Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OKLAHOMA STATE MEDICAID FRAUD CONTROL UNIT: 2014 ONSITE REVIEW

Suzanne Murrin
Deputy Inspector General
for Evaluation and Inspections

April 2016
OEI-06-14-00630

EXECUTIVE SUMMARY: OKLAHOMA STATE MEDICAID FRAUD CONTROL UNIT: 2014 ONSITE REVIEW
OEI-06-14-00630

WHY WE DID THIS STUDY

The Office of Inspector General (OIG) oversees the activities of all Medicaid Fraud Control Units (MFCUs or Units). As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. The reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor compliance with Federal grant requirements.

HOW WE DID THIS STUDY

We conducted an onsite review of the Oklahoma Unit in December 2014. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for fiscal years (FYs) 2012 through 2014; (2) a review of financial documentation for FYs 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management and selected staff; (6) an onsite review of a sample of files for cases that were open FYs 2012 through 2014 ; and (7) an onsite observation of Unit operations.

WHAT WE FOUND

For FYs 2012 through 2014, the Oklahoma Unit reported 56 criminal convictions, 51 civil judgments and settlements, and recoveries of nearly $66 million. During the same period, the State Medicaid agency's Program Integrity Unit (PIU) sent few fraud referrals to the Unit in FYs 2013 and 2014, despite Unit efforts to increase referrals. We identified opportunities for improvement in adhering to the MFCU performance standards. Specifically, we found that 42 percent of Unit case files for cases that had been open longer than 90 days lacked documentation of periodic supervisory review. Additionally, the Unit did not report all convictions and adverse actions to Federal partners within required timeframes. The Unit also claimed unallowable expenditures. We further identified two instances in which the Unit did not adhere to Federal policy or requirements. Specifically, the Unit retained monies for investigative costs associated with criminal judgments and sentencing and claimed Federal financial participation (FFP) for costs associated with two non-MFCU activities.

WHAT WE RECOMMEND

We recommend that the Oklahoma Unit (1) continue its efforts to receive an adequate number of referrals from the PIU; (2) ensure that supervisors conduct and document periodic reviews of case files; (3) implement processes to ensure that the Unit reports all convictions and adverse actions to Federal partners within required timeframes; (4) work with OIG to repay the Federal government for FFP claimed for unallowable expenditures; (5) work with the State Medicaid Agency to ensure that the Federal share of identified investigative cost recoveries related to criminal judgments and sentencing is returned to the Federal government; and (6) claim FFP only for MFCU-related activities and work with OIG to determine the portion of employee salaries corresponding to non-MFCU activities and to return the Federal share of that portion to the Federal government. The Unit concurred with all six recommendations.

TABLE OF CONTENTS

OBJECTIVE

To conduct an onsite review of the Oklahoma State Medicaid Fraud Control Unit (MFCU or Unit).

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute fraud and patient abuse and neglect by Medicaid providers under State law.[1] Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State; and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.[2] In fiscal year (FY) 2014, combined Federal and State grant expenditures for the Units totaled $235 million.[3]

To carry out its duties in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an attorney, an auditor, and an investigator.[4] Unit staff review referrals provided by the State Medicaid agency and other sources and determine their potential for criminal prosecution and/or civil action. In FY 2014, the 50 Units collectively reported 1,318 convictions, 874 civil settlements or judgments, and recoveries of approximately $2 billion.[5]

Units are required to have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.[6] In Oklahoma and 43 other States, the Units are located

---

[1] Social Security Act (SSA) § 1903(q)(3). Regulations at 42 CFR § 1007.11(b)(1) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities.

[2] SSA § 1902(a)(61).

[3] Office of Inspector General (OIG), *State Medicaid Fraud Control Units Fiscal Year 2014 Grant Expenditures and Statistics* (January 28, 2015). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.pdf on March 27, 2015. All FY references in this report are based on the Federal FY (October 1 through September 30).

[4] SSA § 1903(q)(6) and 42 CFR § 1007.13.

[5] OIG, *State Medicaid Fraud Control Units Fiscal Year 2014 Grant Expenditures and Statistics* (January 28, 2015). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.pdf on March 27, 2015. Recoveries are defined as the amount of money that defendants are required to pay as a result of a settlement, judgment, or pre-filing settlement in criminal and civil cases and may not reflect actual collections.

