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Iowa Medicaid Fraud Control Unit: 2021 Inspection

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What OIG Found

The Iowa MFCU reported exceptionally strong case outcomes for FYs 2019–2021, as compared to similarly sized MFCUs. From the data we reviewed, we found that the Unit generally operated in accordance with applicable laws, regulations, and policy transmittals and the MFCU performance standards. However, we made one finding regarding the Unit's adherence to MFCU performance standards.

- Although the Unit operated effectively and achieved high case outcomes, the Unit did not maintain staffing levels in accordance with its approved budget, maintained low staffing levels in relation to State Medicaid expenditures, and experienced significant turnover of investigators and high caseloads.

In addition to the finding, we made observations regarding Unit operations and practices, including the following:

- The Unit took steps to maintain an adequate volume and quality of referrals, but referrals from key sources generally decreased during the review period.
- The Unit took steps to maintain a continuous case flow and to complete cases within appropriate timeframes.
- The Unit maintained a positive working relationship with Federal law enforcement partners, including the Office of Inspector General (OIG) and U.S. Attorney's Offices.

What OIG Recommends and How the Unit Responded

To address the finding, we recommend that the Unit assess the adequacy of existing staffing levels, and if warranted, develop a plan to expand the size of the Unit. The Unit concurred with our recommendation.

Unit Case Outcomes

Federal fiscal years (FYs) 2019–2021:

- 80 indictments
- 79 convictions
- 36 civil settlements and judgments
- $9.2 million in recoveries

Unit Snapshot

The Iowa Medicaid Fraud Control Unit (MFCU or Unit) is housed in the Iowa Department of Inspections and Appeals. The Unit does not have prosecutorial authority and most commonly refers cases for prosecution to Iowa's 99 county attorneys' offices.

At the time of our inspection in November 2021, the Unit had eight staff located in Des Moines.

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BACKGROUND

OBJECTIVE

To examine the performance and operations of the Iowa Medicaid Fraud Control Unit (MFCU or Unit).

Medicaid Fraud Control Units

MFCUs investigate (1) Medicaid provider fraud and (2) patient abuse or neglect in facility settings, and prosecute those cases under State law or refer them to other prosecuting offices.[1, 2, 3] Under the Social Security Act (SSA), a MFCU must be a "single, identifiable entity" of State government, "separate and distinct" from the State Medicaid agency, and employ one or more investigators, attorneys, and auditors.[4] Each State must operate a MFCU or receive a waiver.[5] Currently, 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate MFCUs.[6]

MFCUs are funded jointly by Federal and State Governments. Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.[7] In Federal fiscal year (FY) 2021, combined Federal and State expenditures for the MFCUs totaled approximately $314 million, of which approximately $235.9 million represented Federal funds.[8]

[1] SSA § 1903(q). Regulations at 42 CFR § 1007.11(b)(1) clarify that a Unit's responsibilities may include the review of complaints of misappropriation of patients' private funds in health care facilities.

[2] As of December 27, 2020, MFCUs may also receive Federal financial participation to investigate and prosecute abuse or neglect of Medicaid beneficiaries in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, Public Law 116-260, Division CC, § 207.

[3] References to "State" in this report refer to the States, the District of Columbia, and the U.S. territories.

[4] SSA § 1903(q)(2) & (6).

[5] SSA § 1902(a)(61).

[6] The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

[7] SSA § 1903(a)(6). For a Unit's first 3 years of operation, the Federal Government contributes 90 percent of funding and the State contributes 10 percent. Thereafter, the Federal Government contributes 75 percent and the State contributes 25 percent.

[8] OIG analysis of MFCUs' FY 2021 reporting of expenditures. The Federal FY 2021 was from October 1, 2021, through September 30, 2021.

OIG Grant Administration and Oversight of MFCUs

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.[9, 10] As part of its oversight, OIG conducts a desk review of each Unit during the annual recertification process. OIG also conducts periodic inspections and reviews. Finally, OIG provides ongoing training and technical support to the Units.

In its annual recertification review, OIG examines the Unit's reapplication materials, case statistics, and questionnaire responses from Unit stakeholders. Through the recertification review, OIG assesses a Unit's performance, as measured by the Unit's adherence to published performance standards;[11] the Unit's compliance with applicable laws, regulations, and OIG policy transmittals;[12] and the Unit's case outcomes.

OIG further assesses Unit performance by conducting inspections and reviews of selected Units. These inspections and reviews result in public reports of findings and recommendations for improvement. OIG reports may also include observations regarding Unit operations and practices, including beneficial practices that may be useful to share with other Units. OIG also provides training and technical assistance to Units, as appropriate, during inspections and reviews.

Iowa MFCU

The Iowa Unit is located within the Iowa Department of Inspections and Appeals (DIA) in Des Moines.[13] At the time of our inspection in November 2021, the Unit employed a director, four investigators, an attorney, an auditor, and a paralegal. The Unit director supervised all staff and served as the chief investigator.[14] During our review

[9] As part of grant administration, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal Financial Reports that detail MFCU income and expenditures.

[10] The SSA authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979.

[11] MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012). The performance standards were developed by OIG in conjunction with the MFCUs and were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

[12] OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals are located at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

[13] DIA is a state regulatory agency responsible for inspecting and licensing or certifying health care providers and suppliers and other entities within the state. DIA staff also investigate alleged fraud in Iowa's public assistance programs.

