Office of the Inspector General Overview

Kari Engelke, Assistant Inspector General
IRIS Advisory Committee
September 26, 2024

About the OIG

- The Office of the Inspector General (OIG) protects the people of Wisconsin by preventing, identifying, and investigating fraud, waste, and abuse in public assistance programs administered by the Department of Health Services (DHS).

- OIG's program integrity activities uphold DHS' mission, vision, and values to protect and promote the health and safety of the people of Wisconsin while managing public resources responsibly.

OIG Mission and Vision

- **Mission**: Protecting the people of Wisconsin by preventing, detecting, and investigating fraud, waste, and abuse of DHS programs.

- **Vision**: The OIG is an influential leader in program integrity, leveraging cutting edge strategies with the greatest impact protecting the people of Wisconsin and public program beneficiaries.

OIG Staffing

- OIG has 108.5 staff positions, including:
  - 99 Full Time Equivalent (FTE) positions
  - 9.5 Contractor or Limited Term Employment (LTE) positions

Anthony Baize
Inspector General

Tabitha Ramminger
Deputy Inspector General

Section Responsibilities

About OIG Sections

- OIG consists of the following 7 sections:
  - Administrative Office
  - Business Intelligence Section
  - Clinical Program Integrity and Compliance Section
  - Program Integrity and Compliance Section
  - Fraud Investigation and Recovery Enforcement Section
  - Internal Audit Section
  - Provider Enrollment and Research Section

Administrative Office

- Provides administrative and professional support for all OIG functions.
- Consists of the following team members:
  - The Inspector General, Deputy Inspector General, Budget and Policy Analyst, and Communications Specialist.
  - Office support staff who oversee daily administrative and front desk duties.
  - Nurse Consultants who manage the Payment Integrity Review program.

Payment Integrity Review Program

- Implemented on April 1, 2023 for ForwardHealth providers.
- Authorized under Wis. Admin. Code DHS §§§ 106.08(3)(d), 106.11, and 107.02(2) to prevent potential fraud, waste, and abuse by allowing OIG to:
  - Proactively review select, provider-submitted claims prior to payment to ensure federal and state requirements are met.
  - Offer enhanced, compliance-based technical assistance to meet the specific needs of providers.
  - Increase monitoring of high risk benefit and service areas.

Business Intelligence Section

- Provides data analytics and vendor support for OIG operations, including:
  - Responding to internal and external data requests.
  - Leading and supporting OIG-based systems development.
  - Assisting with business automation and process support.

Fraud Investigation, Recovery and Enforcement Section

- Responsible for mitigating recipient fraud and supporting Women, Infants, and Children (WIC) program vendor compliance through 3 units:
  - Public Assistance Reporting Information System (PARIS) and Trafficking Enforcement Unit.
  - Investigation and Technical Assistance Unit.
  - WIC Vendor and Integrity Unit.

Internal Audit Section

- Consists of experienced auditors who are responsible for:
  - Conducting independent, objective assurance and consulting activities.
  - Investigating improper activities by DHS employees.
  - Conducting DHS-wide Risk Assessments.
  - Performing system and operational control audits.
  - Performing independent audits of contracted agencies.

Provider Enrollment and Research Section

- Consists of investigators, researchers, reviewers, and Fraud Hotline staff who are responsible for:
  - Vetting moderate and high risk providers for Medicaid program enrollment and revalidation.
  - Managing the OIG's fraud reporting tools and process.
  - Investigating and referring reported concerns to the appropriate regulatory agency for possible prosecution.

Clinical Program Integrity and Compliance Section

- Known as CPICS, the team is subdivided into 2 units consisting of Registered Nurses who focus on the clinical activities of providers, including:
  - Conducting Medicaid post-payment audits through provider-focused teams.
  - Conducting Medicaid Caregiver Background Check audits.
  - Supporting provider investigation and enrollment review activities.
  - Providing program integrity-focused education and technical assistance.