[6] SSA § 1903(q)(1).

within offices of State Attorneys General that have this authority. In the remaining six States, the Units are located in other State agencies; generally, such Units must refer cases to other offices with prosecutorial authority.[7] Additionally, each Unit must be a single, identifiable entity of State government, distinct from the single State Medicaid agency, and each Unit must develop a formal agreement—i.e., memorandum of understanding (MOU)—that describes the Unit's relationship with that agency.[8]

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to OIG the authority both to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.[9] All Units are currently funded by the Federal government on a 75-percent matching basis, with the States contributing the remaining 25 percent.[10] To receive Federal reimbursement, each Unit must submit an initial application to OIG.[11] OIG reviews the application and notifies the Unit whether it is approved and the Unit is certified. Approval and certification are valid for a 1-year period; the Unit must be recertified each year thereafter.[12]

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.[13] OIG developed and issued 12 performance standards to define the criteria it applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements.[14] Examples of standards include maintaining an adequate caseload through referrals from various sources, maintaining an annual training plan for all professional disciplines, and establishing policies and procedures manuals to reflect the Unit's operations. See Appendix A for the 12 performance standards.

---

[7] OIG, *Medicaid Fraud Control Units*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/ on March 27, 2015.

[8] SSA § 1903(q)(2) and 42 CFR § 1007.9(d).

[9] The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Medicaid program, including the MFCUs, is called Federal Financial Participation.

[10] SSA § 1903(a)(6)(B).

[11] 42 CFR § 1007.15(a).

[12] 42 CFR § 1007.15(b) and (c).

[13] SSA § 1902(a)(61).

[14] 77 Fed. Reg. 32645 (June 1, 2012). Accessed at http://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf on March 27, 2015. Previous performance standards, established in 1994, are found at 59 Fed. Reg. 49080 (Sept. 26, 1994). When referring to the performance standards, we refer to the 2012 standards, unless otherwise noted.

OIG performs periodic onsite evaluations of the Units. These evaluations differ from other OIG evaluations as they support OIG's direct administration of the MFCU grant program. These evaluations are subject to the same internal quality controls as other OIG evaluations, including internal peer review.

Oklahoma Medicaid Program

The Oklahoma Medicaid program, known as SoonerCare, is operated by the Oklahoma Healthcare Authority (OHCA), a division of the Oklahoma Department of Human Services. As part of OHCA, the Program Integrity Unit (PIU) shares responsibility for protecting the integrity of the Medicaid program. In FY 2014, the Oklahoma Medicaid program provided services to over 800,000 beneficiaries.[15] Oklahoma Medicaid expenditures for FY 2014 were over $4.9 billion.[16]

Oklahoma Unit

The Oklahoma Unit is housed within the Oklahoma Office of the Attorney General (OAG).[17] For FY 2014, the Unit expended nearly $2.4 million in combined State and Federal funds.[18] At the time of our December 2014 onsite review, the Unit employed 24 staff members—1 director, 1 deputy director, 3 assistant attorneys general, 1 senior auditor, 13 agents (including 1 Agent-in-Charge and 2 Special Agents-in-Charge),[19] 1 victim/witness coordinator, 1 docketing clerk, 1 legal assistant, and 2 administrative assistants. The Unit's headquarters is located in Oklahoma City, and the Unit maintains a satellite office in Tulsa.

Referrals. The Unit receives referrals (by telephone, e-mail, fax, or written correspondence, or in person) from a variety of sources, including the PIU, local law enforcement, and providers. Unit referrals by referral source for FYs 2012 through 2014 can be found in Appendix B. For each referral received, Unit management evaluates the referral and determines

---

[15] Oklahoma Healthcare Authority, *Total Enrollment: SoonerCare Fast Facts*, p. 1. Accessed at http://www.okhca.org/research.aspx?id=2987 on March 27, 2015.

[16] OIG, *State Medicaid Fraud Control Units Fiscal Year 2014 Grant Expenditures and Statistics* (January 28, 2015). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.pdf on March 27, 2015.

[17] OAG, *About the Office*. Accessed at http://www.ok.gov/oag/About_the_Office/index.html on April 10, 2015.