[14] The Unit's attorney is an Assistant Attorney General (AAG) assigned solely to the Unit from the Office of Attorney General (OAG). Through a memorandum of understanding between the OAG and DIA, the Unit directs the work of the attorney. The OAG retains certain personnel-related duties such as conducting the AAG's performance evaluation and approval of leave, but the Unit and OAG confer and coordinate on such duties.

period of FYs 2019–2021, the Unit spent approximately $3.1 million (with a State share of nearly $782,000).

Referrals

The Unit receives referrals of Medicaid provider fraud and patient abuse or neglect from several sources, including the State Medicaid agency's program integrity unit, private citizens, and the State survey and certification agency, known as the Health Facilities Division (HFD). When the Unit receives a referral, the MFCU director reviews the referral to determine whether it falls within the MFCU's jurisdiction and decides whether the MFCU will open a case for further investigation. If a referral is within the MFCU's jurisdiction, the director evaluates the likelihood of criminal prosecution or civil action, and whether the Unit has the investigative resources to conduct an investigation. The director typically makes the determination to open a case within 2 days of receipt of the referral. If the director declines the referral, the Unit may refer it to other law enforcement or a State agency or may refer it back to the referring agency for further evaluation.

Investigations and Prosecutions

Once the director decides to open a case, the director assigns the matter to an investigator and creates a case plan, which includes a target date for completing the investigation. Investigators typically work on cases alone, but other investigators may assist on cases as needed, and the auditor assists with any claims data needs. The Unit attorney serves as a resource to investigators and advises on matters such as case strategy, including recommendations on the particular criminal charges to pursue. Investigators participate in quarterly supervisory reviews of their caseloads with the director and the attorney. Upon completion of investigative activities, the Unit investigator provides an investigative case report to the director with a recommendation for referral to prosecute or close the case. The director reviews the report and determines whether to approve the recommendation.

The Unit has no prosecutorial authority and must refer cases to the appropriate State or Federal prosecuting authorities.[15] In Iowa, the local county attorneys' offices have original jurisdiction to accept and prosecute criminal cases in local court, so the Unit may refer cases to the county attorney's office in the county in which the alleged crime occurred.[16] The assigned Unit investigator coordinates with the appropriate county attorney's office regarding the presentation of the investigative case report and case files. Respective county attorneys' offices may also authorize the MFCU attorney to prosecute in local court on their behalf. The Unit may refer both criminal and civil cases to the appropriate U.S. Attorney's Office in Iowa.

[15] In accordance with 42 CFR § 1007.7(b), the Unit has formal written procedures ensuring that the Unit refers suspected cases of criminal fraud in the Iowa Medicaid program or of patient or resident abuse or neglect to the appropriate prosecuting authority.

[16] The State of Iowa has 99 county attorney's offices.

Iowa Medicaid Program

The Iowa Department of Human Services administers the State Medicaid program, known as the Iowa Medicaid Enterprise (IME). As of June 2021, the program served 703,479 beneficiaries.[17] IME transitioned from a fee-for-service model to primarily providing services through managed care organizations (MCOs) in 2016. In FY 2021, approximately 95 percent of Medicaid beneficiaries received services through 2 MCOs.[18] In the same year, Iowa's Medicaid expenditures were approximately $6.1 billion.[19]

IME's Program Integrity Unit (PIU) is responsible for Medicaid program integrity efforts. The PIU receives referrals of suspected provider fraud from MCOs and from a contracted audit and investigation team responsible for the fee-for-service component of Iowa's Medicaid program. The PIU reviews these referrals to determine whether they constitute a "credible allegation of fraud," and then refers those cases to the MFCU as appropriate.

Prior OIG report

OIG conducted a previous onsite review of the Iowa Unit in 2014.[20] In that review, OIG found that the Unit generally complied with applicable laws, regulations, and policy transmittals. However, OIG made two findings regarding the Unit's adherence to MFCU performance standards. OIG found that (1) 47 percent of the Unit's case files lacked documentation of periodic supervisory reviews and (2) the Unit's memorandum of understanding (MOU) with the State Medicaid agency did not reflect all current requirements. After the 2014 onsite review, but prior to the publication of the report, the Unit revised the MOU.

OIG recommended that the Iowa Unit implement processes to ensure that supervisors conduct and document case reviews periodically, consistent with the Unit's revised practice. On the basis of the information received from the Unit, OIG considered the recommendation implemented as of February 2015.

[17] Centers for Medicare & Medicaid Services (CMS), *June 2021 Medicaid and CHIP Enrollment Data Highlights*, accessed at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html on January 10, 2022.

[18] Iowa Medicaid Enterprise, *Managed Care Organization Report: SFY 2022, Quarter 1*, accessed at https://dhs.iowa.gov/sites/default/files/Q1_SFY2022-Report_Final.pdf?020120221720 on February 4, 2022. Federal FY 2021 corresponds to Iowa's State FY 2021 Quarter 2 through State FY 2022 Quarter 1.

[19] OIG, *MFCU Statistical Data for FY 2021*, accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2021-statistical-chart.pdf on March 17, 2022.

[20] OIG, *Iowa State Medicaid Fraud Control Unit: 2014 Onsite Review*, accessed at https://oig.hhs.gov/oei/reports/oei-06-14-00190.pdf on March 4, 2022.

Methodology

OIG conducted an inspection of the Iowa MFCU in November 2021. Our inspection covered the 3-year period of FYs 2019–2021. We based the inspection on an analysis of data and information from 7 sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit managers and selected staff; (5) a review of a random sample of 84 case files from the 372 nonglobal case files that were open at some point during the review period; (6) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (7) onsite review of Unit operations. See the Detailed Methodology.

