Susan Montee, CPA
Missouri State Auditor

SOCIAL SERVICES

MO HealthNet Division

Program Integrity Unit

March 2009

Report No. 2009-26

auditor.mo.gov

Office of the
Missouri State Auditor
Susan Montee, CPA

March 2009

YELLOW SHEET

The following findings were included in our audit report on the Missouri Department of Social Services, MO Healthnet Division, Program Integrity Unit.

The State Auditor is required by state law to conduct an audit of the Department of Social Services (DSS), MO HealthNet Division (MHD), Program Integrity Unit (PIU) "…to quantitatively determine the amount of money invested in the unit and the amount of money actually recovered by such office." The PIU needs to ensure all information required by state law is included and accurately reported in its annual report submitted to the General Assembly and Governor. In fiscal year 2007, the PIU reported recoveries in excess of $5.3 million.

The report did not include some participant investigations completed during the reporting period. In addition, the age and type of provider/participant investigations were not reported. Some overpayments, identified as a result of completed investigations, reviews, or audits, are not reported. Although the report includes overpayments identified by the Welfare Investigations Unit (WIU), the overpayments identified by the PIU and Cost Recovery Unit (CRU) are not reported. The PIU records indicated overpayments identified totaled almost $4.7 million for the year ended June 30, 2007.

The amount of fines and restitution ordered to be reimbursed, and other required information on provider investigations closed by the Office of Attorney General, Medicaid Fraud Control Unit (MFCU), are not reported. Some monetary recoveries (collections) resulting from completed investigations, reviews or audits are not reported. Although the report lists the total amount of recoveries for the PIU and CRU, the monetary recoveries for the WIU are not reported.

The annual report amounts were not always complete and accurate. The report identified overpayments, collections, and costs; however, these amounts were incomplete and/or misclassified. In addition, the amounts identified as cost recovery for the MO HealthNet Investigations Unit (MHIU) and the WIU were actually the overpayment amounts and the actual cost recovery amounts were not reported.

The DSS has not established adequate procedures to ensure the accuracy of amounts included in the annual report and some amounts were not accurately reported. Also, some amounts reported were not always calculated in the same manner from year to year. In March 2007, the PIU began including paper denials when calculating cost avoidance; however, this change in calculating the cost avoidance amount was not disclosed in the annual report. Additionally, the DSS does not disclose that some amounts included in the cost avoidance total were estimates. Finally, the DSS has not established procedures to retain supporting documentation for the report in a centralized location.

The PIU does not have adequate procedures in place to ensure referrals submitted to the MFCU are received and addressed timely. We noted delays between the date the PIU indicated a referral was sent to the MFCU and the date the MFCU indicated the referral was received. In addition, adjustments to the overpayment amounts identified and reported are not tracked and reported in the annual report. Adjustments to overpayment amounts may occur due to the conclusion of an appeal process, or due to a mathematical error in the original overpayment calculation.

The DSS does not deposit monies recovered by the MFCU in the proper funds as provided by state law. According to Section 191.905.11, RSMo, restitution should be deposited in the MO HealthNet Fraud Reimbursement Fund and reimbursements of investigation/prosecution costs should be deposited in the MO HealthNet Fraud Prosecution Revolving Fund. These funds have not had receipt or disbursement activity since (at least) fiscal year 2000.

DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
PROGRAM INTEGRITY UNIT

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STATE AUDITOR'S REPORT

SUSAN MONTEE, CPA
Missouri State Auditor

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

We have audited the Department of Social Services, MO HealthNet Division, Program Integrity Unit, as required by Section 191.909.2, RSMo. The scope of our audit included, but was not necessarily limited to, the year ended June 30, 2007. 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. Determine if the department has complied with certain legal provisions.

Our methodology included reviewing written policies and procedures, financial records, and other pertinent documents; interviewing various personnel of the department, as well as certain external parties; and testing selected transactions.

We obtained an understanding of internal controls that are significant within the context of the audit objectives and assessed whether such controls have been properly designed and placed in operation. However, providing an opinion on the effectiveness of internal controls was not an objective of our audit and accordingly, we do not express such an opinion.