Program Integrity and Compliance Section

- Known as PICS, the team is subdivided into 2 units consisting of Financial Auditors, Registered Nurses, and Certified Medical Coders who are responsible for:
  - Conducting Medicaid post-payment audits through provider-focused teams.
  - Auditing cost reports from Rural Health Centers (RHC), Federally Qualified Health Centers (FQHC), and facilitates interim and quarterly payments.
  - Auditing the federal Electronic Health Records (EHR) Incentive program.
  - Providing program integrity-focused education and technical assistance.

Provider-Focused Teams

- To develop provider-specific strategies to enhance program integrity and reduce or eliminate fraud, waste, and abuse, CPICS and PICS were matrixed into 8 provider-focused teams in early 2019:

CPICS-led Teams	PICS-led Teams
• Homecare • Primary Care and Specialty • Rehab/Restore • Mental Health and Substance Use	• Managed and Long Term Care • Pharmacy • County/Institutional • Service Fulfillment

Audit Process

- Identify audit scope.
- Mail Records Request letters to providers or run data.
- Receive records or conduct onsite visit to obtain records.
- Review records and issue preliminary findings letter and report.
- Review rebuttal and amend findings, as appropriate.
- Issue Notice of Intent to Recover letter.
- Participate in the appeal, if one is filed.
- Establish accounts receivable to collect overpayments.
- Complete any provider education or other measures.

Common Audit Findings

Examples of common audit findings include (not an inclusive list):

- Billing in excess of services provided
- Bundled services billed individually (unbundling)
- Duplicate billing
- Lack of documentation
- Lack of a prescriber's order
- Incorrect procedure codes
- Services are not medically necessary
- Services not rendered

Audit and Recoupment Authority

- Audit authority is codified in Wis. Stat. § 49.45(2)(b)(4).
- Recoupment authority is codified in Wis. Stat. § 49.45(3)(f) and Wis. Admin. Code DHS § 108.02(9).
- OIG has the authority to recoup overpayments when:
  - The service was **not** provided.
  - The claim was **not** accurate.
  - The claim was **not** appropriate.

Other Mitigation Options

- In addition to recoupment, OIG has the following tools to mitigate audit-discovered fraud, waste, and abuse:
  - Education and technical assistance.
  - Intermediate Sanctions under Wis. Admin. Code § DHS 106.08.
  - Termination from Medicaid under Wis. Admin. Code § DHS 106.06.
  - Referral to a partner agency for further investigation and possible prosecution.

Credible Allegations of Fraud Referrals

- Staff investigate allegations and develop Credible Allegations of Fraud (CAF) referrals.
- Federal law requires OIG to refer all CAF to the Wisconsin Department of Justice (DOJ) Medicaid Fraud Control and Elder Abuse Unit (MFCEAU) in accordance with 42 CFR § 455.21.
- If the referral is accepted, OIG suspends Medicaid payments to the provider during the investigation, unless there is a good cause exception as defined under 42 CFR § 455.23(e).

IRIS Program Integrity Activities

IRIS Complaints

- From October 1, 2023 – September 25, 2024, individuals made 132 number of complaints to OIG's fraud hotline and online reporting portal.
- These complaints are first reviewed by IRIS consultant agencies (ICAs) and fiscal employer agents (FEAs).
- OIG engages with IRIS program staff to develop and refer credible allegations of fraud to the MFCEAU.

IRIS Complaints

- OIG will not provide updates on submitted complaints.
- Individuals who report and are the subject of complaints are both entitled to privacy.
- Any complaint of fraud made to OIG may eventually become a criminal or civil case, and we do not want to compromise the investigation by sharing information.

IRIS Complaints

- At most, OIG can verify we received your specific report.
- Investigations can take weeks, months, or years, depending on the scope and complexity.
- Even if a provider is suspended by Medicaid, they can still provide services – they just cannot get paid by IRIS or any other Medicaid program.
- In these cases, payments are held until the investigation is resolved.

IRIS Referrals

- OIG submits full or abbreviated referrals for CAF.
- MFCEAU can accept, decline, or request additional information.
- Zero full referrals were submitted this year.
- OIG submits cases for older dates of service and lower dollar amounts to MFCEAU on an abbreviated spreadsheet.
- OIG has sent 93 IRIS abbreviated referrals to MFCEAU since October 1, 2023, and only one was accepted as a provider notice.