In examining the Unit's operations and performance, we applied the published MFCU performance standards, but we did not assess adherence to every performance indicator for every standard.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program, but they are subject to the same internal quality controls as are other OIG evaluations, including internal and external peer review.

PERFORMANCE ASSESSMENT

In assessing the performance and operations of the Iowa Unit, OIG identified the Unit's case outcomes, evaluated whether the Unit complied with legal requirements, and assessed whether the Unit adhered to each of the 12 performance standards. From the data we reviewed, we found that the Unit generally operated in accordance with applicable laws, regulations, and policy transmittals and the MFCU performance standards. We identified one finding and made several observations regarding the Unit's performance and operations, and we made one recommendation for improvement.

Case Outcomes

Observation: The Unit reported 80 indictments, 79 convictions, and 36 civil settlements and judgments for FYs 2019–2021.

Of the 79 convictions, 43 involved patient abuse or neglect and 36 involved Medicaid provider fraud. Compared to similarly sized MFCUs, the Iowa Unit had a substantially higher number of indictments and convictions.[21, 22, 23]

Several factors may have contributed to the Unit's high number of indictments and convictions. Because the Unit lacks authority to prosecute its cases, the Unit refers its cases to external prosecuting authorities, most commonly Iowa's 99 county attorneys' offices. In OIG's opinion, the Unit's ability to refer cases for prosecution to the county attorneys is a significant prosecutorial resource for the Unit and allows cases to be fully adjudicated with limited delays. Further, the Unit reported that investigators had

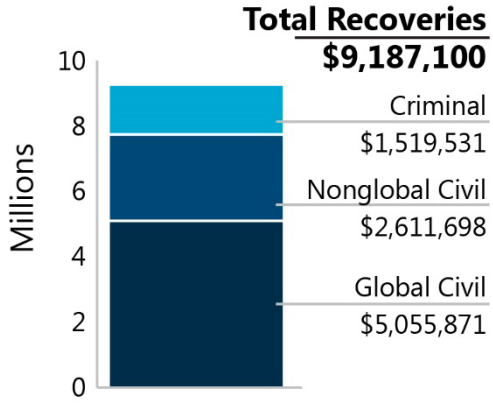
[21] In our analysis, we defined similarly sized MFCUs to be those with staff sizes ranging from 4 to 10 employees. In FY 2021, 12 MFCUs were in this category, including the Iowa Unit with 8 staff.

[22] Of similarly sized MFCUs during the review period, indictments ranged from 2 to 80 with a mean of 21 and convictions ranged from 0 to 79 with a mean of 19. Many factors other than a MFCU's staff size can affect case outcomes.

[23] OIG provides information on MFCU operations and outcomes but does not direct or encourage MFCUs to investigate or prosecute a specific number of cases. MFCU investigators and prosecutors should apply professional judgment and discretion in determining what criminal and civil cases to pursue.

strong relationships with many of the county attorneys, and that cases were rarely declined for prosecution. Additionally, through our review of case files and interviews with multiple Unit stakeholders, we observed that the Unit performed thorough investigations and provided complete and well-organized investigative reports, which likely contributed to swift and positive case resolutions. Finally, the ability to refer cases for external prosecution allowed the Unit to focus its efforts on investigations, and we found that the Unit maintained a continuous case flow by implementing a number of practices that improved efficiency and timeliness (see Performance Standard 5).

Observation: The Unit reported combined civil and criminal recoveries of over $9 million for FYs 2019–2021.



Source: OIG analysis of Unit Annual Statistical Reports, FYs 2019–2021.
Note: "Global" civil recoveries derive from civil settlements or judgments in global cases, which are cases that involve the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

Performance Standard 1: Compliance with Requirements

A Unit conforms with all applicable statutes, regulations, and policy directives.

Observation: According to the data we reviewed, the Iowa Unit complied with applicable laws, regulations, and policy transmittals.

From the information we reviewed, we did not identify any compliance-related concerns.

Performance Standard 2: Staffing

A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.

Finding: Although the Unit operated effectively and achieved high case outcomes, the Unit did not maintain staffing levels in accordance with its approved budget, maintained low staffing levels in relation to State Medicaid expenditures, and experienced significant turnover of investigators and high caseloads.

Staffing not in accordance with Unit budget. According to Performance Standard 2(a), the Unit should employ the number of staff that is included in the Unit's budget estimate as approved by OIG. However, we found that the Unit did not maintain staffing levels in accordance with its approved budget, particularly with its investigative staff. Although the Unit was approved for 11 staff during the 3-year review period, the Unit employed 7 to 8 staff at the end of FYs 2019, 2020, and 2021. Nearly all of the Unit's vacancies consisted of investigator positions; the Unit was approved for seven investigators but employed only four at the end of each year of the review period. [24] At the time of our inspection, the Unit reported that it was in the process of filling one of the investigator vacancies, and had plans to have six Unit investigators on board within 18 months.

Low staffing levels in relation to State Medicaid expenditures. Additionally, the Unit's staffing levels were low in relation to State Medicaid expenditures. According to Performance Standard 2(b), the Unit should employ a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse or neglect. In FY 2021, Iowa's Medicaid expenditures were approximately $6.1 billion, and at the end of FY 2021, the Unit employed eight staff. We found that the Unit's staff size was low compared to that of all other MFCUs relative to their respective States' Medicaid program expenditures.[25] In FY 2021, the

[24] At the end of FY 2020, the Unit had one vacancy in an administrative position.