[18] OIG, *State Medicaid Fraud Control Units Fiscal Year 2014 Grant Expenditures and Statistics* (January 28, 2015). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.pdf on March 27, 2015.

[19] The Agent-in-Charge serves as the Unit's chief of investigations, and the two Special Agents-in-Charge function as agent supervisors.

what action needs to be taken (e.g., whether to open a case for preliminary investigation.)[20]

Investigation Process. When a case is opened, the Agent-in-Charge assigns it to an agent who specializes in investigating either Medicaid fraud or patient abuse and neglect. To assist agents during the investigative process, the Unit holds meetings on a weekly basis to review and discuss cases.[21] Although the Unit typically investigates and maintains most of its cases at the State level, the Unit also collaborates with Federal entities such as OIG, and the Federal Bureau of Investigation (FBI) to investigate cases jointly.

Prosecution Process. The Unit has the authority to prosecute both criminal and civil cases.[22] Unit attorneys review all cases presented for prosecution and determine whether to take the case, refer the case to District attorneys, or close the case. On occasion, some Unit attorneys are appointed as Special Assistant U.S. Attorneys (SAUSAs) to prosecute fraud cases in the U.S. District Courts for Oklahoma. In addition, the Unit sometimes works with the three United States Attorneys' Offices (USAOs) in the State (i.e., for Oklahoma's Eastern, Western, and Northern Districts) to prosecute joint cases.

Previous Review

In 2008, OIG conducted an onsite review of the Oklahoma Unit. OIG found that the Unit was in full compliance with all applicable Federal rules and regulations that govern the grant and the 12 MFCU performance standards.

METHODOLOGY

We conducted an onsite review in December 2014. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for FYs 2012 through 2014; (2) a review of financial documentation for FYs 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) interviews with the Unit's

---

[20] The Special-Agent-in-Charge assesses referrals involving criminal matters, while the Deputy Director assesses referrals involving civil matters.

[21] Unit management includes the Unit Director, Deputy Director, Agent-in-Charge, senior auditor, and at least one Assistant Attorney General. During panel meetings, the case is evaluated to (1) determine the investigative progress made by the agent, (2) assesss the likelihood that the case will warrant a criminal prosecution, (3) decide whether to consult experts, and (4) determine whether the civil division of the Unit should track the case for civil litigation.

[22] 56 O.S. § 1003. Accessed at http://www.oklegislature.gov/osstatuestitle.html on October 20, 2015.

management and selected staff; (6) an onsite review of a sample of case files for cases that were open in FYs 2012 through 2014; and (7) onsite observation of Unit operations. Appendix C contains the details of our methodology.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

For FYs 2012 through 2014, the Unit reported 56 criminal convictions, 51 civil judgments and settlements, and recoveries of nearly $66 million

The Unit reported 56 criminal convictions and 51 civil judgments and settlements during FYs 2012 through 2014. See Table 1.

Table 1: Oklahoma MFCU Criminal Convictions and Civil Judgments and Settlements, FYs 2012 Through 2014

Outcomes	FY 2012	FY 2013	FY 2014	Total
Criminal Convictions	18	21	17	**56**
Civil Judgments and Settlements	16	20	15	**51**

Source: OIG analysis of Unit Quarterly Statistical Reports, FYs 2012 through 2014.

For FYs 2012 through 2014, the Unit reported combined criminal and civil recoveries of nearly $66 million. During the review period, criminal recoveries ranged from $379,000 to $1.36 million.[23] Civil recoveries included over $61 million in "global" recoveries and over $2 million in non-global recoveries.[24] See Table 2.

Table 2: Oklahoma MFCU Recoveries and Expenditures, FYs 2012 Through 2014

Recovery Type	FY 2012	FY 2013	FY 2014	Total Recoveries
Criminal	$379,233	$1,360,329	$447,890	**$2,187,452**
Global Civil	$18,722,317	$26,470,647	$16,293,102	**$61,486,066**
Non-Global Civil	$0	$568,588	$1,680,000	**$2,248,588**
Total Recoveries	**$19,101,550**	**$28,399,564**	**$18,420,992**	**$65,922,106**
Total Expenditures	$1,824,638	$5,296,311	$2,271,908	$9,392,857

Source: OIG analysis of Unit self-reported data, FYs 2012 through 2014.

