

## ***Wyoming Loses Millions to Avoidable Medicaid Waste and Abuse***

### Executive Summary

- **Medicaid Program Integrity is intended to ensure state and federal tax dollars are spent appropriately delivering necessary and quality healthcare and preventing waste, abuse, and fraud.**
- The current structure of Wyoming Medicaid Program Integrity has resulted in significant avoidable waste, abuse, fraud, and substandard healthcare to vulnerable Wyomingites.
- This structure, if left uncorrected, will result in ongoing risks of avoidable waste, abuse, fraud, and substandard care.
- The Wyoming Medicaid Office of Program Integrity lacks independence – a critical component of industry best practices for oversight entities.
- A simple legislative fix, ensuring Wyoming Medicaid Program Integrity performs its mission without interference will result in **immediate positive returns on investment (ROI)**.
- Several examples of obstruction and interference serve as case examples justifying consideration.
- A proven legislative fix is suggested.



## Background & Standards

- **Wyoming Medicaid Program Integrity ensures state and federal taxpayer dollars are spent appropriately delivering quality, necessary care and preventing fraud, waste, and abuse from taking place.<sup>1</sup>**
- Wyoming Medicaid Program Integrity serves an oversight function, as such, industry best practices for review, audit, investigation, and reporting serve as the standard.
- Several standards for industry best practices apply; **all stress the importance of independence.<sup>2</sup>**
- **The current structure of Wyoming Medicaid Program Integrity (PI) requires the PI Director answer upward in the chain of command – effectively providing oversight of his/her boss and boss’s boss.**
- This organizational structure represents a risk to independence and is incompatible with industry best practices.
- **Recent examples stand as case studies on how this organizational structure represents a threat to independence – already costing taxpayer millions of dollars and resulting in Wyomingites receiving grossly substandard healthcare.**

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<sup>1</sup> MACPAC - <https://www.macpac.gov/subtopic/program-integrity/>

<sup>2</sup> See Generally Accepted Government Auditing Standards (GAGAS), also known as the Yellow Book; provides a framework for conducting high-quality audits with competence, integrity, objectivity, and independence.



## What happens when independence in audit and investigation are not observed?

- **Gibson Condie & Northwest Wyoming Treatment Center Fraud and Investigations** – Millions of dollars in lost tax payer dollars; substandard healthcare to vulnerable Wyomingites.
- **State Subsidized Adoption Audit** – *Wyoming's lost children*<sup>3</sup>
- **Program Performance Bar** – the organizational structure encourages maintaining the status quo and job retention not innovation and performance

### Gibson Condie Fraud

- First identified in 2009-2013 – strong evidence the original case/investigation was obstructed and dropped by both the Wyoming Attorney Generals Office and Medicaid Program Integrity.<sup>4</sup>
- This obstruction resulted in an escalation of the fraud, further loss of millions of taxpayer dollars and a continuation of substandard care being provided to vulnerable Wyomingites<sup>5</sup>
- Demonstrative evidence indicates the case/investigation was again obstructed in 2015-2016<sup>6</sup>
- Gibson Condie was not prosecuted until the case was turned over to Federal Authorities by the Manager of Program Integrity<sup>7</sup>
- Condie was eventually prosecuted in part based upon the records and data originally identified and investigated in the obstructed 2009-2015 investigations
- **Program Integrity could have stopped the hemorrhaging of taxpayer dollars from the fraud if Program Integrity independence existed during the obstructed 2009 investigation**

### State Subsidized Adoption – *Wyoming's lost children*

- Referral to Program Integrity reported Wyoming children may be institutionalized in behavioral health facilities **contrary to medical advice**
- A Program Integrity audit was opened after a preliminary examination of data and records indicated a high risk to the State and Medicaid beneficiaries<sup>8</sup>
- The Program Integrity audit was obstructed by the Medicaid Director – the audit represented an uncomfortable subject.
- **Audit independence was not supported**
- Unverified state risk may be in the hundreds of thousands of dollars – **the audit was not conducted to its logical conclusion**
- Unverified human risks, impact on the potential victims, could be significant – **audit was not conducted to its logical conclusion**

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<sup>3</sup> See Appendix C – Subsidized Adoption Audit Announcement Letter

<sup>4</sup> See Appendix A - Document titled: *Status Update and Statement of Concern*

<sup>5</sup> See Star Tribune article titled: *Two Medicaid fraud cases swirl around Powell treatment center* - describing the investigations and fraud - [https://trib.com/news/state-and-regional/two-medicaid-fraud-cases-swirl-around-powell-treatment-center/article\\_913990e1-da94-58a6-992b-783e5918cb10.html](https://trib.com/news/state-and-regional/two-medicaid-fraud-cases-swirl-around-powell-treatment-center/article_913990e1-da94-58a6-992b-783e5918cb10.html)

<sup>6</sup> Document titled: *Status Update and Statement of Concern*

<sup>7</sup> See Appendix B – Law Enforcement Referral Letter

<sup>8</sup> See Appendix C – Subsidized Adoption Audit Announcement Letter



## Program Performance Bar

- The Medicaid Program Integrity Director was fired after refusing to obstruct the Gibson Condie investigation - “make it go away, like before.”
- The Medicaid Program Integrity Director was fired immediately after turning records over to Federal investigators.
- Innovation and best practices are stifled in this environment. The Program Integrity Director’s focus tends to migrate to job/career retention vs. supporting industry best practices when audit and investigation independence are not guaranteed.
- Performance drift is evident in the number of quality audits opened, findings reported, findings accepted, corrective action plans completed, educational interventions performed.
- The current Program Integrity structure promotes “sugar coated cotton candy” – Program Integrity activities may be sweet, but lack substance and efficacy.

## Solution

- **Ensure audit, investigation and oversight independence**
- **Remove Program Integrity from the Medicaid Office of Healthcare Finance**
- Place Program Integrity in a more independent setting with controls that promote oversight independence
  - Wyoming State Auditor’s Office can contain the *Wyoming Office of Medicaid Inspector General*
  - This is in alignment with the State Auditor’s mission:  
  
*“The Auditor protects public money by ensuring that it is properly accounted for in the most efficient and cost-effective means at all times. Promoting transparency and financial accountability are the Auditor’s top priorities.”*
- Potential ROI
  - Utah<sup>9</sup>
    - **Year one - 906 %**
    - **Year two - 468%**
- Example of other states with Inspector General’s Office providing independent oversight of Medicaid:
  - Utah
  - Arizona
  - Arkansas
  - New York
  - Wisconsin
  - Illinois
  - Georgia
  - Texas
  - many others.....