[25] OIG found that both the Unit's actual staffing level (8) and approved staffing level (11) were low relative to State Medicaid expenditures.

Unit had approximately $759 million in Medicaid expenditures per MFCU employee, which was the third-highest Medicaid expenditure per employee of all MFCUs nationally. This was also more than double the national average of Medicaid expenditures per MFCU employee across all MFCUs.

While the Unit's staffing levels were low with respect to Medicaid expenditures, the Unit's case outcomes were high compared to those of similarly sized MFCUs for a number of reasons (see Case Outcomes). One small mitigating factor for the Unit's relatively low staffing levels is that, unlike most MFCUs, the Unit does not have the authority to prosecute its own cases, and therefore, it does not need the additional staff that other MFCUs may require to prosecute cases.[26]

Turnover of investigators. One of the reasons for the Unit's low staffing levels was vacancies created by frequent turnover of investigators. While the total number of investigators employed remained consistent during the review period, with four investigators at the end of each FY, there was significant turnover of investigators. During this period, the Unit hired five new investigators and six investigators left the Unit. Of the six investigators who left, four were employed with the Unit for short periods—between 1 week and 15 months. Two of the six investigators who left the Unit did not complete the Unit's 6-month probationary period and the other four left due to general attrition, such as retiring or taking another job. Three long-time investigators remained employed with the Unit throughout the review period.

Impact of COVID-19 pandemic. Another reason for the low staffing levels was the Unit's strategic response to the COVID-19 pandemic. Specifically, the Unit reported that it strategically did not fill investigator vacancies during the pandemic because of the reduced number of referrals it received and because of pandemic-related limitations on the Unit's ability to investigate patient abuse or neglect. The Unit experienced a general decline in referrals of fraud and patient abuse or neglect during the review period, particularly in FY 2020, which was attributable to COVID-19 and other factors (see Performance Standard 4). Additionally, the director reported that the pandemic significantly limited the Unit's ability to conduct field investigative activities in nursing facilities. As a result, the Unit strategically maintained the investigator vacancies while focusing on efforts to increase referrals, such as stakeholder training and outreach. The director acknowledged that the Unit's current staffing would not be sufficient once referrals return to prior levels.

High caseloads. The low staffing levels led to high caseloads, which may have affected the timeliness of investigations. Unit investigators carried caseloads of

[26] In FY 2021, the 8 States with similar Medicaid expenditures to Iowa's (as defined by +/- $1.5 billion in expenditures) had nonattorney staffing levels ranging from 8 to 28 with a median of 15, while Iowa had a nonattorney staff of 7. Therefore, even after accounting for potential differences in the numbers of attorneys required to prosecute cases, we found that the Iowa MFCU was still smaller than MFCUs with similar Medicaid expenditures.

approximately 20 active cases, which OIG and the Unit observed to be high.[27] Although we did not find evidence of substantial investigative delays in our review of the Unit's case files (see Performance Standard 5), the director and investigative staff reported that the caseloads affected how quickly cases could be completed. The director reported that he would like caseloads to be approximately 12 to 15 cases per investigator and that lighter caseloads would better ensure that cases are worked in a timely manner.

Performance Standard 3: Policies and Procedures

A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures

Observation: The Unit maintained policies and procedures.

The Unit maintained a policies and procedures manual specific to the MFCU's functions and jurisdiction. The Unit updated the manual as needed, and staff were familiar with Unit policies and procedures.

Performance Standard 4: Maintaining Adequate Referrals

A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

Observation: The Unit took steps to maintain an adequate volume and quality of referrals, but referrals from key sources generally decreased during the review period.

Consistent with Performance Standard 4, the Unit took steps to encourage high-quality fraud and patient abuse or neglect referrals from key referral sources during the review period. IME's PIU is responsible for Medicaid program integrity and was an important source of fraud referrals, providing the Unit with referrals from both the fee-for-service and managed care components of IME. To encourage quality fraud referrals from the PIU, the Unit provided education and training to the PIU and MCOs. Additionally, the Unit maintained strong relationships and regular communication with the PIU, including a monthly meeting of the MFCU and PIU, as well as a separate monthly meeting with the PIU and MCOs. To encourage patient abuse or neglect referrals, the Unit maintained a strong relationship and communication with Iowa's State survey and certification agency, HFD, which was the Unit's primary source of patient abuse or neglect complaints. To encourage higher-quality referrals, the Unit provided training to HFD on the types of complaints that could potentially constitute abuse or neglect according to State laws.

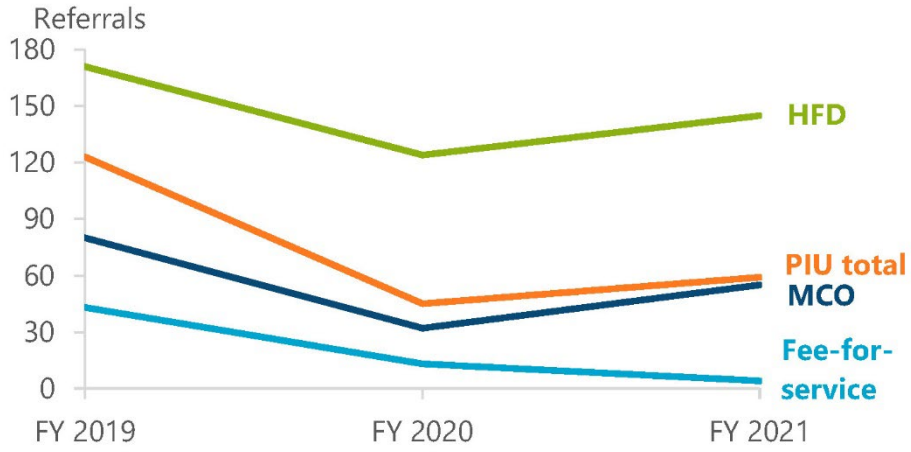
In addition to the Unit's efforts to encourage quality referrals from the PIU and HFD, the director conducted outreach to various professional groups and law enforcement

[27] Investigators' caseloads did not include cases referred for prosecution, which were monitored by the paralegal (see Performance Standard 5).

agencies to provide education on Medicaid provider fraud and patient abuse and neglect and to develop these groups as referral sources.