The Program Integrity Unit sent few fraud referrals to the Unit in FYs 2013 and 2014, despite Unit efforts to increase referrals

We found that the PIU sent few fraud referrals in FYs 2013 and 2014, sending a total of 9 referrals for the 2-year period—a decline

[23] During FY 2013, the Unit had three cases that involved large criminal recoveries.

[24] "Global" cases are civil false claims cases that are brought by the U.S. Department of Justice and involve a group of State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the States.

from FY 2012, when the PIU sent 19 referrals to the Unit. According to Performance Standard 4, the Unit should take steps to maintain an adequate volume and quality of fraud referrals from the State Medicaid agency and other sources. Typically, referrals from the State Medicaid agency are an essential component of a Unit's ability to effectively investigate and prosecute Medicaid provider fraud. Since 2013, the Unit has made efforts to ensure that the PIU sends referrals—for example, the Unit has maintained open communication with the State Medicaid agency and discussed referrals informally during monthly meetings with PIU staff. The State Medicaid agency changed the referral process following the implementation of the payment suspension regulations in 2011.[25] The Unit Director believes that this change may have caused the low number of referrals in FYs 2013 and 2014.

Forty-two percent of Unit case files for cases open longer than 90 days lacked documentation of periodic supervisory reviews

Nearly half of case files for cases open longer than 90 days lacked documentation of periodic supervisory reviews. Of the 42 percent that lacked documentation, nearly all (39 percent) had documentation of at least one supervisory review. According to Performance Standard 7(a), a Unit should, consistent with Unit policies and procedures, conduct supervisory reviews periodically and note them in the case files. In the year prior to the onsite, the Unit reported that they implemented a new system of oversight for case reviews. However, the Unit's policies and procedures manual did not establish a specific timeframe in which each agent's case files should receive periodic supervisory reviews. As we did in previous MFCU onsite reviews when a Unit had not established a timeframe for periodic supervisory reviews, we used 90 days as the threshold for such reviews to occur.

The Unit did not report all convictions and adverse actions to Federal partners within required timeframes

The Unit did not report all convictions to OIG for the purpose of program exclusion, nor did it report all adverse actions to the National Practitioner Data Bank (NPDB). According to Performance Standard 8(f), the Unit

[25] The process was changed to have the PIU send all referrals to the State Medicaid agency's legal division, which reviews each referral and determines whether to forward it to the Unit.

should report to OIG all convictions for the purpose of exclusion from Federal health care programs within 30 days of sentencing.[26] Additionally, Federal regulations require that Units report any adverse actions generated as a result of investigations or prosecutions of healthcare providers to the NPDB within 30 days following final action.[27]

The Unit did not report 45 percent of convictions to OIG for program exclusion within the required timeframe

The Unit did not report 25 of its 56 convictions to OIG for program exclusion within 30 days of sentencing. Specifically, the Unit reported 15 convictions between 31 and 60 days of sentencing, 6 convictions between 61 and 90 days of sentencing, and 1 conviction after 90 days of sentencing, and it never reported 3 convictions.

The Unit Director reported that court delays in providing the Unit with documents regarding judgment and sentencing led to Unit delays in reporting exclusions to OIG within the required timeframe. According to the Unit Director, the Unit's reporting process requires staff to obtain court documents in order to verify conviction information before submitting it to OIG for program-exclusion purposes. As a result, the Unit stated that it is unable to report convictions within 30 days of sentencing.

In addition to having 22 convictions that it reported late because of court delays, the Unit had 3 convictions that it did not report at all. The Unit Director explained that two of the three unreported convictions were for nonhealthcare providers. The Unit Director erroneously believed that convictions of such providers did not need to be reported to OIG. The remaining conviction was prosecuted by the USAO, not by Unit attorneys. The Unit Director was not aware that the Unit needed to report to OIG convictions prosecuted by a Federal agency. Following our site visit, the Unit reported all three convictions to OIG for exclusion.

The Unit did not report 38 percent of adverse actions to the NPDB within the required timeframe

The Unit did not report 19 of its 50 adverse actions to the NPDB within 30 days of the action. Specifically, the Unit reported 16 adverse actions

---

[26] If a Unit fails to ensure that convicted individuals are reported for exclusion, those individuals may be able to continue to submit claims to and receive payments from Medicaid and other Federal healthcare programs. See 42 CFR § 1001.1901.