We obtained an understanding of legal provisions that are significant within the context of the audit objectives, and we assessed the risk that illegal acts, including fraud, and violations of grant agreement or other legal provisions could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting instances of

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noncompliance significant to those provisions. However, providing an opinion on compliance with those provisions was not an objective of our audit and accordingly, we do not express such an opinion. Abuse, which refers to behavior that is deficient or improper when compared with behavior that a prudent person would consider reasonable and necessary given the facts and circumstances, does not necessarily involve noncompliance with legal provisions. Because the determination of abuse is subjective, our audit is not required to provide reasonable assurance of detecting abuse.

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 History and Organization is presented for informational purposes. This information was obtained from the department's management and was not subjected to the procedures applied in our audit of the Program Integrity Unit.

The accompanying Management Advisory Report presents our findings arising from our audit of the Department of Social Services, MO HealthNet Division, Program Integrity Unit.

Susan Montee, CPA
State Auditor

The following auditors participated in the preparation of this report:

Director of Audits:	John Luetkemeyer, CPA
Audit Manager:	Toni Crabtree, CPA
In-Charge Auditor:	Heather Stiles, CPA, MBA
Audit Staff:	Ashley Lee
	Sarah Schulte

MANAGEMENT ADVISORY REPORT -
STATE AUDITOR'S FINDINGS

DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
PROGRAM INTEGRITY UNIT
MANAGEMENT ADVISORY REPORT -
STATE AUDITOR'S FINDINGS

1. Annual Report

The Department of Social Services (DSS), MO HealthNet Division (MHD), Program Integrity Unit's (PIU) annual report did not include some information required by state law. We compared the information included in this report to the statutory requirements. In addition, we reviewed the supporting documentation to ensure the report information was complete and accurate.

Starting in 2008, pursuant to Section 191.909.2, RSMo, the DSS is to report annually, by January 1 of each year, the following activities:

"(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 ordered to 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."

The DSS's interpretation of Section 191.909.2, RSMo, required all recovery activity of the MHD be reported, including PIU recoveries. In addition, although not required, the DSS also reported 1) cost avoidance amounts for various MHD units for the current year, 2) cost recovery and cost avoidance amounts for three previous years for the PIU and various other MHD units, and 3) recoveries of MHD monies by DSS's Division of Legal Services.

For the year ended June 30, 2007, the PIU reported recovering the following funds:

Collections	$	1,539,593	
Adjustments		2,155,380	(1)
Recoupments		1,666,271	(2)
Total	$	5,361,244	

(1) Reduction in payments based on specific claims.

(2) Reduction in payments not based on specific claims.

For the year ended June 30, 2007, the costs incurred to operate the PIU were:

Salaries and wages	$	889,538	
Fringe benefits		376,796	
Travel, in-state		6	
Travel, out-of-state		119	
Supplies		832	
Professional development		90	
Professional services		188,767	
Maintenance and repair services		1,034,439	
Miscellaneous expenses		2,716	
Building lease payments		20,926	
Total	$	2,514,229	(1)

(1) Some office expenses (computer equipment, office equipment, and office supplies such as paper products) 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.

The following concerns were noted:

A. Some provider and participant investigations were not included in the report.

1) The report did not include some participant investigations completed during the reporting period. Although the report included the 280 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 provider/participant investigations were not reported.

Both the MHIU and WIU are units within DSS's 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 DSS should report the MHIU investigations and the age and type of all investigations.

2) 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 DSS referrals, is not reported.

The MFCU, not the DSS, is responsible for provider investigations related to fraud and abuse. However, the MFCU notifies the PIU of the outcome of all investigations completed on referrals from the DSS.

The DSS should consider reporting information regarding investigations completed by the MFCU on the DSS referrals.

B. Some overpayments, identified as a result of completed investigations, reviews, or audits, are not reported. Although the report includes overpayments identified by the WIU, the overpayments identified by the PIU and Cost Recovery Unit (CRU) are not reported. PIU records indicated overpayments identified totaled almost $4.7 million for the year ended June 30, 2007.

The DSS should ensure all overpayments identified are reported.