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<sup>9</sup> See Appendix D & E: Utah Office of Medicaid Inspector General year one and year two Annual Reports.



Appendix A: Document Titled: *Status Update and Statement of Concern*, dated April 19, 2016



## Wyoming Department of Health, Division of Healthcare Financing, Program Integrity - Status Update and Statement of Concern

- Northwest Wyoming Treatment Center
- Big Horn Basin Mental Health Group

April 19, 2016

### Executive Summary

The Wyoming Medicaid Fiscal Agent (Xerox) referred four anomalous claims to the Wyoming Department of Health, Division of Healthcare Financing, Program Integrity on or about 10/8/15. Program Integrity performed a preliminary examination of these claims and expanded the review to include the provider's complete claim profile. Several suspicious activities were identified within the claims profile. An investigation was opened and a second closely affiliated provider was identified as having claims with a similar profile. Medical records were requested from both providers.

Review of the medical records identified significant overpayments and suspected fraudulent activities. Referrals were made to the Wyoming Medicaid Fraud Control Unit (MFCU) and notices of recovery issued for the identified overpayments.

The Program Integrity investigation identified collateral problems among many mental health providers in the communities surrounding the two providers under investigation; these collateral problems were directly connected to the activities of the two providers. To date, an investigation has been opened on a third provider and several others have been denied enrollment as Wyoming Medicaid providers. Additional investigations and referrals to the Wyoming State Board of Psychology, the Mental Health Licensing Board, the Internal Revenue Service, the Federal Bureau of Investigation and the United States Attorney's Office may be forthcoming.

The Program Integrity investigation identified non-Medicaid enrolled providers receiving Medicaid funds for services rendered to Medicaid beneficiaries;<sup>1</sup> medical records and clinical care that failed to meet standards required by Wyoming Medicaid and federal policy and procedure; non-allowed services being submitted and paid under clinical codes; false claims; and claims/medical records believed to be fraudulent.

The activities identified in these investigations represent a significant financial risk to Wyoming and a quality of care risk to Medicaid beneficiaries.<sup>2</sup>

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<sup>1</sup> To date, approximately sixty (60) non-enrolled providers have been identified as having provided services to Medicaid beneficiaries through the Big Horn Basin Mental Health group.

<sup>2</sup> Thirty-two (32) medical records have been reviewed by Program Integrity from Big Horn Basin Mental Health Group – a relatively small percentage of the total population. One hundred percent of these records failed the review for multiple violations. All medical records submitted by Big Horn Basin Mental Health Group, one hundred percent, reviewed to date by internal reviewers, Sandra Jensen, Ph.D. and James Bush, MD also failed multiple tests for quality of care. Eight records were outsourced for independent review (CQS); all records (100%) externally reviewed failed multiple tests. The state FMAP vulnerabilities/liabilities potentially apply to the entire (all claims), not merely the sampled and reviewed Medical records represented in the recovery letters.

The providers currently under investigation were previously investigated by MFCU and Program Integrity (2009-2012). MFCU referred the case back to Program Integrity (April 2014) where it was not fully investigated. The current investigation has identified evidence that the previous MFCU investigation may have been unduly influenced resulting in no or inadequate actions.

The current investigations have identified suspected fraudulent activities as well as egregious and gross violations of Wyoming and federal policy and procedure as well as deficiencies in quality of care. These violations and conditions were present at the time of the previous investigations. Failures within the 2009-2012 investigations have resulted in significant financial risk and damage to Wyoming and permitted a perpetuation of problems now contributing to compromised care to vulnerable Medicaid beneficiaries.

Program Integrity identified potential conflicts of interest and ethical violations that are believed to have contributed to failure of the 2009-2012 investigations. Specifically, Program Integrity has identified evidence of the following:

- Gibson Condie PhD, the subject of the 2009-2012 investigation, was present at the Greg Phillips swearing in ceremony as Wyoming Attorney General. Mr. Phillips personally named Dr. Condie during the ceremony – *“all the way back to the age of three, the kid across the ally, Gibson Condie, my friend, and continues to be my friend, college roommate.”*<sup>3</sup>
- MFCU representatives present at Mr. Phillips swearing in ceremony identified this potential conflict of interest.
- The MFCU director, Christine Stickley, consulted with Elizabeth Gagen, Deputy Attorney General, and Mr. Phillips was Chinese walled off from the investigation.
- Mr. Phillips allegedly did not honor the Chinese wall and may have influenced and retaliated against MFCU and /or the MFCU director.
- Ms. Gagen was replaced by Peter Michael as Deputy Attorney General. Both Mr. Michael and Mr. Phillips allegedly did not honor the Chinese wall established by Ms. Stickley and Ms. Gagen.

Program Integrity is now encountering resistance to, and receiving unusual inquiries about, the current investigations.

- Wyoming Attorney General’s Office is resistant to provide supportive counsel to Program Integrity in regard to these investigations – supportive counsel is conditional upon conveying detailed information regarding Program Integrity investigation.<sup>4</sup>
- Wyoming Attorney General’s Office is inappropriately probing for Program Integrity investigation details.<sup>5</sup>
- The Wyoming Medicaid Fraud Control Unit (MFCU) within the Wyoming Attorney General’s Office is withholding or delaying investigative services.<sup>6</sup>

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<sup>3</sup> Recording of Greg Phillips swearing in ceremony – minute number 3, recording no. 9.

<sup>4</sup> Email dated Fri, Mar 25, 2016 at 2:35 PM, Donna Murray

<sup>5</sup> See emails from Donna Murray; transcript of 3/30/16 phone call with Misha Westby

<sup>6</sup> Program Integrity team notes from Fri, Mar 25, 2016 meeting with MFCU

- A MFCU staff member, instrumental in the 2009-2012 investigation, is again a key component to the current investigation. This investigator/analyst has communicated incorrect procedural and policy interpretations on critical issues relating to the current investigation.
- Program Integrity is encountering pressure to refrain making statutorily required referrals to outside law enforcement and regulatory agencies.