Although the Unit took steps to encourage referrals from the PIU and HFD, referrals from these key referral sources generally declined during the review period, with sharp declines in FY 2020 and modest increases in FY 2021 (see Exhibit 1). During the review period, the Unit received 227 fraud referrals from the PIU; 60 of these were from the fee-for-service component of the Medicaid program and 167 originated with MCOs. During this period, fee-for-service referrals from the PIU declined dramatically, and referrals from the PIU that originated with MCOs decreased in FY 2020 and increased modestly in FY 2021 (see Exhibit 1). Similarly, referrals of patient abuse or neglect from HFD declined in FY 2020 and increased slightly during FY 2021. See Appendix A for all sources of referrals involving fraud and patient abuse or neglect during FYs 2019–2021.

Exhibit 1: Referrals received from the PIU and HFD decreased sharply in FY 2020 and increased slightly in FY 2021



Source: OIG analysis of Unit Annual Statistical Reports, FYs 2019–2021.
Note: The PIU total includes referrals originating with MCOs and fee-for-service referrals.

Two factors contributed to the general decline in numbers of fraud referrals from the PIU. In FY 2020, the PIU modified its long-standing practice of referring all cases of potential fraud to the Unit and began to only refer cases for which documentation supported a "credible allegation of fraud." [28] A second factor that affected fraud

[28] CMS regulations define "credible allegation of fraud" at 42 CFR § 455.2 as an allegation that has been verified by the State from any source, including but not limited to fraud hotline tips verified by further evidence; claims data mining; and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered "credible" when they have indicia of reliability and the Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

referrals was MCOs leaving and joining the Iowa Medicaid program.[29] These transitions disrupted MCO program integrity operations, limiting the number and quality of referrals to the Unit for a period of time following the changes.

The primary factor that contributed to the decrease in referrals of patient abuse or neglect from HFD in FY 2020 was the COVID-19 pandemic. Long-term care complaints to HFD decreased in FY 2020 because of limits on HFD's survey activity and restricted visitation in long-term care facilities, which in turn limited the number of complaints referred to the MFCU. In FY 2021, the survey activity increased and visitation restrictions were eased, which provided more opportunities for identification and reporting of patient abuse and neglect concerns.

Performance Standard 5: Maintaining Continuous Case Flow

A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.

Observation: The Unit took steps to maintain a continuous case flow and to complete cases within appropriate timeframes.

According to Performance Standard 5(b), supervisors should approve the opening and closing of all investigations, review the progress of cases, and take action as necessary to ensure that each stage of an investigation is completed within an appropriate timeframe. Our review of the Unit's case files found no significant delays in the completion of the investigations or in the subsequent prosecutions or settlements. Further, nearly all case files contained appropriate documentation of supervisory approval for case openings and applicable case closings, as well as applicable quarterly reviews of case files.

We identified several practices that may have contributed to the Unit's continuous case flow. First, case assignments were made to investigators on the basis of their preferences and expertise.[30] Unit staff and management identified this practice as highly beneficial to productivity and timeliness of cases. One staff member stated that, because of the investigators' areas of expertise, when the investigators "go out to investigate, they're well-versed and know what to look for and what to ask. They know how to interpret the evidence they get back." Another practice that contributed to continuous case flow was that the director developed a case plan, which he shared with the investigator when assigning the case. The case plan established the scope of the investigation and the primary allegations to be investigated; determined any necessary coordination with law enforcement partners; and addressed any additional administrative, procedural, or investigative issues. In addition, the case plan

[29] One of three MCOs left the Iowa Medicaid program in FY 2018, which disrupted MCO program integrity operations into the review period. Additionally, one MCO left the program during the review period and one new MCO joined.

[30] The cases were assigned to investigators depending upon whether the case involved provider fraud, patient abuse or neglect, or drug diversion.

established a date by which the investigator was expected to submit a case to be closed or to be reviewed for referral for prosecution. The investigation completion date was flexible and could be modified as needed as the investigation progressed. The timelines for investigations were also incorporated into the investigators' performance evaluations, which the director believed provided incentive to complete cases in a timely manner.

Finally, to improve investigators' efficiency, the Unit transferred responsibility for administrative duties from the investigators to the Unit's paralegal. The director's goal in doing so was to have investigators focusing solely on investigative activities. For example, investigators did not have to track their cases after they were referred and accepted for prosecution. Those cases were transferred to the Unit's paralegal for monitoring.[31]

Performance Standard 6: Case Mix

A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

Observation: The Unit's caseload included both fraud and patient abuse or neglect cases and covered a broad mix of provider types.