Credible Allegations of Fraud Referrals in IRIS

Intent is a required component of proving fraud and means a person knowingly and willfully committed the fraudulent action.

Fraud Includes:	Fraud Does Not Include:
• Billing for hours not worked. • Billing more than 24 hours a day. • Billing when the member or worker is hospitalized, incarcerated, or deceased.	• Accidental errors. • Simple mistakes.

IRIS Background Check Audit

- OIG is working on a background check audit to ensure participant-hired workers and other providers meet requirements.
- A Lexis Nexis data query shows numerous workers with non-compliant background checks.
- OIG is validating data against federal, state, and IRIS policy.
- When the list is finalized, OIG will collaborate with Division of Medicaid Services (DMS) IRIS staff to determine next steps.

IRIS Quarterly Meetings

- OIG conducts meetings with ICAs and FEAs each quarter to discuss program integrity topics and provide technical assistance and education.
- Other attendees include OIG's executive management team, DMS staff, and law enforcement partners.
- OIG also conducts similar meetings for managed care entities.

Previous IRIS Activities

- In 2018, OIG met with ICAs and FEAs to determine compliance with program integrity requirements.
- OIG completed compliance audits of FEAs for dates of service from 2016 to 2020 to verify if claims were paid according to rules and regulations and all appropriate caregiver and criminal background checks were obtained and recorded.
- Data was used to support federal reporting on performance measures.
- The components of these audits have been added to the record reviews conducted by MetaStar.

Here's How You Can Help

Supporting IRIS Participants

- Encourage participants to:
  - Report suspected fraud using the hotline or portal and be patient.
  - Contact their IRIS consultant to find a new worker or provider if they have concerns about fraud.
  - Submit the proper paperwork when they terminate a worker.
- Remind participants and other potential fraud reporters OIG cannot provide updates on complaints and referrals.
- Explain how long investigations can take and what workers and providers can do if payments are suspended.

Available Resources

Report Fraud, Waste, and Abuse

The OIG encourages everyone to report suspected fraud in DHS programs. Call the Fraud Hotline at 877-865-3432 or visit the Fraud Reporting Portal at www.reportfraud.wisconsin.gov.

Fraud, Waste, and Abuse Trainings

Providers also are encouraged to review OIG's Fraud, Waste, and Abuse Modules and Payment Integrity Review training on the ForwardHealth Trainings page.

www.forwardhealth.wi.gov/WIPortal/cms/public/trainings/home

Contact Information

Kari Engelke
Office of the Inspector General
Assistant Inspector General
kari.engelke@wisconsin.gov

Time to Ask Questions

IRIS Waiver Renewal: Summary of Public Input

Wisconsin Department of Health Services
Division of Medicaid Services, Bureau of Programs and Policy

IRIS Advisory Committee
September 24, 2024

Overview

- Summary of DHS strategies for gathering waiver renewal input
- Description of participant/respondent characteristics
- Overview of feedback themes
- Next steps