[27] SSA § 1128E(g)(1) and 45 CFR § 60.3. The NPDB is intended to restrict the ability of physicians, dentists, and other healthcare practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions. Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. Final adverse actions must be reported to the NPDB within 30 days following the action. See 45 CFR § 60.5.

between 31 and 60 days of the action, 2 between 61 and 90 days of the action, and 1 after 91 days of the action.

The Unit director reported difficulties—similar to those in obtaining information for reporting convictions to OIG—in obtaining the required information to report adverse actions to the NPDB. According to the Unit Director, court delays result in delays in the Unit's receiving the sentencing documents that it needs to submit reports of adverse actions to the NPDB. Sentencing documents include the final charges at sentencing—i.e., information on restitution, fines, and penalties. The Unit stated that because of court delays, it is unable to report adverse actions within 30 days of the action as required.

The Unit claimed unallowable expenditures

The Unit claimed $31,304—the Federal share of which is $23,478—in unallowable expenditures for FYs 2012 through 2014. According to Performance Standard 11, the Unit should exercise proper fiscal control over its resources.[28] Proper and efficient performance and administration of Federal awards require costs to be necessary, reasonable, adequately documented, and allocable. The Unit's claims for unallowable expenditures resulted from several factors, including lack of adequate supporting documentation and improper allocation. We found that all expenditures claimed by the Unit other than this $31,304 unallowable amount—i.e., a total of $6,009,212, the Federal share of which is $4,506,908— were allowable, allocable, reasonable, and in accordance with applicable Federal requirements. See Appendix D, Table D-1 for more detail.

The Unit retained investigative cost recoveries related to criminal judgments and sentencing

Our review found that for FYs 2012 through 2014, the Unit deposited $167,944 (the Federal share of which is $107,492) received from criminal judgments and sentencing directly into the Unit's State account used for cost-matching obligations. These monies are associated with the recovery of investigative costs. The Unit should have worked with the State Medicaid agency to ensure the return of the Federal share to the Federal

[28] Additionally, OMB Circular A-87, Attachment A, §§ (c)(1)(a) and (c)(1)(j) require that costs are necessary and reasonable for proper and efficient performance and administration of Federal awards and are adequately documented. OMB Circular A-87, Attachment A, § (c)(3)(a) states that a cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received.

government. According to State Fraud Policy Transmittal Number 10-01, the Unit should not retain monies obtained in a Medicaid fraud settlement or judgment entered into by the State.[29, 30] Instead, the Unit should work with the State Medicaid agency to ensure the return of the Federal Government's share of recoveries.[31] The State Medicaid agency is responsible for returning the Federal share of those recoveries to the Federal government and for distributing the remaining State share in accordance with the State's policy or practice.

The Unit claimed Federal financial participation for costs associated with two non-MFCU activities

The Unit claimed Federal financial participation (FFP) for the time that agents worked on non-MFCU related activities. Additionally, the Unit did not maintain its records to allow for proper time distribution and lacked documentation necessary to ensure that FFP was received only for employee work on MFCU-specific activities. Federal regulations and policy transmittals state that Units may claim FFP only for costs associated with the investigation and prosecution of Medicaid fraud and complaints of patient abuse or neglect in healthcare or board and care facilities.[32] Furthermore, MFCU Performance Standard 11 requires the Unit to exercise proper fiscal control over Unit resources, which includes maintaining an effective time and attendance system and maintaining personnel activity reports.

---

[29] OIG State Fraud Policy Transmittal Number 10-01, *Program Income*. This OIG transmittal relied on and summarized the content of the Centers for Medicare & Medicaid Services (CMS) policy statement outlined in the State Health Official (SHO) Letter #08-004, which stated that the Federal share of the total amount of any legal judgements or settlement proceeds received by a State in a Medicaid false claims action should be returned to CMS. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/policy_transmittals/2010-1%20State%20Fraud%20Policy%20Transmittal%20Number%2010-01%20Program%20Income%203-22-2010.pdf on May 27, 2015.