Of the 764 cases that were open during FYs 2019–2021, 83 percent (631 cases) involved provider fraud and 17 percent (133 cases) involved patient abuse or neglect. During this period, the Unit's cases covered 48 different provider types, including various types of physicians, licensed practitioners, health care facilities, and medical service providers.

Performance Standard 7: Maintaining Case Information

A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.

Observation: The Unit maintained case files with appropriate documentation and was able to efficiently access performance data and case information.

The Unit maintained case files electronically within two platforms for case management purposes. Unit investigators documented case milestones, supervisory reviews, and summaries of investigative activities within a proprietary case management system. Additionally, the Unit stored copies of all electronic case materials on a shared drive. OIG examined the Unit's case files by reviewing a random sample of 84 cases open during our review period. In addition to assessing whether the case management system was efficient, we determined whether the case files contained the appropriate documentation, such as opening and closing documents,

[31] Upon case reassignment, the MFCU paralegal monitored cases throughout the adjudication process, entering case updates into the case monitoring system. The paralegal notified investigators if follow-up work was necessary. Additionally, the paralegal submitted, as appropriate, documentation on convictions to OIG and the NPDB (see also Performance Standard 8).

interview summaries, investigative activity summaries, and quarterly supervisory reviews. In OIG's professional judgment, the Unit's case files were maintained in an effective manner, and the case management system allowed efficient access to case information and performance data. We also judged the case files to be complete and organized in such a way that an investigator unfamiliar with the case could understand the case history and continue the investigation with little to no difficulty.

Performance Standard 8: Cooperation with Federal Authorities on Fraud Cases

A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.

Observation: The Unit maintained a positive working relationship with Federal law enforcement partners, including OIG and U.S. Attorney's Offices.

During the review period, the Unit reported working 38 joint cases with OIG's Office of Investigations (OI). The Unit director communicated regularly with OI management, and Unit investigators maintained strong working relationships with OI agents. The Unit also maintained positive working relationships with both U.S. Attorney's Offices in Iowa.

Observation: The Unit submitted all convictions and adverse actions to Federal partners within the appropriate timeframes.

During the review period, the Unit submitted all of its 84 convictions to OIG within 30 days of sentencing, as required by Performance Standard 8(f).[32] The Unit also submitted all of its 84 adverse actions to the NPDB within 30 days of the final adverse action, as required by Federal regulations.[33, 34]

Performance Standard 9: Program Recommendations

A Unit makes statutory or programmatic recommendations, when warranted, to the State government.

Observation: The Unit made recommendations to the State Medicaid agency during the review period.

[32] Effective May 21, 2019, 42 CFR § 1007.11(g) required the Unit to transmit information on convictions within 30 days of sentencing, or as soon as practicable if the Unit encountered delays in receiving the necessary information from the court.

[33] 45 CFR § 60.5. Examples of adverse actions include, but are not limited to, health care-related criminal convictions and civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(a) and (g)(1).

[34] The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions.

Performance Standard 9(b) states that the Unit, when warranted and appropriate, should make recommendations regarding program integrity issues to the State Medicaid agency. During the review period, the Unit recommended that IME eliminate existing rules requiring some beneficiaries to hire independent support brokers, after the Unit identified a lack of oversight and program integrity controls. The Unit reported that IME had not implemented this recommendation. The Unit also recommended that IME extend rules prohibiting spousal and parental relationships between personal care service providers and beneficiaries to include any individual with whom the beneficiary resides. As of April 2022, the Unit reported that IME had not provided an update regarding this recommendation.

Performance Standard 10: Agreement with Medicaid Agency

A Unit periodically reviews its Memorandum of Understanding (MOU) with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.

Observation: The Unit's MOU with the State Medicaid agency reflected current practice, policy, and legal requirements.

The MFCU and the State Medicaid agency had a current MOU, amended in February 2021.

Performance Standard 11: Fiscal Control

A Unit exercises proper fiscal control over its resources.

Observation: From our limited review, we identified no deficiencies in the Unit's fiscal control of its resources.

From the responses to a detailed fiscal controls questionnaire, we identified no issues related to the Unit's budget process, accounting system, cash management, procurement, electronic data security, property, or personnel. In our inventory review, we located 30 of the 30 sampled inventory items.

Performance Standard 12: Training

A Unit conducts training that aids in the mission of the Unit.

Observation: The Unit provided training to its staff that aided in the mission of the Unit, and Unit staff met training requirements.

The Unit had a training plan that included minimum training hours for professional staff, and staff exceeded the training hour requirements. Professional staff attended a range of classes that aided in the mission of the Unit, and new employees completed a series of in-house training sessions provided by the Unit director and other staff.

CONCLUSION AND RECOMMENDATION

The Iowa Unit reported exceptionally strong case outcomes for FYs 2019–2021, as compared to those of similarly sized MFCUs. OIG observed a number of factors contributing to the Unit's success in combatting Medicaid provider fraud and patient abuse or neglect, including the Unit's ability to refer cases for prosecution to county attorneys and the thorough investigations conducted by Unit staff. We also observed several practices that contributed to an efficient case flow and positive relationships with State and Federal stakeholders.

From the information we reviewed, we determined that the Iowa Unit complied with applicable legal requirements and generally adhered to the performance standards. However, we found one opportunity for the Unit to enhance its success. We found that although the Unit generally operated effectively and achieved high case outcomes despite significant turnover of investigators and high caseloads, the Unit's staffing levels were low in relation to State Medicaid expenditures, and the Unit did not maintain staffing levels in accordance with its approved budget during the review period, particularly with its investigator positions.