In order to advance the current investigations, avoid potential conflicts of interest, and to avoid a disposition similar to the 2009-2012 investigations the following recommendations are suggested:

1. The Attorney General and the Attorney General's office should be walled off from the investigations described in this report and other related inquiries/investigations that may emerge.
2. Independent and third party counsel should be hired to represent Program Integrity for the course and duration of these investigations.
3. Outside referrals should be made to appropriate federal authorities
4. The conflict of interest within MFCU should be addressed; persons associated with the 2009-2012 investigations should be removed from the current investigations.
5. Potential conflicts of interest within Program Integrity should be addressed; persons associated with the 2009-2012 investigations should be removed from the current investigations.
6. Additional/temporary investigative support should be retained to assist Program Integrity complete the current investigations.
7. Independent, outside, third party counsel should provide review and oversight of the current MFCU investigation.

## Current Status and Timeline

### Northwest Wyoming Treatment Center

1. Referral received from State Fiscal Agent (~10/8/15)
2. Program Integrity Investigation opened (10/14/15)
3. Records requested (11/10/15)
4. Case referred to MFCU (12/4/2015)
5. Provider placed on pre-payment review (1/22/16)
6. Recovery letter issued - \$1,349,403.50 (1/28/16)
7. Request for reconsideration received (2/18/16)
8. Additional records requested (3/11/16)<sup>7</sup>
9. Additional records not received in required manner. Request for reconsideration to be denied with prejudice.<sup>8</sup>

<sup>7</sup> Wyoming Medicaid Rules, Chapter 16, § 20 (c)

<sup>8</sup> Wyoming Medicaid Rules, Chapter 3, § 14 (c)

**Big Horn Basin Mental Health Group**

1. Investigation opened (11/10/2015)
2. Records requested (11/10/15)
3. Case referred to MFCU (12/4/2015)
4. Provider payments suspended - credible allegation of fraud (1/22/16)
5. Recovery letter issued - \$803,158.75 (2/11/16)
6. Request for reconsideration received (4/4/16)
7. Additional records requested (3/14/16)<sup>9</sup>
8. Additional records received and reviewed (4/11/16)
9. A second records request was issued (4/6/16) - anomalous assessment claims associated with NOWCAP
10. Denial of request for reconsideration drafted (4/15/16)

[REDACTED]

[REDACTED]

**Providers Denied Enrolment (to date)**

[REDACTED]

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<sup>9</sup> Wyoming Medicaid Rules, Chapter 16, § 20 (c)

## Appendix B: Law Enforcement Referral Letter





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Thomas O. Forslund, Director

Governor Matthew H. Mead

April 10, 2016

John E. Lynch, Special Agent  
Federal Bureau of Investigation  
1109 Airport Parkway  
Cheyenne, WY 82001-1503

RE: Medicaid Program Integrity Law Enforcement Referral

Mr. Lynch:

In accordance with 42 CFR §455.15 Medicaid Program Integrity recently referred two investigations to the Wyoming Medicaid Fraud Control Unit (Big Horn Basin Mental Health Group and Northwest Wyoming Treatment Center). Potential conflicts of interest identified in the Program Integrity investigations necessitate referral to additional ancillary law enforcement agencies. Please note, Program Integrity could find no statutory language prohibiting referrals to additional law enforcement. Please consider this document and the accompanying files and records said referral.

We have attempted to remove medical records associated with substance abuse treatment in accordance with 42 CFR Part 2 (Northwest Wyoming Treatment Center Medical Records and Big Horn Basin Mental Health Group record No's 8, 9, 10, 11). Some of these records are important to the Program Integrity investigation, allegation of fraud, and referral. These records will be provided to all law enforcement agencies after appropriate authority has been documented.

The Wyoming Medicaid Program Integrity team welcomes the opportunity to review and explain the records and documents accompanying this referral with the Federal Bureau of Investigation.

If you have questions, please feel free to contact me at [Mark.Gaskill@wyo.gov](mailto:Mark.Gaskill@wyo.gov) or to my attention at the address on this letter.

Sincerely,

Mark J. Gaskill  
Manager of Quality Assurance  
and Program Integrity

MG  
C. File



## Appendix C: Subsidized Adoption Audit Announcement





Wyoming  
Department  
of Health

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Thomas O. Forslund, Director

January 8, 2016

Ref: MG-2016-002

Teri Green, State Medicaid Agent  
6101 Yellowstone Road, Suite 210  
Cheyenne, WY 82002

RE: Audit Announcement

Dear Ms. Green:

The Medicaid Program Integrity (PI) staff will be performing an audit beginning 1/11/16 of Medicaid beneficiaries enrolled under program codes A86 and A52 - Subsidized Adoption Title 19, IV-E Adoption respectively.

The audit will examine costs, care, and policy associated with A86 and A52 children and adolescents who received extended residential care.

Tisha Kilpatrick and I will be conducting the audit. I do not believe an entrance meeting is necessary unless you wish to schedule one. We will begin our fieldwork next week and anticipate completing the audit in four to six weeks.

Sincerely,

Mark Gaskill  
Manager of Quality Assurance and  
Program Integrity  
Wyoming Department of Health  
Division of Healthcare Financing

MG  
Attachment

**Division of Healthcare Financing, Medicaid** • 6101 Yellowstone Road, Suite 210  
Cheyenne WY 82002 • WEB Page: <http://www.health.wyo.gov>  
Toll Free: 1-866-571-0944 • FAX (307) 777-6964 • (307) 777-7531



**Example 1: Contiguous Treatment Contacts at Residential Treatment Facilities (Differential Admitting Diagnoses)**

Admitting Diagnoses	Beneficiary A	Grand Total
<b>Residential Treatment Center 1</b>	<b>Residential Treatment Center 1</b>	<b>\$550,471.00</b>
OPPOSITIONAL DEFIANT DISORDER	3/13/11 Admission Date	<b>Days</b>
	5/20/12 Discharge Date	<b>1,724</b>
<b>Residential Treatment Center 2</b>	<b>Residential Treatment Center 2</b>	
POSTTRAUMATIC STRESS DISORDER	5/21/12 Admission Date	<b>Years</b>
	10/9/14 Discharge Date	<b>4.72</b>
<b>Residential Treatment Center 3</b>	<b>Residential Treatment Center 3</b>	
POST-TRAUMATIC STRESS DISORDER UNSPECIFI	10/9/14 Admission Date	
POSTTRAUMATIC STRESS DISORDER	11/30/15 Discharge Date	