[30] CMS SHO Letter #08-004. Accessed at http://www.kslaw.com/Library/publication/HH111008_CMSLetter.pdf on July 27, 2015.

[31] Ibid. The Federal share of investigative cost recoveries from criminal judgments and sentencing is based upon the total incurred amount.

[32] SSA § 1903(q)(3) and 42 CFR §§ 1007.11(a), (b), and 1007.19(d). OIG State Fraud Policy Transmittals Numbers 2014-1 and 89-1. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/policy_transmittals/State%20Fraud%20Policy%20Transmittal%20No%20%202014-1.pdf and http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/policy_transmittals/89-1%20Full%20time%20and%20Part%20time%20Employees.pdf on May 28, 2015.

The Unit claimed and received FFP for two non-MFCU related activities. First, four Unit agents served as "executive security"[33] for the Attorney General, typically filling in when the individual normally accompanying the Attorney General was not available. The Unit reported that this practice stopped prior to our onsite review. Second, agents conducted background checks for summer interns and newly hired non-MFCU OAG staff. The Unit Director reported that agents continue to conduct background checks for non-MFCU staff. However, agents are now logging their time spent on this activity in the case management system to ensure the Unit does not claim FFP for this activity.

Federal cost principles also require the Unit to periodically certify that employees worked solely on MFCU-specific activities. The Unit must track any time employees that spend on non-MFCU-related activities.[34] However, our review found that the Unit did not make these certifications.

Subsequent to our onsite review, the Unit Director reported instituting internal controls for tracking all off-grant activities for Unit staff within the case management system. Now that staff time is being tracked, the Unit Director plans to deduct non-MFCU associated costs from the MFCU grant.

[33] "Executive security" refers to armed agents accompanying the Attorney General for the purpose of providing security and transportation services.

[34] OMB Circular A-87 Att. B, §§ (8)(h)(3) and (8)(h)(4), codified at 2 CFR pt. 225. After our review period, OMB and Federal agencies revised the cost principles, now found at 45 CFR 2 CFR pt. 200.

CONCLUSION AND RECOMMENDATIONS

For FYs 2012 through 2014, the Oklahoma Unit reported 56 criminal convictions, 51 civil judgments and settlements, and recoveries of nearly $66 million. During the same period, the State Medicaid agency's PIU sent few fraud referrals to the Unit in FYs 2013 and 2014, despite Unit efforts to increase referrals.

We identified opportunities for improvement in adhering to MFCU performance standards. Specifically, we found that 42 percent of Unit case files lacked documentation of periodic supervisory reviews. Additionally, the Unit did not report all convictions and adverse actions to Federal partners within required timeframes, and the Unit claimed unallowable expenditures.

We further identified two instances in which the Unit did not adhere to Federal policy or requirements. Specifically, the Unit retained investigative cost recoveries related to criminal judgments and sentencing and claimed FFP for costs associated with two non-MFCU activities.

Therefore, we recommend that the Oklahoma Unit:

Continue efforts to receive an adequate number of referrals from the PIU

Referrals from a State's PIU remain an important component of a Unit's ability to effectively investigate and prosecute Medicaid provider fraud. The Unit should continue to work with the PIU to receive an adequate number of referrals.

Ensure that supervisors conduct and document periodic reviews of case files

The Unit should continue to ensure supervisors review and document case files periodically. Additionally, the Unit should revise its policies and procedures manual to include the new procedures for periodic reviews of case files.

Implement processes to ensure that the Unit reports all convictions and adverse actions to Federal partners within required timeframes

The Unit should implement processes to ensure that convictions are reported to OIG within 30 days of sentencing and that adverse actions are reported to the NPDB within 30 days of the action. This could include working with the courts to ensure that the courts provide conviction information to the Unit in a timely manner. The Unit could contact the various courts to explain the necessity of receiving copies of sentencing

documents so that the Unit can submit the required reports to Federal partners within the required timeframes.

Work with OIG to repay the Federal government for FFP claimed for unallowable expenditures

The Unit should repay $23,478 to the Federal government for FFP claimed for unallowable expenditures.