IRIS Waiver Renewal

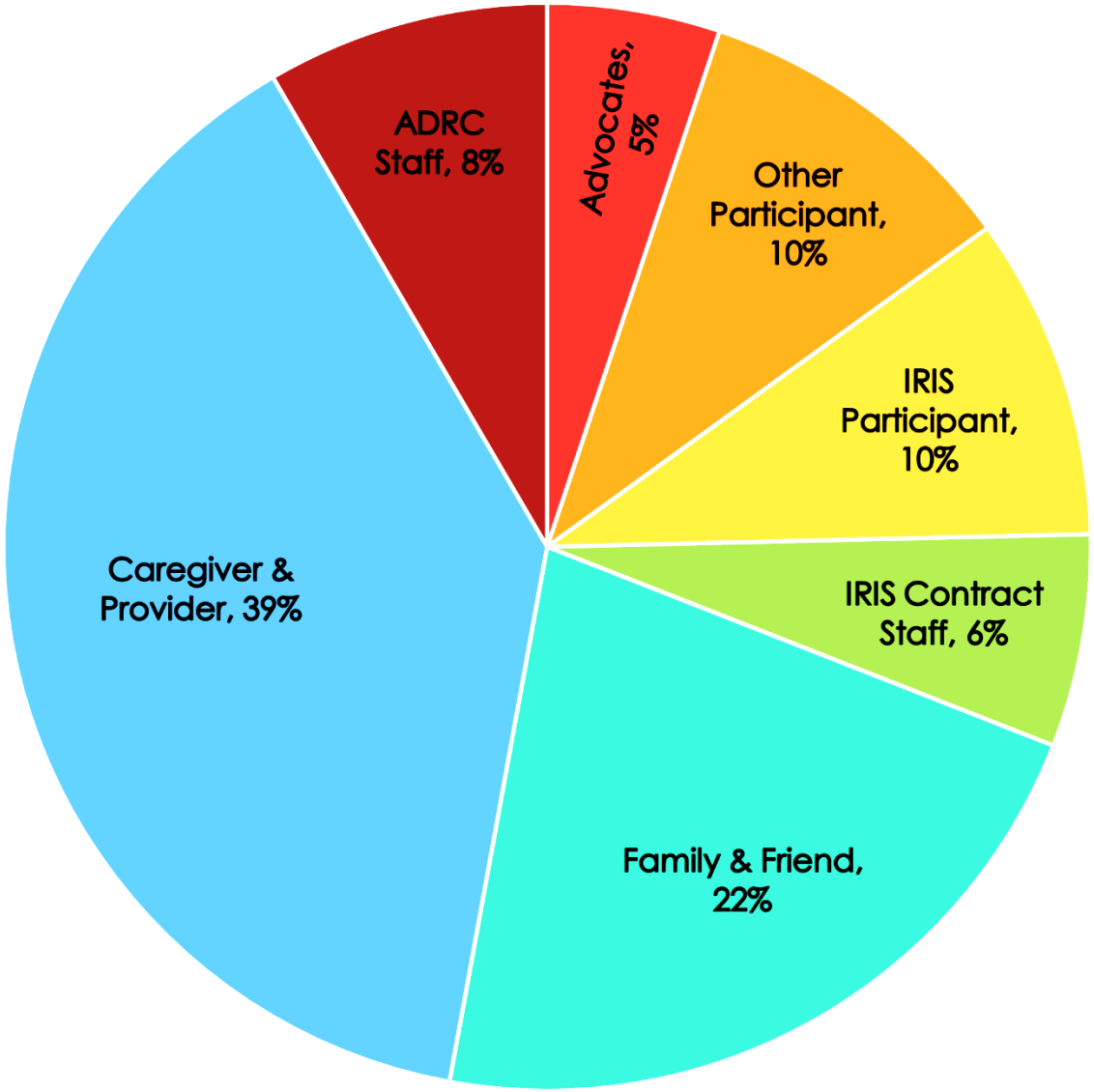
- 1915(c) HCBS waivers are applications to the federal government that let us have Medicaid programs like the IRIS program.

- 1915(c) HCBS waivers need to be renewed and approved every five years.
  - The IRIS program's waiver is due for renewal by January 2026.

- As part of this process, DHS pursued and gathered input from participants, families, legal decision makers, providers, IRIS Consultant Agency (ICA) and Fiscal Employer Agent (FEA) staff, advocates, and other partners.