**Example 2: Contiguous Treatment Contacts at Residential Treatment Facilities**

Admitting Diagnoses	Beneficiary B	A52	A86	Grand Total
<b>Residential Treatment Center 1</b>	<b>Residential Treatment Center 1</b>	<b>\$360,280.00</b>	<b>\$141,771.00</b>	<b>\$502,051.00</b>
BIPOLAR AFFECTIVE DISORDER, MIXED, SEVER	1/4/11 Admission Date			
	9/1/11 Discharge Date			
<b>Residential Treatment Center 2</b>	<b>Residential Treatment Center 2</b>			<b>Days</b>
BIPOLAR AFFECTIVE DISORDER, MIXED, SEVER	9/1/11 Admission Date			<b>1,792</b>
	7/31/12 Discharge Date			
<b>Residential Treatment Center 3</b>	<b>Residential Treatment Center 3</b>			<b>Years</b>
BIPOLAR AFFECTIVE DISORDER, MIXED, SEVER	7/31/12 Admission Date			<b>4.91</b>
	6/29/15 Discharge Date			
<b>Residential Treatment Center 4</b>	<b>Residential Treatment Center 4</b>			
BIPOLAR AFFECTIVE DISORDER, MIXED, UNSPE	6/29/15 Admission Date			
BIPOLAR D/O CURRENT EPISODE DEPRESSED MO	11/30/15 Discharge Date			



Example 3: Near Contiguous Treatment Contacts at Residential Facilities (Differential Admitting Diagnoses)

Admitting Diagnoses	Beneficiary C	Grand Total
<b>Residential Treatment Center 1</b>	<b>Residential Treatment Center 1</b>	<b>\$443,670.85</b>
MAJOR DEPRESSIVE DISORDER, RECURRENT EPI	6/10/11 Admission Date	<b>Days</b>
MAJOR DEPRESSIVE DISORDER, SINGLE EPISOD	9/2/11 Discharge Date	<b>1,115</b>
<b>Residential Treatment Center 2</b>	<b>Residential Treatment Center 2</b>	
MAJOR DEPRESSIVE DISORDER, SINGLE EPISOD	9/14/11 Admission Date	
	4/23/12 Discharge Date	<b>Years</b>
<b>Residential Treatment Center 3</b>	<b>Residential Treatment Center 3</b>	<b>3.05</b>
MAJOR DEPRESSIVE DISORDER, RECURRENT EPI	4/23/12 Admission Date	
	7/23/13 Discharge Date	
<b>Residential Treatment Center 4</b>	<b>Residential Treatment Center 4</b>	
MAJOR DEPRESSIVE DISORDER, RECURRENT EPI	8/12/13 Admission Date	
	10/28/13 Discharge Date	
<b>Residential Treatment Center 5</b>	<b>Residential Treatment Center 5</b>	
POSTTRAUMATIC STRESS DISORDER	10/28/13 Admission Date	
UNSPECIFIED AFFECTIVE PSYCHOSIS	6/28/14 Discharge Date	

Example 4: Near Contiguous Treatment Contacts at Residential Facilities (Differential Admitting Diagnoses)

Admitting Diagnoses	Beneficiary D	Grand Total
<b>Residential Treatment Center 1</b>	<b>Residential Treatment Center 1</b>	<b>\$412,974.73</b>
MAJOR DEPRESSIVE DISORDER, SINGLE EPISOD	4/8/11 Admission Date	<b>Days</b>
	11/1/11 Discharge Date	<b>1433</b>
<b>Residential Treatment Center 2</b>	<b>Residential Treatment Center 2</b>	
BIPOLAR AFFECTIVE DISORDER, MIXED, SEVER	11/1/11 Admission Date	<b>Years</b>
	4/27/12 Discharge Date	<b>3.93</b>
<b>Residential Treatment Center 3</b>	<b>Residential Treatment Center 3</b>	
BIPOLAR AFFECTIVE DISORDER, MIXED, SEVER	4/27/12 Admission Date	



	1/10/13 Discharge Date	
<b>Inpatient Treatment Center 4</b>	<b>Inpatient Treatment Center 4</b>	
(blank)	11/19/13 Admission Date	
	11/29/13 Discharge Date	
<b>Residential Treatment Center 5</b>	<b>Residential Treatment Center 5</b>	
POSTTRAUMATIC STRESS DISORDER	1/11/13 Admission Date	
	3/10/15 Discharge Date	

**Example 5: Near Contiguous Treatment Contacts at Residential Facilities (Differential Admitting Diagnoses)**

<b>Admitting Diagnoses</b>	<b>Beneficiary E</b>	<b>\$325,371.57</b>
<b>Residential Treatment Center 1</b>	<b>Residential Treatment Center 1</b>	
MAJOR DEPRESSIVE DISORDER, SINGLE EPISOD	4/25/13 Admission Date	<b>Days</b>
	8/14/13 Discharge Date	<b>~ 946</b>
<b>Residential Treatment Center 2</b>	<b>Residential Treatment Center 2</b>	
REACTIVE ATTACHMENT DISORDER OF INFANCY	8/17/13 Admission Date	<b>Years</b>
UNSPECIFIED AFFECTIVE PSYCHOSIS	4/14/14	<b>2.60</b>
<b>Residential Treatment Center 3</b>	<b>Residential Treatment Center 3</b>	
REACTIVE ATTACHMENT DISORDER OF INFANCY	4/14/14 Admission Date	
	5/28/15 Discharge Date	
<b>Residential Treatment Center 4</b>	<b>Residential Treatment Center 4</b>	
OTHER CHILDHOOD EMOTIONAL DISORDERS	6/1/15 Admission Date	
REACTIVE ATTACHMENT DISORDER OF INFANCY	11/30/15 Discharge Date	



Appendix D: Utah Office of Medicaid Inspector General  
Year One Annual Report



# OFFICE OF THE INSPECTOR GENERAL OF MEDICAID SERVICES ANNUAL REPORT



9/14/2012

Inspector General of Medicaid Services

The Office of the Inspector General of Medicaid Services was established on July 1, 2011. It was created to monitor and evaluate the Medicaid program in the state of Utah.

September 14, 2012

TO: Governor Gary Herbert, Senator Lyle W. Hillyard, Chair, Representative Melvin R. Brown, Chair, Senator Kevin T. Van Tassell, Vice Chair, Representative John Dougall, Vice Chair and the Executive Appropriations Subcommittee

SUBJECT: 2012 Annual Report for the Office of Inspector General of Medicaid Services (OIG)

Attached is our 2012 annual report to the Governor and the Executive Appropriations Subcommittee, in compliance with **Utah Code 63J-4a-502**. This report shows the results from the Office of Inspector General for fiscal year 2012. The OIG was created to serve as an independent oversight mechanism for Utah Medicaid and all Medicaid related spending. This report presents progress achieved since the inception of the office one year ago.

