1.1 Include the number of all participant and provider investigations completed by DSS units and the MFCU in the annual report. Additionally, information about the age and type of completed investigations should be included.
- 1.2 Include the amount of fines and restitution ordered, and other required information on cases closed by the PIU and referred to and closed by the MFCU.
- 1.3 Establish procedures to ensure information obtained from other DSS units other than the PIU is verified for accuracy, either by the PIU or by the other DSS units.
- 1.4 Establish procedures to report subsequent adjustments to overpayment amounts initially identified.



Auditee's Response

- 1.5 Ensure supervisory reviews of data entered into the SURS are performed.
- 1.1 *DSS had obtained an investigations report from MHIU and the WIU for the reporting purposes of Sections 191.900 to 191.910. DSS will acquire supporting documentation from WIU which includes the age of the case and the type of case for the totals given along with the participants' names and DCNs. As of April 1, 2011, MHIU was dissolved and the duties and responsibilities are now under Missouri Medicaid Audit and Compliance (MMAC) Investigations. DSS will obtain the final MHIU report (July 1, 2010 to April 1, 2011) and will verify MMAC referrals match with the supporting documentation. The second report (April 1, 2011 to June 30, 2011) will be from MMAC Investigations and the report will also be verified.*
- 1.2 *DSS has obtained a copy of the SB577 report from MFCU. Discussions were held with MFCU staff. DSS will report fines and restitution ordered to be reimbursed, as well other required information on provider investigations closed by MFCU on a calendar year basis instead of fiscal year for this section only.*
- 1.3 *DSS will make every effort to have supporting documentation from all units providing information to MMAC for the SB577 report and verify for accuracy.*
- 1.4 *DSS acknowledges the adjustments were overlooked for state fiscal year 2010. DSS has not knowingly withheld any reporting factors to fabricate our financial status.*
- 1.5 *DSS acknowledges our responsibility for the implementation of policies and controls to prevent errors in documentation.*

2. Payment of Performance Review Costs

During fiscal years 2011 and 2010, the DSS paid salary and travel expenses related to a performance review of the PIU conducted under the direction and supervision of the Office of Administration (OA) Division of Budget and Planning Director, thus circumventing the appropriation process established by the General Assembly. Related expenditures totaled approximately \$80,000 and \$59,000, in 2011 and 2010, respectively.

Beginning in March 2010, the salaries and fringe benefits of two persons who conducted a performance review of the PIU were paid from DSS appropriations. While these persons were placed on the DSS payroll, they did not perform PIU-related functions and did not report to the PIU Director, but instead reported to the OA Division of Budget and Planning Director. According to the OA Division of Budget and Planning Director,



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the concept and development of the performance review team was a joint effort by the Governor's office and the OA Division of Budget and Planning. Through June 30, 2010, the DSS paid approximately \$54,400 in salary and fringe benefit costs related to these persons. A Governor's office employee also participated in the review, but that person's payroll costs were paid from a Governor's office appropriation.

In addition to the payroll costs for two of these employees, beginning in March 2010, travel costs of one of these persons and the Governor's office employee involved in the performance review, both domiciled in St. Louis, were charged to DSS appropriations. The expenses charged included mileage to and from St. Louis, as well as lodging that was direct billed to the DSS. Through June 30, 2010, the DSS paid approximately \$2,500 in mileage and \$2,400 in lodging for these two employees.

The costs of the performance review of the PIU continued to be charged to the DSS during part of fiscal year 2011. From July 2010 to November 2010, at least \$79,900 in additional costs of the three persons to complete the performance review of the PIU were paid from DSS appropriations. In November 2010, all three performance review team members began a performance review of the Department of Revenue and were no longer paid from DSS appropriations.

Since these persons were working on a performance review under the direction and supervision of the OA Division of Budget and Planning Director, it appears their salary and other costs should have been paid accordingly from appropriations of the OA and the Governor's office.

Recommendation

The DSS work with the Governor's office and the OA to discontinue the practice of using DSS appropriations to pay costs not directly associated with the operations of the PIU.

Auditee's Response

Health care waste, fraud and abuse costs all healthcare payers, including taxpayers, billions of dollars annually. In order to protect taxpayer resources, DSS with the approval of the Office of Administration, Division of Budget and Planning (OA B&P) determined that an extensive performance review of the PIU was needed to ensure the unit was operating as efficiently as possible and making every effort to maximize audit efforts to protect taxpayer resources.

The performance review was critically important to Director Levy. The review needed to happen quickly while using reviewers independent of the department. Just like it's essential to have an independent SAO to perform the annual PIU audit, Director Levy felt this review needed to be done completely independent of PIU management since reviewers reporting to PIU management would not have yielded independent results. Director Levy



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reached out to the OA B&P to recommend non-DSS staff to perform the performance review. OA B&P identified highly qualified, independent state staff to do an exhaustive performance review and to assist with operationalizing recommendations of the Lewin Group.