Outreach Plan
Summer 2024

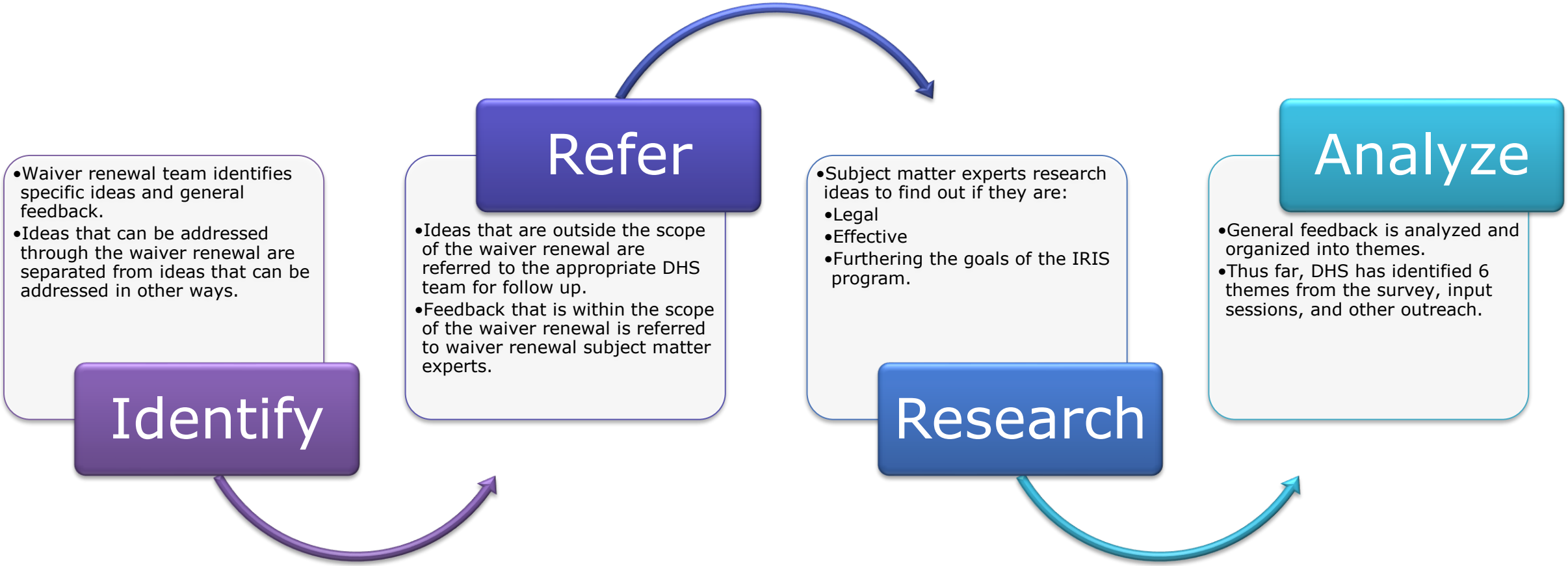
What	Who	When
Survey (Available in English, Spanish, and Hmong with accessibility features)	• Participants • Family, Friends, and Caregivers • Providers • Advocates • ICA/FEA staff • Other Partners	• July 9, 2024 - August 2, 2024
Targeted Outreach	• IAC	• July 23, 2024
Public Input Sessions	• All partners • Open to the public	• July 30, 2024 (Evening option) • July 31, 2024 (Day option)