I am available to meet with members of the subcommittee to discuss any item contained in this report and to answer any questions regarding the ongoing efforts of this office to identify waste and abuse of Medicaid funds and the recoupment of those funds.

Sincerely,

Lee Wyckoff, CPA, CIA  
Inspector General of Medicaid Services

cc: President Michael Waddoups  
Speaker Rebecca Lockhart  
Senator Allen Christensen  
Representative Bill Wright  
Representative Bradley Last  
Derek Miller  
Mike Mower  
Ally Isom

Kristen Cox  
Ron Bigelow  
David Patton, Ph.D  
Michael Hales  
Robert Rolfs, M.D.  
Zackery King  
Stephen Jardine  
Clifford Strachan

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DRAFT

## INTRODUCTION

### EXECUTIVE SUMMARY

The Office of the Inspector General (OIG) was created through legislation during the 2011 general session and became an independent office on July 1, 2011. The OIG serves as an independent oversight mechanism for Utah Medicaid and all Medicaid related spending. Significant progress has been achieved since the creation of the office one year ago.

A summary of critical items we have accomplished in the first year include the following:

- People and infrastructure
  - Developed a new office in a political environment with strong, demonstrated success as measured by return on investment, employee morale, and sustainability of operations
  - Created a case management database and a related process that monitors case progress and assigns resources
  - Implemented a hearing process for administrative appeals, including development of administrative hearing rules and retention of two, part-time administrative law judges (ALJs)
  - Developed a data mining team (2 associates) and a related process that uses creative, real-time data analytics to keep the OIG investigative pipeline full
  - Established
- Savings and Recovery (ROI)
  - Identified **nearly \$29 million\*** dollars that have been or are in the recovery process, while spending slightly under the \$2+ million budget allotted
  - Performed Hospital Utilization Reviews (HURs) as required by statute and reduced outstanding inventory by approximately 1,000 cases; HUR inventory is now current
  - Provided significant policy recommendations to Medicaid and the Department of Health (DOH)
- Partnering with the provider community
  - Conducted routine meetings with the provider community to facilitate patient access to care and appropriate use of that care
  - Hired a Training and Policy Coordinator and conducted over 30 training sessions statewide to educate providers on common fraud, waste, and abuse to reduce future occurrences
  - Communicated with the provider community in an effort to minimize political ramifications of large fraud, waste, and abuse recoveries

\*See appendix A

**OIG: AN OVERVIEW OF THE OFFICE****ROLE AND RESPONSIBILITIES**

The mission of the Office of Inspector General of Medicaid Services Audit division is to:

- Ensure compliance with state and federal requirements as they pertain to Medicaid.
- Audit, inspect, and evaluate the functioning of the division to improve Medicaid operations.
- Advise the Department and Division of an action that should be taken to ensure the state Medicaid program is managed in the most efficient and cost-effective manner possible.
- Identify, prevent and reduce fraud, waste and abuse in the state Medicaid program.
- Recoup, reduce costs and avoid or minimize increased costs of the state Medicaid program.

See 63J-4a-202

**STAFF**

<b>Inspector General</b>		<b>Lee Wyckoff, CPA, CIA, CISA, CISSP, CFE</b>	
Data Analysts	Mark Gaskill, MFT Sam Vanhous, PHD	Administrative	Gene Cottrell Ann Carrillo
Auditor Manager	Broc Christensen, MA	Legal	Stephen Alderman, JD
Auditors	Doug May, CIA, EMBA		Lena Ward, JD
	T. Jason Mott, CPA, CFE		Carol Clawson, JD
	David Stoddard	PI Manager	Noleen Warrick
	Deepa Ramkumar, CPA, CISA	Policy and Training	Michael Green, MS, JD
	Kevin Anderson	PERM/Pharmacy	John Slade, CRT
Nurse Manager	Toni Shepard, RN, BSN, CPC, IQCI		Kylene Hilton
Nurse Investigators	Marian West, RN, BSN, CPC, CPC-H		Kathy Cordova
	Sally Valdez, RN, MPA		Terra Shockey
	Shanna Anderson, RN		Isabella Wright
	Dean Healey, RN, BS, MSNc		Audrey Curtis
	Burdean Wirtz, RN, MSN, SSW		Dani Ibrahim, BS, CPhT
Physicians	John Hylan, MD, MPH		
	Dr. George Smith, MD, DFAPA		

**ORGANIZATION**

The OIG organization is based on a matrix or cross-functional organizational structure. While there are clear reporting lines and a clear mission for each team, there are responsibilities that transcend the various teams. Strong communication across the organization is the basis for efficiency in that we can accomplish more with fewer people and with less duplication of effort. From a top-down view, the Office is divided into three groups as follows:

- Internal Audit Team
- Program Integrity/ Medical Review Team
- Data Mining, Policy, and Strategy Team

## **OIG IMPACT AND PROGRESS**

### **INTERNAL AUDIT TEAM**

The purpose of the Audit Team is to function as an overall preventive control. The group's objective is to prevent fraud, waste, and abuse through proactive measures. Examples include recommending policy improvements to Medicaid and the DOH and reviewing areas of high organizational risk, such as project implementations, major initiatives, external reporting, or significant budget items. Through a historical analysis of payments recovered by the Program Integrity Function, the Audit Team's goal is to reduce the number of incorrect payments **before** they are made. The Internal Audit Team is comprised of audit professionals with expertise in accounting, fraud investigations, internal control structures and process improvement.

During FY2012, the Audit Department hired an additional four (4) auditors, bringing the total number of auditors to six (6). They released seven (7) reports, performed an internal review of the OIG's financial database, and reviewed federally excluded providers. The seven audit reports resulted in 26 recommendations; 25 or 96% of those recommendations are agreed to by audit clients and have specific implementation deadlines.