The performance review in question resulted in recommendations that elevated PIU within the department and reallocated resources from the Departments of Mental Health and Health and Senior Services. The actions taken by DSS to initiate the review resulted in budget reductions that were approved by the General Assembly. Even though the reviewers didn't report to PIU management, DSS believes it was perfectly appropriate to temporarily pay salaries of state staff for work being done on behalf of the unit. Similar work performed by a contractor would certainly have been paid by DSS appropriations and likely would not have resulted in a similar finding.

Auditor's Comment

At no time during fieldwork did personnel of either the DSS or the OA Division of Budget and Planning indicate the performance review was solicited by the DSS. In addition, neither the DSS nor the OA Division of Budget and Planning could provide documentation detailing the request, scope, and/or methodology of the review, or the estimated and maximum costs the DSS was willing to pay. As a result, we cannot determine if the review was properly planned and whether the DSS received fair value for expenditures totaling approximately \$139,000.

Department of Social Services, MO HealthNet Division

Program Integrity Unit

Organization and Statistical Information

The Department of Social Services (DSS) is officially designated as the single state agency charged with the administration of the Missouri Medicaid program. The Program Integrity Unit (PIU), organizationally located within the MO HealthNet Division (MHD), is responsible for monitoring compliance by providers and participants as described in federal regulations by conducting post payment reviews to determine the propriety of claims reimbursed by the Medicaid program. The Family Support Division within the DSS determines participant eligibility for the Medicaid program. The Code of Federal Regulations, 42 CFR 455.13, requires a state Medicaid agency to have "a) methods and criteria for identifying suspected fraud cases; b) methods for investigating these cases. . . ; and c) procedures, developed in cooperation with state legal authorities, for referring suspected fraud cases to law enforcement officials." During fiscal year 2011, the PIU was reorganized into the DSS, Missouri Medicaid Audit and Compliance (MMAC) Unit and is now organizationally located within the DSS Director's office.

A post-payment review of Medicaid claims reimbursed is performed on selected providers or projects to determine program compliance. Providers are selected to be reviewed from referrals, exception reports and/or other system generated reports. Referrals concerning possible misutilization may be received from providers, recipients, consultants, and division employees, as well as staff from other agencies. Exception reports are produced on providers that have unusual patterns of utilization, or that deviate from established norms. This review is completed by either a desk or field review. Programs are evaluated for adequate documentation and the appropriateness and quality of service. Reviews of allegations of participant fraud or abuse are completed for all referrals received. Participants committing fraud or abuse may be limited to using one provider, or referred to local authorities for legal action, or both.

Based on a preliminary review of reports and referrals, the PIU makes the determination on what enforcement activities to pursue. These enforcement activities may include one or more of the following administrative actions or sanctions: 1) provider education, 2) demand of repayment, 3) suspension or termination of the provider's Medicaid participation agreement, 4) transfer to closed-end agreement, 5) placement on prepayment review status, 6) participant lock-in, and 7) referral to the Attorney General, Medicaid Fraud Control Unit (MFCU) or the DSS-MO HealthNet Investigation Unit (MHIU).

At June 30, 2010 and June 30, 2009, the PIU consisted of 29 and 27 employees, respectively.



Department of Social Services, MO HealthNet Division,
Program Integrity Unit
Organization and Statistical Information

American Recovery and
Reinvestment Act 2009
(Federal Stimulus)

The DSS - MHD - PIU did not receive any federal stimulus monies during
the 2 years ended June 30, 2010.

Appendix A

Recoveries - 2 Years Ended June 30, 2010

For the 2 years ended June 30, 2010, the PIU recovered the following funds:

		Year Ended June 30,	
		2010	2009
Collections	\$	3,507,903	3,624,598
Adjustments		1,910,977	1,840,735 (1)
Recoupments		3,090,526	1,638,691 (1)
Overpayment memos/refunds		(59,866)	(25,533) (1)
Total	\$	<u>8,449,540</u>	<u>7,078,491</u>

(1) Adjustments, recoupments, and overpayment memos/refunds adjust the amount of claims. Adjustments are individual claims that have been overpaid and need to be adjusted. Recoupments are accounts receivable adjustments. Overpayment memos/refunds are duplicate payments made by providers related to previous overpayments or judicial decisions.

Appendix B

Operating Costs - 2 Years Ended June 30, 2010

For the 2 years ended June 30, 2010, the costs incurred to operate the PIU were:

	<u>Year Ended June 30,</u>	
	<u>2010</u>	<u>2009</u>
Salaries and wages	\$ 1,071,432	929,439
Fringe benefits	483,708	386,586
Travel, in-state	5,081	8,399
Travel, out-of-state	42	1,581
Supplies	762	2,981
Professional development	835	915
Professional services	1,073,408	824,123
Maintenance and repair services	762,339	1,045,340
Office equipment	0	509
Miscellaneous expenses	1,852	2,165
Building lease payments	28,523	25,916
Total	\$ <u>3,427,982</u>	<u>3,227,954</u> (1)

(1) Some office expenses such as phone charges and office supplies related to the MHD are not allocated to individual units within the division. Thus, there are additional expenditures related to the PIU not included above.