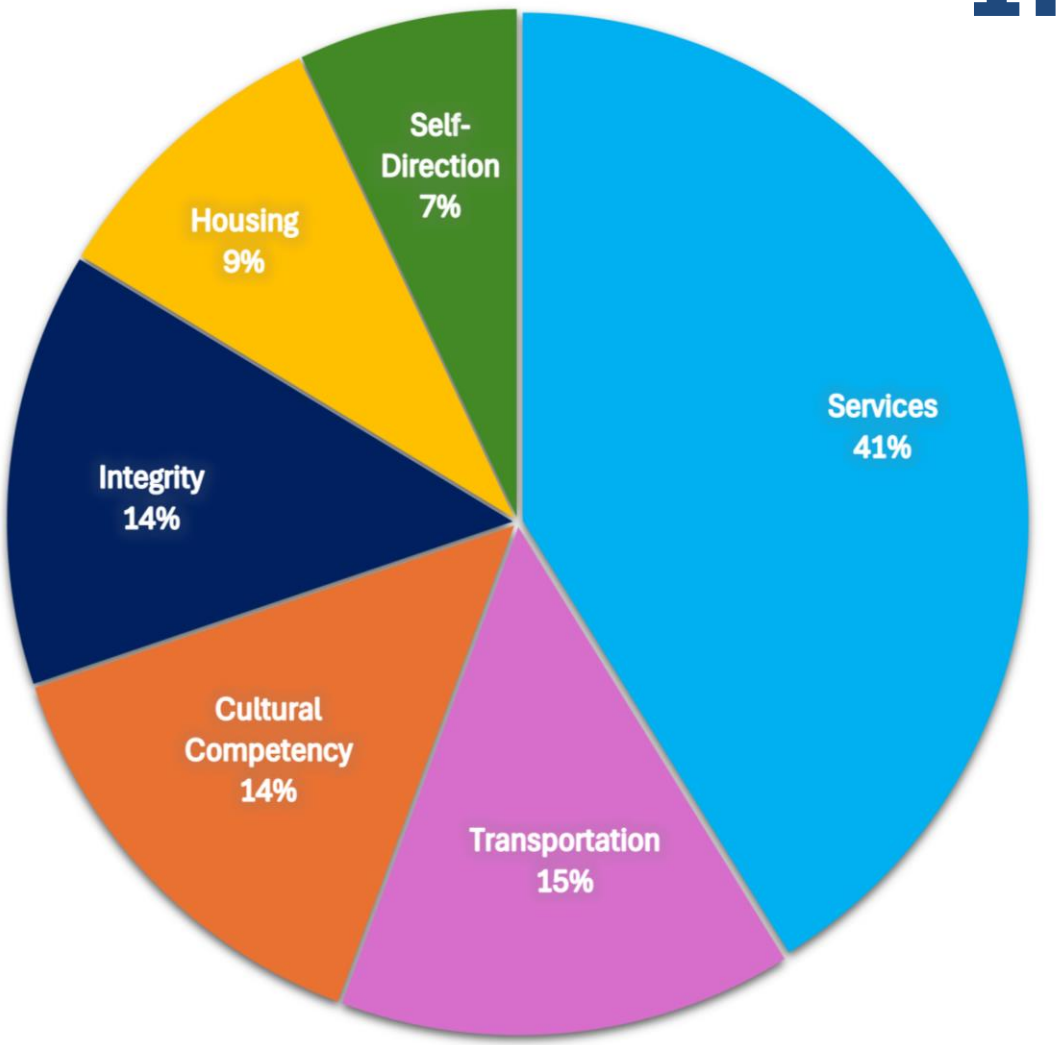
Survey Responses and Input Session Attendees

- Over 2,100 survey responses
- More than 150 input session attendees

Reviewing Feedback



IRIS Feedback Themes



- The themes represent common **requests**, **issues**, and **experiences** reported by IRIS participants, family, friends, support people, and other program partners.
  - The themes were identified based upon feedback from the survey, public input sessions, and other outreach.
- Many of the themes represent complex issues that cannot or would not be addressed through the waiver renewal.
- Common issues about ICAs and FEAs were identified and provided to Quality and Oversight for program improvement.

Theme #1: Services

- Providing access to necessary services empowers individuals to live more independently.
- Equitable access to services helps bridge gaps in care and support.

From a provider perspective, a community needs assessment and clear information on how to access information on covered services, which would be beneficial to aid in the development of services that will support the needs of the community.

-ADRC Staff

Theme #2: Transportation

- Lack of transportation is a major barrier to accessing the community and needed services.
- Participants, families, and support people desire more reliable, accessible, flexible, and convenient transportation options.

> Transportation assistance is lacking for me. I get money for public transit, but that's it. If I needed to go somewhere I couldn't access by bus, my only good option is to ask my caregiver to drive me. This puts more stress on my caregiver since I can only access this through him.
>
> -IRIS Participant

Theme #3: Cultural Competency

Match participants with providers who can relate to their culture, background and values. If that is not possible, consider annual diversity trainings and practical ways to be inclusive.

-IRIS Caregiver and Provider

- Explore additional services to support cultural differences and minimize barriers to care.

- Consider a resource for culturally competent services to ensure that care is tailored to the diverse needs of individuals.