Some key outcomes from these audits include:

- Performance audit on the *Baby Your Baby* program demonstrated that controls needed improvement. By shortening the eligibility period (adopted recommendation), Medicaid will save approximately \$500,000 per year on a prospective basis. As recommended, controls and oversight of the program have been consolidated, with oversight by one person, decreasing the risk of abuse.
- An audit of Provider Enrollment helped reduce the likelihood of fraud by strengthening the requirements for Medicaid provider eligibility. Medicaid also agreed to eliminate many of the out-of-state providers active in the claims system, who are not frequently used by Utah Medicaid recipients.
- The Provider Sanctioning report recommended a concise plan and strong policy for sanction reporting. The audit also recommended more discretion in sanctioning providers who acted inappropriately.

As of 6/30/2012, the OIG had partnered well with Medicaid and DOH management to identify emerging risks. Any discussions held with Medicaid management as they developed their action plans could be described as healthy tension. The Inspector General has recently become concerned because of one nearly completed audit where Medicaid management has contributed to an element of excess tension.

### **Audit Plan**

The Audit Team has enhanced their audit plan to include many high risk business processes. They prioritize audits based on risk rating and available resources and expertise. They adjust the audit plan throughout the year based on feedback from audit clients, changing organizational priorities, and a real-time evaluation of Medicaid's risk profile. Audit Management routinely meets with DOH and Medicaid Management and has also extended the scope of the audit plan to include broad-based Medicaid spending (Department of Workforce

Services (DWS), Department of Human Services (DHS)). There are currently nine audits in process and 37 audits on the risk prioritized audit plan.

### **Follow-Up Reviews**

The Audit Team is now a year old and beginning to follow up on issued audit reports and the corresponding management action plans. This practice helps achieve organizational change by fostering an environment of accountability. It is also a necessary component of operating in accordance with Generally Accepted Government Auditing Standards (GAGAS). This will allow the office to monitor DOH and Medicaid compliance with implementation dates for management action plans.

### **PROGRAM INTEGRITY / MEDICAL REVIEW TEAM**

The Program Integrity and Medical Review Team focus on the post-payment review and recovery of Medicaid payments that are high risk, outliers or statutorily required. By partnering with the Data Mining Team, Program Integrity has significantly increased their efficiency and capacity by focusing more directly on areas of risk. This function is mandated by Federal law, but their newly adopted methodology has caused their return on investment to increase exponentially. Their team is comprised of medical professionals (nurses/doctors), medical administrators and eligibility experts.

Audits conducted by the Program Integrity / Medical Review team have identified amounts for recovery of \$28.9 million dollars in one-time state and federal Medicaid funds during fiscal year 2012. This amount includes \$3.48 million dollars that were identified by the Medicaid Fraud Control Unit (MFCU) and ultimately collected by the OIG.

The increasing effectiveness and accuracy of the team can be seen in several areas. There has been a significant reduction in the number of cases that providers are appealing. Because the original notices of recovery are based on strong legal and policy interpretation, the proclivity of providers to pursue an appeal process has been diminished.

Two key performance measures are presented below:

<b><u>Performance Measure</u></b>	<b><u>FY 2012</u></b>	<b><u>FY 2013 Target</u></b>
Approximate Return on Investment	906 %	500 %
Approximate Recoveries per FTE	\$ 733,565	\$ 404,656

The main measurement is a return on investment (ROI) for the OIG unit. Based on collections for fiscal year 2012, and an estimate of the overall collectible amount currently in administrative hearing or noticed to the provider, the unit produced an ROI of approximately 906%.

Program Integrity refers suspected fraud case to the Medicaid Fraud Control Unit (MFCU) on a routine basis as they are identified. The OIG has routine meetings with the MFCU and has partnered well to help identify blatant cases for prosecution. Currently, the OIG is going through preparation to refer approximately five (5) cases to MFCU.

### **DATA MINING, POLICY, AND STRATEGY TEAM**

The Data Mining, Policy, and Strategy team consists of two data analysts and one policy expert. The Data Mining, Policy and Strategy team focuses on using creative, real-time data analytics to identify areas of high risk. Having an inventory of high risk areas allows Program Integrity to focus their time and efforts where they can make an immediate impact and achieve a high ROI.

Potential problems or questions identified by the Data Mining, Policy, and Strategy Team are prioritized using preliminary risk evaluation, including policy and legal implications, risks to providers and recipients, and potential return on investment. Analytic, investigative, and medical research resources are allocated to cases based on this preliminary evaluation.

The methodology used for data pulls is one supported by the Centers for Medicare and Medicaid Services (CMS) and consists of the following:

1. **Case Concept Development** – Identify problem or question related to waste, abuse or fraud
2. **Algorithm Development** (Data Pulls) – Identify the data universe/population
3. **Sampling** – Select the focus group
4. **Statistical Analysis** – Evaluate the focus group(s)
5. **Model Development** – Apply findings to other populations or problems
6. **Artificial Intelligence & Fuzzy Logic** – Make connections to other problems/questions in the absence of direct linkages
7. **Other Data Mining and Analysis Methods** – High-level fishing and other creative brainstorming

The Policy Team also provides training to the provider community and other agencies. The OIG has conducted 30 training sessions to all provider types statewide. The OIG has lectured on fraud, waste and abuse to the Division of Child and Family Services (DCFS) and The Utah Division of Services for People with Disabilities (DSPD). These training seminars focus on how to identify and report suspected or actual fraud, waste and abuse. Moreover, the training gives examples of best practices & procedures and how the OIG works procedurally if the provider has an interaction with the office.

### **Looking Forward**

Medicaid is proposing a transition to a capitated health care delivery model for the majority of Utah's Medicaid recipients in FY 2013. This transition will shift Medicaid from a claims based to a capitated reimbursement model.

Capitated reimbursement results in encounter data versus individual reimbursement claims data. This transition will require the OIG Data Mining, Policy and Strategy Team to adjust our analytic approach. The team's focus will shift from a payment analysis model to a quality of care, access to care and a case risk adjustment analysis focus. The OIG has prepared for this transition by hiring an expert on Utah's managed care community and associated quality measures (HEDIS and CHAPS) (see 2nd FTE/ data miner discussion above). In addition, the Data Mining, Policy and Strategy Team will be utilizing additional software analytic tools that will aid in the evaluation and oversight of the encounter data and performance measures.