C. The amount of fines and restitution ordered to be reimbursed, and other required information on provider investigations closed by the MFCU, are not reported. The MFCU provides the PIU documentation regarding damages and restitution ordered to be reimbursed on cases referred to the MFCU by the DSS.

The DSS should consider reporting the information regarding damages and restitution on cases referred to the MFCU and closed by the MFCU during the reporting period.

D. Some monetary recoveries (collections) resulting from completed investigations, reviews, or audits are not reported. Although the report lists the total amount of recoveries for the PIU and CRU, the monetary recoveries for the WIU are not reported. According to WIU records, recoveries totaled over $143,000 for the year ended June 30, 2007.

The DSS should include the WIU's monetary recoveries in the report.

The DSS needs to ensure all information required by Section 191.909.2, RSMo, is included and accurately reported in its annual report submitted to the General Assembly and Governor.

WE RECOMMEND the DSS through the PIU:

A. Include the number of all participant and provider investigations completed by DSS units and MFCU in the annual report. Additionally, information about the age and type of completed investigations should be included.

B. Include the total amount of overpayments identified by all DSS units in the annual report.

C. Include damages, restitution ordered, and other required information resulting from DSS referrals to the MFCU in the annual report.

D. Include the total amount of monetary recoveries received as a result of completed investigations, reviews, or audits by all DSS units in the annual report.

AUDITEE'S RESPONSE

A. We partially agree with this recommendation. We do not agree that DSS should report provider investigations completed by the Attorney General's Medicaid Fraud Control Unit (MFCU). That data is reported by the MFCU as prescribed in Section 191.909.1 RSMo. We agree with the recommendation to ensure all cases, including the MO HealthNet Investigation Unit (MHIU), are shown in the report for state fiscal year 2009.

B. We partially agree with this recommendation. The Cost Recovery Unit (CRU) does not currently have a database necessary to report identified overpayments. With the reengineering of the Medicaid Management Information System (MMIS), system enhancements will allow CRU to systematically report out the total identified overpayments. The enhancement is scheduled to be implemented in state fiscal year 2010. For the annual report for state fiscal year 2009, DSS will include the overpayment amounts identified separately from the recovery amounts for PIU and MHIU.

C. We disagree with this recommendation. As noted in our response to A, MFCU reports its performance separately.

D. We agree with this recommendation. DSS will ensure that the total amount of monetary recoveries by all DSS units will be included in the annual report for state fiscal year 2009.

2. Internal Controls, Procedures, and Records

The DSS needs to improve its internal controls, procedures, and records. The annual report amounts were not always complete and accurate and procedures to follow-up on referrals made to the MFCU need to be improved. Additionally, subsequent adjustments made to overpayment amounts identified and reported are not tracked and reported.

A. Some amounts in the annual report were either incomplete and/or mislabeled. Also, there are no procedures to ensure the accuracy of the amounts reported, some amounts reported were not calculated in the same manner from year to year, and the use of estimates for cost avoidance is not disclosed. Additionally, supporting documentation is not retained in a centralized location.

1) The annual report identified overpayments, collections, and costs; however, these amounts were incomplete and/or misclassified.

For each year from fiscal years 2004 to 2007, a table presented the combined cost avoidance and cost recovery (actual collections) amounts for the PIU/CRU, the number of investigations and cost recovery amounts for the MHIU/WIU, the cost avoidance amount for any reinvestigations, and a grand total for each year. However, the amounts identified as cost recovery for the MHIU/WIU were actually the overpayment amounts. Thus, the actual cost recovery amounts for the MHIU/WIU were not reported.

The DSS should ensure overpayment, collection, and cost information reported is complete, accurate and properly classified. In this regard, the DSS should consider reporting the overpayments, cost recoveries and cost avoidances separately for the PIU, CRU, MHIU and WIU, as applicable.

2) The DSS has not established adequate procedures to ensure the accuracy of amounts included in the annual report and some amounts were not accurately reported.