We could use more cultural/language-specific day service opportunities, especially for the elderly. There are few adult daycare programs for Hmong or Spanish-speaking participants.

-Family Member or Friend

Theme #4: Integrity

Assess for when the IRIS member is no longer able to self-direct. There seem to be a lot of folks on the program who can't advocate for their own best interest.

-Other Partner

There are individuals on IRIS that should have an alternate decision maker. There are times when IRIS is not appropriate or the participants are not safe or when the alternate decision maker's decisions are not in the best interest of the person.

-IRIS Caregiver and Provider

- A program with strong integrity guarantees that resources are used effectively and responsibly, which ensures participants receive the services and supports needed to achieve their long-term care outcomes.

Theme #5: Housing

- Participants request more assistance with finding affordable, safe, and accessible housing.

There are a limited number of housing options for adults with disabilities to maintain the quality of life they are accustomed to when living at home with parents/loved ones. It would be great to invest/expand partnerships between organizations that offer housing vouchers so there are more resources to provide affordable quality housing options.

-IRIS Participant

Theme #6: Self-Direction

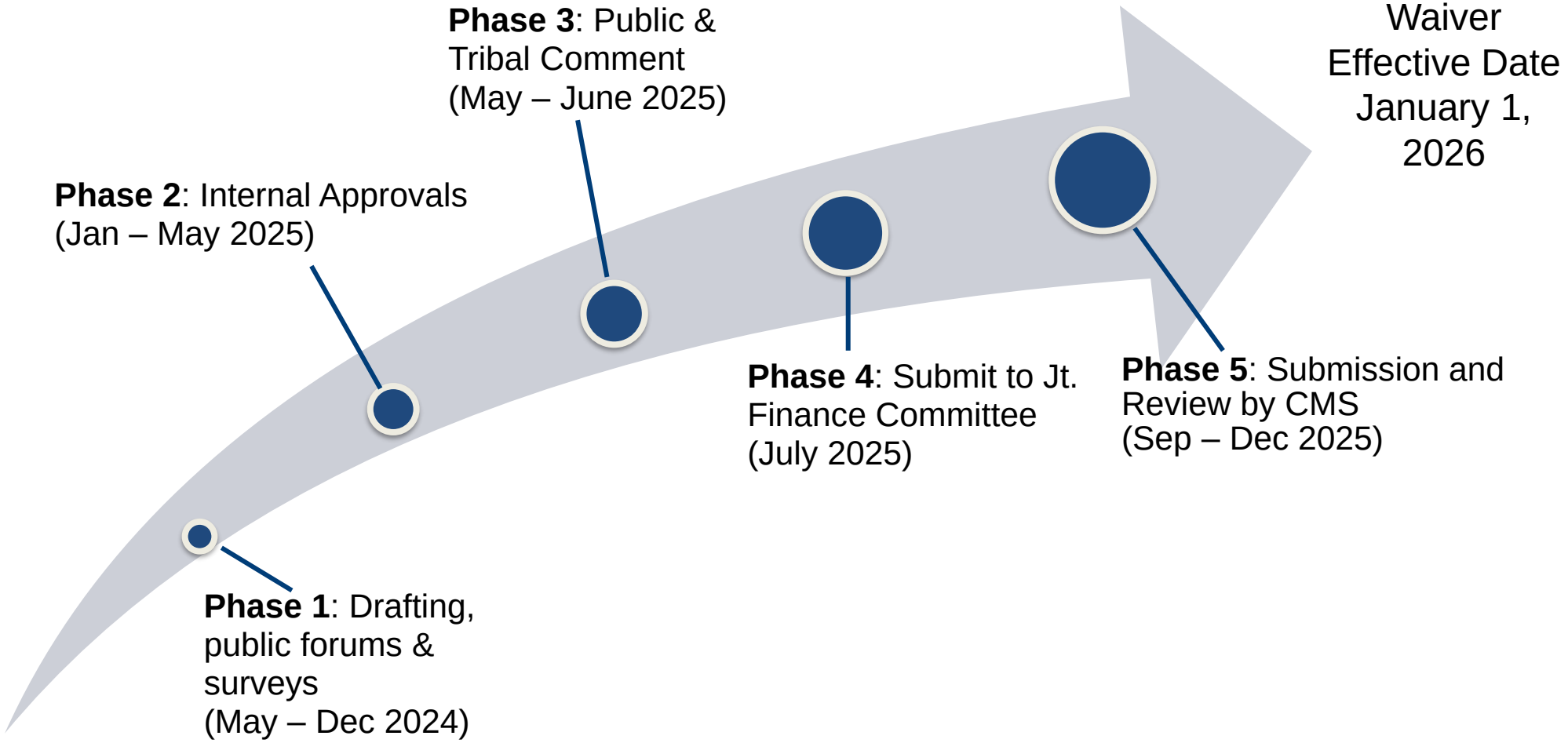
- Provide self-direction opportunities for participants to make independent decisions about the services and supports that best meet their unique needs and preferences.