Appendix A: Summary of Recovered Amounts

<b>Cash Collected</b>	7,532,652
<b>Cash Being Collected by DOH Through Offset In Hearing Process as of 6/30/2012</b>	2,660,249
<b>Noticed, but Not Collected as of 6/30/2012</b>	18,339,703
	<u>398,788</u>
	28,931,392

DRAFT



Appendix E: Utah Office of Medicaid Inspector General  
Year Two Annual Report



# OFFICE OF THE INSPECTOR GENERAL OF MEDICAID SERVICES ANNUAL REPORT



9/25/2013

Inspector General of Medicaid Services

The Office of the Inspector General of Medicaid Services was established on July 1, 2011. The primary goal of the Office is to safeguard taxpayer assets through the reduction of waste, abuse, and fraud, while treating stakeholders fairly.



STATE OF UTAH

LEE WYCKOFF  
*Inspector General*

Office of the Inspector General

September 25, 2013

TO: Governor Gary Herbert and The Executive Appropriations Committee: Senator Lyle W. Hillyard, Chair; Representative Melvin R. Brown, Chair; Senator Jerry Stevenson, Vice Chair; Representative Brad R. Wilson, Vice Chair

SUBJECT: 2013 Annual Report for the Office of Inspector General of Medicaid Services (OIG)

Attached is our 2013 annual report to the Governor and the Executive Appropriations Committee, in compliance with **Utah Code § 63A-13-502**. This report shows the results from the Office of Inspector General for fiscal year 2013. The OIG was created to serve as an independent oversight agency for Utah Medicaid and all Medicaid related spending. This report presents progress achieved in SFY 2013.

I am available to meet with members of the Committee to discuss any item contained in this report and to answer any questions regarding the ongoing efforts of this office to identify waste, abuse, and fraud of Medicaid funds and the recovery of those funds.

Sincerely,

Lee Wyckoff, CPA, CIA, CISA  
Inspector General of Medicaid Services

cc: President Wayne Niederhauser  
Speaker Rebecca Lockhart  
Derek Miller  
Mike Mower  
Ally Isom  
Kristen Cox

David Patton, Ph.D  
Michael Hales  
Robert Rolfs, M.D.  
Russ Fransden  
Stephen Jardine  
Zackery King  
Health and Human Services Appropriations

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## Executive Summary

The Office of the Inspector General (OIG) was created through House Bill 84, 4th Substitute during the 2011 legislative general session. The 2013 legislative general session introduced and passed House Bill 106, 3rd Substitute, which established the Office of Inspector General as an independent entity within the Department of Administrative Services. HB 106 also provided additional direction and clarification on a number of sensitive subjects important to the OIG and Medicaid stakeholders.

The OIG has continued to advance the mission established in 2011 while meeting both the letter and spirit of the most recent legislation.

A summary of items we have accomplished this year include the following:

### **Achievements – The OIG:**

- Researched, identified, and recovered approximately \$12 million of taxpayer funds. The OIG also partnered with MFCU to collect approximately \$13 million in global drug rebate settlements and fraud related recoveries. A total of approximately \$25 million were returned to the Medicaid general fund to help further Medicaid's mission;
- Demonstrated an extremely conservative return on investment of more than 468% (excluding all work on MFCU related cases, but including all department costs);
- Completed 1,489 investigations that examined compliance with Medicaid policies, recipient quality of care, and identification of waste, abuse, and potential fraud; and
- Published a Strategic Plan which defines Office goals and objectives, stakeholders, and strategies (see Appendix A).

### **Response to HB 106 – The OIG:**

- Completed the transition from the Governor's Office of Planning and Budget to the Department of Administrative Services;
- Issued Rule 30. This rule defines the scope of the Utah Office of Inspector General of Medicaid Services and the provisions necessary to administer the Office;
- Conducted 26 provider trainings, canvassing nearly all Utah counties. These trainings encourage provider participation in Utah's Medicaid program while informing healthcare professionals about OIG audit policies and compliance issues; and
- Accommodates and supports the submission of secured electronic files.

**The OIG is positioned well to continue to serve as an independent oversight agency for Utah Medicaid and all related spending into the future.**

# OIG Mission, Goals, Objectives, Challenge, and Methods

## OIG Mission

The OIG's mission is to safeguard taxpayer assets through the reduction of waste, abuse, and fraud within the Utah Medicaid system while treating all key stakeholders fairly.

## OIG Goals & Objectives

The OIG intends to:

- Support delivery of quality healthcare to the State's most vulnerable people for the best value;
- Continue to seek improvements in Medicaid payment accuracy, legal compliance, and efficiency through accurate payment of Medicaid claims – correcting both over and underpayments to Medicaid providers;
- Continue to build and maintain trust with the provider community and taxpayers through training, accessibility, and transparency; and
- Promote interagency communication, cooperation, and efficiency

## OIG Challenge

The OIG is often challenged to balance the divergent, and sometimes competing, interests of multiple stakeholders. For example, an OIG action viewed as a benefit by one stakeholder may be interpreted as an encumbrance by another.

The OIG seeks to achieve balanced, win-win solutions whenever possible. When a stakeholder is dissatisfied with an OIG action, the office ensures the action is supported with thorough explanations, statutory justification, provider training, and accessibility to the Office.

## OIG Methods

The Utah OIG accomplishes its mission through three key interactive teams:

- I. **Program Integrity/Medical Review (PIMR):** This OIG team reviews and investigates Medicaid payments that are high risk or where review is required by law.
- II. **Performance Audit:** This OIG team focuses on reducing waste, abuse, and fraud through preventive control audits and independent reviews of key Medicaid processes.
- III. **Data Mining, Policy, and Strategy:** This OIG team uses research and advanced data analytics to increase the impact and efficiency of the Medical Review and Performance Audit teams.

## OIG Results (SFY 2013)

### Taxpayer Funds Recovered (Returned to the Medicaid General Fund)

<b>Cash Collected</b>		
Cash Received <sup>1</sup>	\$	11,574,873
Joint MFCU-OIG		525,512
MFCU Global Settlements <sup>2</sup>		12,815,569
<b>Total Taxpayer Funds Recovered</b>	<b>\$</b>	<b>24,915,954</b>
<b>OIG FY 2013 Spend</b>	<b>\$</b>	<b>2,472,266</b>
<b>ROI Excluding MFCU Collections</b>		<b>468%</b>
<b>ROI Including MFCU Collections</b>		<b>1008%</b>

<sup>1</sup> Cash Received includes offsets to future provider billing and lockbox funds

<sup>2</sup> Global Settlements are shown net of a retention amount kept by MFCU

## OIG Response to Recent Legislation

The 2013 legislative general session passed House Bill 106, 3rd Substitute (HB 106). This bill moved the Office of Inspector General of Medicaid Services into the Department of Administrative Services as an independent entity.