Work with the State Medicaid Agency to ensure that the Federal share of identified investigative cost recoveries related to criminal judgments and sentencing is returned to the Federal government

The Unit should work with the State Medicaid agency to ensure that the Federal share of $167,944 in investigative cost recoveries related to criminal judgments and sentencing is appropriately returned to the Federal government. Also, the Unit should implement procedures to ensure that the Unit works with the State Medicaid agency to return to the Federal Government the Federal share of investigative cost recoveries related to criminal judgments and sentencing.

Claim FFP only for MFCU-related activities and work with OIG to determine the portion of employee salaries corresponding to non-MFCU activities and to return the Federal share of that portion to the Federal government

The Unit should only claim FFP for appropriate MFCU-related activities. The Unit should continue its system of internal controls that track and support allowable MFCU activities.

The Unit should also work with OIG to determine the portion of employee salaries associated with the time spent on non-MFCU activities (i.e., executive security for the Attorney General and conducting background checks) and to return the Federal share of that portion to the Federal Government.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Oklahoma Unit concurred with all six of our recommendations.

Regarding the first recommendation, the Unit stated that it will continue to encourage referrals from the PIU (e.g., making suggestions for referral sources and providing criteria for possible referrals at the Unit's monthly meeting with the PIU).

Regarding the second recommendation, the Unit stated that it took measures to ensure supervisory oversight at least every 90 days.

Regarding the third recommendation, the Unit stated that its ability to report convictions within 30 days is often outside its control. Nevertheless, the Unit stated that it will make every effort to timely and accurately report all convictions.

Regarding the fourth recommendation, the Unit stated that it would work with the OIG to repay all FFP for unallowable expenditures and ensure proper credits are applied.

Regarding the fifth recommendation, the Unit took measures to transfer the identified cost recoveries to the Medicaid Agency with correspondence indicating that these funds are to be repaid to CMS. Additionally, the Unit implemented a policy to ensure appropriate identification and transfer of the Federal share of investigative cost recoveries in the future.

Regarding the sixth recommendation, the Unit stated that it implemented policies and procedures to record all non-MFCU related activities in its case management software. Each quarter non-MFCU related activities are deducted from FFP and reported properly on the Federal Financial Report (FFR). In addition, the Unit identified all prior non-grant related activities and removed them from any FFP in the final 2014 FFR.

APPENDIX A

2012 Performance Standards[35]

1. A UNIT CONFORMS WITH ALL APPLICABLE STATUTES, REGULATIONS, AND POLICY DIRECTIVES, INCLUDING:
A. Section 1903(q) of the Social Security Act, containing the basic requirements for operation of a MFCU;
B. Regulations for operation of a MFCU contained in 42 CFR part 1007;
C. Grant administration requirements at 45 CFR part 92 and Federal cost principles at 2 CFR part 225;
D. OIG policy transmittals as maintained on the OIG Web site; and
E. Terms and conditions of the notice of the grant award.
2. 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.
A. The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
B. The Unit employs 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 and neglect.
C. The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows 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 and neglect.
D. The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
E. To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.
3. A UNIT ESTABLISHES WRITTEN POLICIES AND PROCEDURES FOR ITS OPERATIONS AND ENSURES THAT STAFF ARE FAMILIAR WITH, AND ADHERE TO, POLICIES AND PROCEDURES.
A. The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.
B. The Unit adheres to current policies and procedures in its operations.
C. Procedures include a process for referring cases, when appropriate, to Federal and State agencies. Referrals to State agencies, including the State Medicaid agency, should identify whether further investigation or other administrative action is warranted, such as the collection of overpayments or suspension of payments.
D. Written guidelines and manuals are readily available to all Unit staff, either online or in hard copy.
E. Policies and procedures address training standards for Unit employees.
4. A UNIT TAKES STEPS TO MAINTAIN AN ADEQUATE VOLUME AND QUALITY OF REFERRALS FROM THE STATE MEDICAID AGENCY AND OTHER SOURCES.

[35] 77 Fed. Reg. 32645, June 1, 2012.