> A better understanding of the budget, what it is used for, and how much if any is left over would be helpful.
>
> -IRIS Caregiver and Provider

> Not everyone fits into a box where they all need the same thing.
>
> -IRIS Participant

- Allow participants more flexibility in creating and managing their service plans.

Waiver Renewal Timeline



Next Steps

- Ideas and issues that can be addressed through the waiver renewal will be considered as part of the drafting process.
- DHS will continue to review feedback for specific themes and actionable ideas.
- For program improvement, provide Quality and Oversight with common issues about ICAs and FEAs identified through public input.

Thank You!

https://www.dhs.wisconsin.gov/iris/waiver-renewal.htm

WISCONSIN DEPARTMENT of HEALTH SERVICES

2025 IRIS Provider Agreement Proposed Changes

IRIS Advisory Committee
September 24, 2024

Substantive Changes

Program Enrollment & Transfers (Article VI)
Provider Management Project (Article I, IV, IX.B)
Workers Compensation (Article VIII.J)
Staff for Language Translation (Article IV.T)
Marketing Outreach Prohibited Practices (Article IV.Y.6)
Timesheet Approvals (Article IX.E.3.c)
Temporary Living Arrangements (Article V.A.5.c)
ICA Customer Service Standards (Article IV.K)

Program Enrollment & Transfers

Updated provider agreement to accurately reflect program policy

Enrollment & Transfers

- Program Referral and Orientation Services
- Referral Timeline Expectations
- Program and Contractor Transfers

Disenrollment

- Processing Disenrollments
- Types of Disenrollment
  - Participant Requested Disenrollment
  - Program Requested Disenrollment
  - Eligibility-Related Disenrollments

Article VI (#27)

Provider Management Project

Define expectations for vendor and individual provider packets once the project is live

Provide contractor responsibilities regarding provider enrollment through ForwardHealth

New Definition: Third Party Delegate

- (in substantive part) FEA employee who upon request by vendor and individual provider, assists in completing the initial Medicaid enrollment, re-enrollment, revalidation, etc., in the ForwardHealth Portal

Article I, Article IV, Article VIII.G, Article IX.B, Appendix III.C (#59 - #64)

Workers' Compensation

Update the entire section for clarity.

FEA comment:
This language is conflicting or misleading where it states that the percentage invoiced will be determined by written agreement under Article VIII.I.1.a but then later under Article VIII.I.2.a. states it is the lesser of the actual or agreed upon amount.

Article VIII.I (#146)

Staff for Language Translation

This new requirement mandates that contractors have staff and/or subcontractors available during hours of operation for language translation, interpreter services, and for Limited English Proficient participants.

Article IV.T (#112)

Marketing Outreach Prohibited Practices

Provision was updated for alignment across long-term care programs.

Article IV.Y.6 (#127)

Timesheet Approvals

Added language to allow a participant's legal decisionmaker as someone who can approve a worker's timesheet.

Article IX.E.3.c (#130)

ICA Customer Service Standards

This new requirement provides customer service guidelines which includes follow-up communications expectations and procedures for ensuring a consistent and high-quality experience for all participants.

Article IV.K (#124)

ICA Customer Service Standards