We also observed that the Unit took steps to maintain an adequate volume and quality of referrals, but referrals from key sources, such as the PIU and HFD, generally decreased during the review period. If the circumstances that led to decreased referrals resolve and the Unit begins to receive an increased volume of referrals, employing a full staff of investigators will be important for the Unit's future success. Further, in OIG's judgment, a full staff of investigators would result in reduced caseloads, which may improve the timeliness of investigations and improve upon the Unit's already strong case outcomes. Increasing the Unit's staff size to be more proportionate with the size of Iowa's Medicaid program would ultimately enhance the Unit's ability to protect the Medicaid program and its beneficiaries.

To address the finding identified in this report, we made the following recommendation to the Iowa Unit.

We recommend that the Iowa Unit:

Assess the adequacy of existing staffing levels, and if warranted, develop a plan to expand the size of the Unit

At the time of our review, the Unit reported that it was in the process of hiring one additional investigator, with plans to have six of the seven approved investigator positions filled by mid-2023. In addition to those hiring plans, the Unit should assess whether its planned staffing levels are sufficient, and if warranted, develop a plan to further increase its staff. In assessing staffing levels, the Unit should consider the

number of referrals received by the Unit, the timeliness of investigations, the relatively high caseloads of investigators, and the State's total Medicaid program expenditures. As a part of the assessment, the Unit should also consider the causes of turnover of investigators and whether any steps can be taken to reduce turnover. The Unit should share its assessment with OIG, and if warranted, the Unit should propose an expansion plan to satisfy current and/or future needs.

UNIT COMMENTS AND OIG RESPONSE

The Iowa Unit concurred with our recommendation to assess the adequacy of existing staffing levels, and if warranted, develop a plan to expand the size of the Unit. In its response, the Unit indicated that it had hired an additional investigator in the period following our onsite inspection. The Unit stated, on the basis of its most recent staffing assessments, that its current staffing level is sufficient to respond to its current volume of referrals and to ensure reasonable investigative caseloads. The Unit noted that as it continues to develop and enhance referral sources in order to increase the number of investigations, it will continue to assess existing staffing levels and fill vacant investigator positions when appropriate to do so.

Although the Unit concurred with our recommendation, it noted that it disagrees with aspects of our finding. The Unit stated that the finding implies that if the Unit is below the staffing levels allowed by its budget, regardless of the Unit's workload, the Unit will be out of compliance in a future inspection conducted by OIG. Although OIG examines approved budget projections when evaluating MFCU staffing levels, we consider this alongside many other factors, including State Medicaid expenditures, investigative caseloads, and overall Unit effectiveness.

For the full text of the Unit's comments, see Appendix B.

DETAILED METHODOLOGY

Data Collection and Analysis

We collected and analyzed data from the seven sources described below to identify any opportunities for improvement and instances in which the Unit did not adhere to the performance standards or was not operating in accordance with applicable laws, regulations, or policy transmittals. We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards.

Review of Unit Documentation

Prior to the onsite inspection, we reviewed the recertification information for FYs 2019–2021, which involved examining the Unit's recertification materials, including (1) the annual reports; (2) the Unit director's recertification questionnaires; (3) the Unit's MOU with the State Medicaid agency (IME); (4) the IME program integrity director's questionnaires; and (5) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for FYs 2019–2021. Additionally, we examined the recommendation from the 2014 OIG onsite review report and the Unit's implementation of the recommendation.

Review of Unit Financial Documentation

We conducted a limited review of the Unit's control over its fiscal resources. Before the onsite inspection, we analyzed the Unit's responses to a questionnaire about internal controls and conducted a desk review of the Unit's financial status reports. We also selected a purposive sample of 30 items from the current inventory list of 290 items maintained in the Unit's office and verified those items onsite.

Interviews with Key Stakeholders

In September and October 2021, we interviewed key stakeholders, including officials in the IME Program Integrity Unit, the State survey and certification agency (HFD Abuse Coordinating Unit), the two U.S. Attorney's Offices located in Iowa, and a county attorney's office. We also interviewed a manager from OIG's Office of Investigations who works with the Unit. We focused these interviews on the Unit's relationship and interaction with the stakeholders, as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management and staff.

Onsite Interviews with Unit Management and Selected Staff

We conducted structured interviews with the Unit's management and selected staff in November 2021. We interviewed the director, the attorney, three investigators, and the auditor. In addition, we interviewed the supervisor of the Unit—the DIA Investigations Division Administrator. We asked these individuals questions related to (1) Unit operations; (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; (3) opportunities for the Unit to improve its operations and/or performance; (4) clarification regarding information obtained from other data sources; and (5) the Unit's training and technical assistance needs.

Onsite Review of Case Files

We requested that the Unit provide us with a list of cases that were open at any time during FYs 2019–2021 and include the status of each case; whether the case was criminal, civil, or global; and the dates on which the case was opened and closed, if applicable. The total number of cases was 764. We excluded all global cases from our review of the Unit's case files because global cases are civil false claims actions that typically involve multiple agencies, such as the Department of Justice and a group of State MFCUs. We excluded 392 global cases, leaving 372 case files. We then selected a simple random sample of 84 cases from the population of 372 cases. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with absolute precision of no more than +/- 10 percent at the 95-percent confidence level. We reviewed the 84 case files for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals. During the review of the sampled case files, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

Review of Unit Submissions to OIG and the National Practitioner Data Bank

We also reviewed all convictions submitted to OIG for program exclusion during the review period (84) and all adverse actions submitted to the NPDB during the review period (84). We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and all adverse actions to the NPDB for FYs 2019–2021. We also assessed the timeliness of the submissions to OIG and the NPDB.