Each month, from various supporting documentation, amounts for the annual report are recorded on a spreadsheet. The spreadsheet is then used to prepare the annual report. However, a reconciliation of the documentation to the spreadsheet is not performed. We tested supporting documentation for one monthly spreadsheet and found 12 participant cases reviewed by the PIU were not included on the spreadsheet or annual report.

The failure to develop procedures to ensure amounts reported are complete and accurate reduces the reliability of the report. If the amounts recorded on monthly spreadsheets were periodically reconciled to supporting documentation, the DSS would have more assurance the annual report was complete and accurate.

3) Some amounts reported were not always calculated in the same manner from year to year.

In March 2007, the PIU began including paper denials when calculating cost avoidance; however, this change in calculating the cost avoidance amount was not disclosed in the annual report. Paper denials are claims submitted on a paper form rejected by the PIU. Also, the third party liability calculation did not consistently include the same categories in fiscal years 2004 to 2007. To effectively evaluate performance from year to year, amounts reported should be consistently calculated.

4) The DSS does not disclose in the annual report that some amounts included in the cost avoidance total were estimates. When the PIU identifies an amount as an overpayment to a provider, this overpayment is used to estimate a projected cost avoidance for the next 12 months for that provider. For the year ended June 30, 2007, the estimated cost avoidance for providers totaled approximately $11.5 million.

For greater accountability and full disclosure, the DSS should consider disclosing when cost avoidance estimates are utilized.

5) The DSS has not established procedures to retain supporting documentation for the report in a centralized location.

In some instances, when we requested supporting documentation, the documentation had to be recreated or requested from various units within the MHD.

It would be more efficient, for reconciliation and audit purposes, for supporting documentation to be retained in a centralized location.

B. The PIU does not have adequate procedures in place to ensure referrals submitted to the MFCU are received and addressed timely.

We noted delays between the date the PIU indicated a referral was sent to the MFCU and the date the MFCU indicated the referral was received. For 4 of 26 (15 percent) referrals submitted to the MFCU, the date the referral was stamped as received by the MFCU was more than four months after the date PIU indicated the referral was sent. Additionally, we reviewed 7 referral files and noted 2 did

not contain a copy of the referral form. As a result, the PIU has less assurance that cases referred to the MFCU are properly investigated.

To ensure all referrals submitted to the MFCU are received and addressed timely, the PIU should establish procedures to follow-up on referrals made to the MFCU and maintain a copy of each referral in the case file.

C. Adjustments to the overpayment amounts identified and reported are not tracked and reported in the annual report.

Adjustments to overpayment amounts may occur due to the conclusion of an appeal process, or due to a mathematical error in the original overpayment calculation. By not accounting for these adjustments, overpayments may be reported incorrectly. To help ensure overpayment amounts are correctly reported, the DSS should establish procedures to include subsequent adjustments in the annual report.

WE RECOMMEND the DSS through the PIU:

A.1. Ensure the amounts for overpayments, collections and cost recovery are accurately reported and properly identified. The DSS should also consider reporting these amounts separately for the PIU, CRU, MHIU, and WIU as applicable.

2. Establish procedures to reconcile supporting documentation to monthly spreadsheets and the annual report.

3. Ensure amounts reported are calculated consistently from year-to-year, or disclose any changes to calculation methodologies.

4. Disclose the use of cost avoidance estimates in the annual report. The DSS should also report the total estimates calculated.

5. Retain supporting documentation in a centralized location.

B. Establish procedures to follow-up referrals made to the MFCU and maintain a copy of each referral in the applicable case file.

C. Establish procedures to track and report subsequent adjustments to overpayment amounts initially identified.

AUDITEE'S RESPONSE

A.1. We partially agree with this recommendation. The MHIU investigations generally result in administrative actions with no associated cost recovery amounts but potential

costs avoidances. An example of an administrative action is to restrict a participant to a specified pharmacy or primary care provider to prevent over utilization of services, resulting in cost avoidance of future expenditures. However, DSS will separately report overpayments, collections and cost recovery amounts for each of the other DSS units in the annual report for state fiscal year 2009.

