

Report to the Social Services Appropriations Subcommittee

Implementation of Improved Provider Payment Controls

Prepared by the Division of Medicaid and Health Financing

September 30, 2017



Background

This report is submitted in compliance with UCA 26-18-604 which states in part:

- (2) Each year, the division shall report the following to the Social Services Appropriations Subcommittee:
- (a) incidents of improperly used or paid Medicaid funds and medical or hospital assistance funds;
 - (b) division efforts to obtain repayment from providers of the funds described in Subsection (2)(a);
 - (c) all repayments made of funds described in Subsection (2)(a), including the total amount recovered; and
 - (d) the division's compliance with the recommendations made in the December 2010 Performance Audit of Utah Medicaid Provider Cost Control published by the Office of the Legislative Auditor General.

Identification of Improper Payments

A. Status Update of Items from Last Year's Report:

Audit of Medicaid's Dental Program – The OIG identified \$35,123 in Medicaid duplicate dental claims, dental claims without surfaces, and claims with transposed surfaces.

Status Reported in 2016: Medicaid asked the OIG to perform post-payment review of this type of issue and to recover any overpayments. The OIG was in the process of recovering these overpayments in 2016.

Current Status: The OIG recouped \$6,748. The OIG made the determination not to pursue collections on the remaining claims because they were outside the criteria for timely collections. The OIG determined significant improvements in the dental claims area were made through the addition of edits in the claims system.

B. FY2017 Identified Improper Payments

State Audit of Pharmacy Expenditures (Finding 1) – The State Auditor's Office found that Medicaid appeared to have paid for 59 prescriptions that were written after the death of 11

prescribers. Of the 59 prescriptions identified in this finding, 11 were fee for service (FFS) claims and 48 were ACO encounters.

Status – Medicaid reversed the claim payments in the pharmacy vendor’s system for the 11 identified FFS claims and recouped \$969. We also notified the ACOs of the 48 encounters identified and requested that they reverse the related pharmacy claims in their systems and adjust the encounter data submitted to Medicaid.

State Audit of Pharmacy Expenditures (Finding 2) – The State Auditor’s Office found that Medicaid appeared to have paid for 52 prescriptions that were dispensed subsequent to the death of the 25 recipients to whom the prescriptions were prescribed. In addition, some prescriptions appeared to be written after the death of the recipient. Of the 52 prescriptions identified in this finding, 35 were FFS and 17 were ACO encounters.

Status – Medicaid reversed the claim payments in our pharmacy vendor’s system for the 35 identified FFS claims and recouped \$5,100. We also notified the ACOs of the 17 encounters identified and requested that they reverse the related pharmacy claims in their systems and adjust the encounter data submitted to Medicaid.

State Audit of Pharmacy Expenditures (Finding 3) – The State Auditor’s Office found that Medicaid appeared to have authorized payment for 234 prescriptions written by prescribers not enrolled to prescribe to Medicaid recipients. Of the 234 prescriptions identified in this finding, 28 were FFS and 206 were ACO encounters. The audit also found that Medicaid appeared to have authorized payment for 138 prescriptions written by two prescribers that were sanctioned by Medicaid.

Status – Medicaid submitted the 206 encounters identified to the respective ACOs and requested that they perform a detailed review of the prescriber enrollment data in their systems to determine if the prescriber was appropriately enrolled in the ACOs’ systems. The ACOs determined that the prescribers were properly enrolled in their systems. Since the prescribers were not enrolled in the Medicaid provider enrollment system, however, it was a contract violation. Therefore, we requested that the ACOs void the related encounter data to prevent its use in future rate setting.

Of the 138 prescriptions related to sanctioned providers, 76 were FFS claims and 62 were ACO encounters. We reviewed the enrollment history of the two sanctioned providers and found that they were dually enrolled as both a Medicaid health care provider and a Medicaid prescriber. When the sanction was applied to the enrollment record, the dual enrollment was not addressed and only the Medicaid health care provider enrollment contract was closed. We reversed the claim payments in our pharmacy vendor’s system for the 76 identified FFS claims for the sanctioned providers and recouped \$7,839. We have also notified the ACOs of the 62 encounters identified and requested that they reverse the related pharmacy claims in their systems and adjust the encounter data submitted to Medicaid.

CMS Health Information Technology (HIT) Audit – CMS found that some hospitals receiving HIT incentive payments utilized cost report year end data from the wrong year which caused the HIT payment amounts to be incorrect.

Status – With CMS guidance, the Department has resolved three of the incorrect calculations administratively. CMS allowed for the program year to be corrected which made it unnecessary to collect money from these three facilities. Another facility was underpaid by approximately \$370,000. We expect to resolve this underpayment within the next month. The calculations with two additional facilities are pending additional direction from CMS audit staff.

Payment on Behalf of Ineligible Recipient – The State Auditor’s Office tested 60 Medicaid cases and noted that one recipient remained on the Utah Medicaid program for one month after moving out of state. This error occurred because the case was not properly closed by the caseworker when the change of residence notification was received. As a result, \$704 in medical assistance costs were improperly paid.

Status – Because the error was a result of the state’s eligibility determination and not the fault of providers, the Department paid back to the federal government \$495 in federal funds associated with this error but did not collect money back from providers.

Additional Information – The OIG prepares a separate annual report that includes information on other collections made on improper payments. The OIG fiscal year 2016 annual report is available online at oig.utah.gov.

Compliance with 2010 Performance Audit of Utah Medicaid Provider Cost Control

The Legislative auditor General issued Report #2010-16, *A Performance Audit of Utah Medicaid Provider Cost Control*, in December 2010. There were five specific recommendations to the Department of Health, Division of Medicaid and Health Financing. UCA 26-18-604(2)(d) requires the Department to report compliance with these recommendations. As reported in prior years, all five recommendations have been implemented by the Department.