### **In addition, HB 106:**

- Required the Office of Inspector General of Medicaid Services to adopt administrative rules to develop audit and investigation procedures.

*On June 21, 2013 Rule 30 (Administrative Services, Office of Inspector General of Medicaid Services) became effective. This rule defines the scope of the Utah Office of Inspector General of Medicaid Services and the provisions necessary to administer the Office.*

- Directed the OIG to identify and reduce waste, abuse, and fraud in the state Medicaid program; and recoup costs, balance efforts to reduce costs, and avoid or minimize increased costs of the state Medicaid program with the need to encourage robust health care professional and provider participation in the state Medicaid program.

*The OIG conducted 26 provider trainings, canvassing nearly all Utah counties in SFY 2013. Provider training encourages provider participation in Utah's Medicaid program while increasing awareness and transparency of OIG audit policies and compliance reviews.*

- Directed the OIG to investigate, discover, and recover fraud, waste, and abuse in the Medicaid program, apply the state Medicaid plan, department administrative rules, Medicaid provider manuals, and Medicaid information bulletins in effect at the time the medical services were provided.

*The OIG conducted 1,489 investigations in SFY 2013. These investigations and the partnership with MFCU drove the identification and recovery of inappropriate Medicaid payments totaling approximately \$25 million (See OIG Results section on page 4 above).*

- Shortened the period of time for which the OIG can review claims to 36 months from the inception of the investigation, except in cases of fraud.

*This was, and remains, an existing practice of the OIG. The OIG has continued to review Medicaid services performed within 36 months from inception of the investigation.*

- Provided direction for when the OIG can access, review, and copy provider records.

*The OIG continues to interact with providers in a manner that is minimally disruptive to the health care provider's care of patients. The OIG visits providers at their place of business very infrequently (<10 times since inception of the Office). These visits were scheduled with the providers and accommodated their schedules to minimize impact. The OIG also accommodates and supports the submission of secured electronic files from all providers who request this option.*

## Appendix A: Office of the Inspector General Strategic Plan

### Background

House Bill 84, 4th Substitute created The Office of the Inspector General (OIG) during the 2011 legislative general session. House Bill 106, 3rd Substitute replaced this statute during the 2013 legislative general session.

The OIG's mission is to safeguard taxpayer assets through the reduction of waste, abuse, and fraud within the Utah Medicaid system.

The Utah OIG accomplishes its mission through three key interactive teams:

- I. **Program Integrity/Medical Review (PIMR):** This OIG team reviews and investigates Medicaid payments that are high risk or where review is required by law.
- II. **Performance Audit:** This OIG team focuses on reducing waste, abuse, and fraud through preventive control audits and independent reviews of key Medicaid processes.
- III. **Data Mining, Policy, and Strategy:** This OIG team uses research and advanced data analytics to increase the impact and efficiency of the Medical Review and Performance Audit teams.

### Situational Analysis/Central Challenge:

The OIG is often challenged to balance the divergent, and sometimes competing, interests of multiple stakeholders. For example, an OIG action viewed as a benefit by one stakeholder may be interpreted as an encumbrance by another. The OIG seeks to achieve balanced, win-win solutions whenever possible.

When a stakeholder is dissatisfied with an OIG action, the office ensures the action is supported with thorough explanations, statutory justification, and provider training.

### Goal:

The OIG's goal is to safeguard taxpayer assets through the reduction of waste, abuse, and fraud within the Utah Medicaid system while treating all key stakeholders fairly.

### Key Audiences

1. Medicaid Providers
2. Utah and Federal Taxpayers
3. Utah Governor's Office and Legislature
4. Medicaid Leadership and Operations

## Key Messages:

1. OIG promotes Medicaid payment accuracy, legal compliance, and efficiency.
2. OIG supports quality healthcare delivery to the state's most vulnerable people for the best value.
3. OIG supports the provider community through training and accessibility.

## Objectives

### Objective 1: Support Healthcare Delivery Reform and Efficiencies

**Key Message:** OIG supports quality healthcare delivery to the state's most vulnerable people for the best value.

**Target Audience:** Medicaid Leadership, Utah Governor's Office, and Legislature

**Strategy:** The OIG shall continue to review and audit ACO implementation progress and contract performance through:

- a) Post payment review of claims and encounter data
- b) Review of ACO contracts through audit function
- c) Quarterly meetings with ACO contractor, Program Integrity, and data personnel
- d) Continued communication with Medicaid regarding any issues identified

### Objective 2: Facilitate accurate payment of Medicaid claims

**Key Message:** OIG promotes Medicaid payment accuracy, legal compliance, and efficiency.

**Target Audience:** Medicaid Leadership and Operations, Medicaid Providers

**Strategy:** The OIG shall continue to review medical claims data, intensifying focus on high risk claims. The OIG shall:

- a) Reduce inappropriate payments through strong provider education
- b) Communicate control recommendations to Medicaid Leadership and Operations
- c) Execute effective post payment review
- d) Finalize case tracking and financial accounting system implementation

### Objective 3: Continue to build and maintain trust with the provider community and taxpayers

**Key Message:** OIG promotes Medicaid payment accuracy, legal compliance, and efficiency.

**Key Message:** OIG supports the provider community through training and accessibility.

**Target Audience:** Medicaid Providers, Utah and Federal Taxpayers

**Strategy:** The Utah OIG shall continue an intensive provider training and public outreach program. The OIG shall:

- a) Continued provider training – live and webinar

- b) Expand Web presence – web site redesign and use of social media outlets
- c) Release public service announcements about waste, abuse, and fraud
- d) Issue press releases as needed for important OIG findings and recoveries

**Objective 4: Promote Interagency Communication and Cooperation**

**Key Message:** OIG promotes Medicaid payment accuracy, legal compliance, and efficiency.

**Target Audience:** Medicaid Leadership and Operations, Utah Governor's Office and Legislature

**Strategy:** The OIG shall highlight critical barriers and isolated management structures that impede efficiency and efficacy in administering Medicaid services. Upon identifying barriers, the OIG will seek and promote creative solutions to minimize or remove barriers, thereby allowing increased partnership between agencies and departments. This strategy shall be advanced through:

- a) Quarterly interagency taskforce meetings
- b) Monthly meeting between the Inspector General and Medicaid Director
- c) Monthly meeting between the OIG and the Medicaid Fraud Control Unit (MFCU)