2. *We agree with this recommendation. DSS has developed a process to reconcile the monthly report with supporting documentation to ensure the annual report also reconciles to the supporting documentation.*

3. *We agree with this recommendation. DSS will include footnotes to disclose if variations occurred in the cost avoidance or recovery calculations from year to year. The footnotes will be included in the annual report for state fiscal year 2009.*

4. *We agree with this recommendation. DSS will disclose when cost avoidance estimates are utilized and report the estimated amounts. This information will be included in the annual report for state fiscal year 2009.*

5. *We agree with this recommendation. DSS has implemented a procedure to maintain supporting documentation for the state fiscal year 2008 annual report in a centralized location.*

B. *We agree with this recommendation. DSS records the date of referrals to MFCU and has implemented a process to follow-up with MFCU on a monthly basis if confirmation of receipt has not been accepted. DSS has also implemented procedures to ensure that a copy of the referral is maintained in the provider file.*

C. *We agree with this recommendation. DSS has implemented procedures to separately identify subsequent adjustments in the annual report. The adjustments will be separately identified in the annual report for state fiscal year 2009.*

3. Accounting Policies and Procedures

The DSS does not deposit monies recovered by the MFCU in the proper funds as provided by state law. According to Section 191.905.11, RSMo, restitution should be deposited in the MO HealthNet Fraud Reimbursement Fund and reimbursements of investigation/prosecution costs should be deposited in the MO HealthNet Fraud Prosecution Revolving Fund. Monies in the reimbursement fund are to be used to refund the federal government and state agency(s) for amounts overpaid. Monies in the revolving fund are to be used to refund the Attorney General's and prosecuting and circuit attorneys' costs of prosecution and investigation. However, these funds have not had receipt or disbursement activity since at least fiscal year 2000.

Restitution and investigation/prosecution costs recovered by the MFCU are transmitted to the DSS, Division of Finance and Administrative Services (DFAS) for depositing and recording in the state's accounting system (SAM II). The DFAS deposits these monies to the General Revenue Fund, or Title XIX-Federal and Other Fund, even though the MFCU instructs the DSS to deposit the monies in the MO HealthNet Fraud Reimbursement and Fraud Prosecution Revolving Funds. According to DSS personnel, the monies are deposited in this manner because payments were originally made from these funds.

The DSS should ensure monies recovered by the MFCU are deposited in the appropriate funds as prescribed by law.

WE RECOMMEND the DSS deposit and record monies received by the MFCU for restitution and investigation/prosecution costs reimbursements in accordance with state law.

AUDITEE'S RESPONSE

We partially agree with this recommendation. The Division of Finance and Administrative Services (DFAS) will deposit monies into the MO HealthNet Fraud Prosecution Revolving Fund as reported by MFCU. DFAS will work with MFCU on protocols for identification and deposit of funds to the MO HealthNet Fraud Reimbursement Fund.

HISTORY AND ORGANIZATION

DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
PROGRAM INTEGRITY UNIT
HISTORY AND ORGANIZATION

The Department of Social Services (DSS) is officially designated as the single state agency charged with the administration of the Missouri Medicaid program. The Division of Medical Services was established within the DSS in February 1985 by a Governor's executive order. Pursuant to Senate Bill 577, The Missouri Health Improvement Act of 2007, effective September 1, 2007, the division's name changed to the MO HealthNet Division (MHD). The Program Integrity Unit (PIU), organizationally located within the 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 DSS determines participant eligibility for the Medicaid program. The Code of Federal Regulations, at 42 CFR 455.13, requires a state Medicaid agency to have "… 1) methods and criteria for identifying suspected fraud cases; 2) methods for investigating these cases; and 3) procedures, developed in cooperation with state legal authorities, for referring suspected fraud cases to law enforcement officials."

A post-payment review of Medicaid claims reimbursed is performed on selected providers or projects in order 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) placed on prepayment review status, 6) participant lock-in, and 7) referral to another state agency.

If a question of potential fraud exists regarding a provider, the case is referred to the Attorney General, Medicaid Fraud Control Unit (MFCU). The PIU meets regularly with the MFCU to discuss providers suspected of fraud. In fiscal year 2007, the PIU referred 26 cases to the MFCU.

At June 30, 2007, the PIU consisted of 23 employees.