Onsite Review of Unit Operations

During the onsite inspection, we observed the Unit's workspace and operations of the Unit's office in Des Moines. We observed the Unit's office and meeting spaces; security of data and case files; location of select equipment; and the general functioning of the Unit.

APPENDICES

Appendix A: Unit Referrals by Source for Fiscal Years 2019–2021

Referral Source	FY 2019		FY 2020		FY 2021		3-Year Total		
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Total
Adult Protective Services	0	2	0	0	0	0	0	2	2
Anonymous	1	0	1	0	1	0	3	0	3
HHS-OIG	4	0	9	0	7	1	20	1	21
Law enforcement (other)	18	6	9	4	10	2	37	12	49
Licensing board	1	0	1	0	2	0	4	0	4
Local prosecutor	0	2	1	1	2	0	3	3	6
Long-Term Care Ombudsman	0	0	0	0	0	1	0	1	1
Medicaid agency (IME-PIU), fee-for-service*	43	0	13	0	4	0	60	0	60
Medicaid agency (IME-PIU), MCO*	80	0	32	0	55	0	167	0	167
Medicaid agency (other)	0	0	0	0	0	1	0	1	1
Private citizen	72	1	55	1	44	0	171	2	173
Provider	0	2	0	2	4	1	4	5	9
State survey and certification agency	2	171	2	124	4	145	8	440	448
State agency (other)	3	1	0	0	5	1	8	2	10
Other	6	0	0	0	1	0	7	0	7
Sub-Total	**230**	**185**	**123**	**132**	**139**	**152**	**492**	**469**	**961**
Total	**415**		**255**		**291**		**961**		

Source: OIG analysis of Unit Annual Statistical Reports, FYs 2019–2021.
* The IME Program Integrity Unit (IME-PIU) provided both fee-for-service referrals and referrals that originated from MCOs.

Appendix B: Unit Comments

Iowa Department of
INSPECTIONS & APPEALS

KIM REYNOLDS, GOVERNOR
ADAM GREGG, LT. GOVERNOR

LARRY JOHNSON, JR., DIRECTOR

June 7, 2022

Suzanne Murrin
Deputy Inspector General, Evaluations and Inspections
Office of Inspector General
Department of Health and Human Services
Cohen Building, Room 5660
330 Independence Ave SW
Washington, DC 20201

RE: Iowa Medicaid Fraud Control Unit: 2021 Inspection, OEI-07-21-00340

Deputy Inspector General Murrin:

The Iowa Department of Inspections and Appeals reviewed the *Iowa Medicaid Fraud Control Unit: 2021 Inspection* report.

OIG reported one finding pertaining to Unit staffing pursuant to Performance Standard 2:

> ***Although the Unit operated effectively and achieved high case outcomes, the Unit did not maintain staffing levels in accordance with its approved budget, maintained low staffing levels in relation to State Medicaid expenditures, and experienced significant turnover of investigators and high caseloads.***

OIG also provided the following recommendation:

> ***Assess the adequacy of existing staffing levels, and if warranted, develop a plan to expand the size of the Unit.***

The Department appreciates the OIG's comments that the Unit operated effectively and achieved high case outcomes. The Unit achieved these results due to the hard work and dedication of the Unit's staff, the policies and procedures developed and implemented by the Unit's leadership, and the working relationships among the Unit's stakeholders, including the Iowa Medicaid Enterprise.

The Department disagrees with aspects of the OIG's finding but agrees with the overall recommendation. The OIG's finding implies if the Unit is below the staffing levels allowed by its budget, regardless of the Unit's workload, the Unit would be out of compliance in a future audit conducted by the OIG.

The Department agrees with the recommendation to continue its practice of assessing the adequacy of its staffing levels based on its workload. As of today, the Unit maintains nine full-time employees consisting of the Unit director, attorney, auditor, paralegal, and five investigators. The Unit currently maintains two vacant investigator positions. Based on most recent staffing assessments, the Unit determined that nine full-time employees are adequate at this time to operate effectively and

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efficiently. Specifically, five investigators are sufficient to respond to current referral intakes. This has resulted in reasonable caseloads to keep investigators working diligently on Unit investigations without overwhelming investigators with unmanageable caseloads or using taxpayer funds to employ unnecessary personnel based on current investigative needs. Current staffing has also allowed the Unit to accept all quality referrals that fall within the scope and authority of the Unit's investigative activities without declining quality referrals solely due to insufficient investigative resources. As the Unit continues to develop and enhance referral sources in order to generate more investigations, the Unit will continue to assess existing staffing levels and fill vacant investigator positions when appropriate to do so.

Thank you for the opportunity to respond to the 2021 audit report.

Sincerely,

Larry Johnson, Jr.
Director
Iowa Department of Inspections & Appeals

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Susan Burbach of the Medicaid Fraud Policy and Oversight Division served as the team leader for this inspection. Sarah Smith and Jordan Swoyer served as analysts. Medicaid Fraud Policy and Oversight Division staff who consulted on the inspection include Jordan Clementi Gerken. Office of Evaluation and Inspections headquarters staff who provided support include Robert Gibbons and Sara Swisher.

Two agents from the Office of Investigations also participated in the inspection and provided technical assistance to the Unit.

This report was prepared under the direction of Brian Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Dana Squires and Abbi Warmker, Deputy Regional Inspectors General, as well as in consultation with Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

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