A. The Unit takes steps, such as the development of operational protocols, to ensure that the State Medicaid agency, managed care organizations, and other agencies refer to the Unit all suspected provider fraud cases. Consistent with 42 CFR 1007.9(g), the Unit provides timely written notice to the State Medicaid agency when referred cases are accepted or declined for investigation.
B. The Unit provides periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.
C. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).
D. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.
E. The Unit provides timely information, when requested, to those agencies identified in (D) above regarding the status of referrals.
F. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.
5. 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.
A. Each stage of an investigation and prosecution is completed in an appropriate timeframe.
B. Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.
C. Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.
6. 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.
A. The Unit seeks to have a mix of cases from all significant provider types in the State.
B. For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.
D. As part of its case mix, the Unit maintains a balance of fraud and patient abuse and neglect cases for those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases.
C. The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.
E. As part of its case mix, the Unit seeks to maintain, consistent with its legal authorities, a balance of criminal and civil fraud cases.
7. 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.
A. Reviews by supervisors are conducted periodically, consistent with MFCU policies and procedures, and are noted in the case file.
B. Case files include all relevant facts and information and justify the opening and closing of the cases.
C. Significant documents, such as charging documents and settlement agreements, are included in the file.
D. Interview summaries are written promptly, as defined by the Unit's policies and procedures.
E. The Unit has an information management system that manages and tracks case information from initiation to resolution.
F. The Unit has an information management system that allows for the monitoring and reporting of case information, including the following:

1. The number of cases opened and closed and the reason that cases are closed.
2. The length of time taken to determine whether to open a case referred by the State Medicaid agency or other referring source.
3. The number, age, and types of cases in the Unit's inventory/docket
4. The number of referrals received by the Unit and the number of referrals by the Unit to other agencies.
5. The number of cases criminally prosecuted by the Unit or referred to others for prosecution, the number of individuals or entities charged, and the number of pending prosecutions.
6. The number of criminal convictions and the number of civil judgments.
7. The dollar amount of overpayments identified.
8. The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of recoveries and the types of relief obtained through civil judgments or prefiling settlements.
8. A UNIT COOPERATES WITH OIG AND OTHER FEDERAL AGENCIES IN THE INVESTIGATION AND PROSECUTION OF MEDICAID AND OTHER HEALTH CARE FRAUD.
A. The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.
B. The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, cases involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.
C. The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.
D. For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.
E. For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.
F. The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.
G. The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.
9. A UNIT MAKES STATUTORY OR PROGRAMMATIC RECOMMENDATIONS, WHEN WARRANTED, TO THE STATE GOVERNMENT.
A. The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.
B. The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.
10. 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.
A. The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.
B. The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR § 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR § 455.23, "Suspension of payments in cases of fraud."
C. The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the CMS.

D. Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.
E. The MOU incorporates by reference the *CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit*.

APPENDIX B

Referrals of Provider Fraud and Patient Abuse and Neglect to the Oklahoma Unit by Source, FYs 2012 Through 2014

Table B-1: Referrals of Fraud and Abuse to MFCU

Case Type	FY 2012	FY 2013	FY 2014
Provider Fraud	84	69	120
Patient Abuse and Neglect	110	123	157
Total	**194**	**192**	**277**

Source: Oklahoma MFCU response to OIG data request.

Table B-2: Referrals to MFCU, by Referral Source

Referral Source	FY 2012		FY 2013		FY 2014	
	Provider Fraud	Patient Abuse and Neglect	Provider Fraud	Patient Abuse and Neglect	Provider Fraud	Patient Abuse and Neglect
Medicaid Agency – Program Integrity Unit	19	0	4	0	5	0
Medicaid Agency - Other	10	25	1	4	4	14
State Survey/Certification	0	0	0	0	0	0
State Agencies – Other	2	31	1	83	0	62
Licensing Boards	3	0	3	0	1	1
Law Enforcement	22	15	32	5	60	46
HHS OIG	3	1	0	0	0	1
Prosecutors	4	2	0	3	3	0
Providers	11	23	10	23	12	20
Private Health Insurers	0	0	0	0	0	0
Ombudsman	0	0	0	0	0	0
Adult Protective Services	0	0	0	0	0	0
Private Citizens	9	13	10	5	12	11
MFCU Hotline	0	0	6	0	17	1
Other	1	0	2	0	6	1
Total Referrals Received	**84**	**110**	**69**	**123**	**120**	**157**

Source: Oklahoma MFCU response to OIG data request.

APPENDIX C

Detailed Methodology

We used data collected from the seven sources below to describe the caseload and assess the performance of the Unit.

Data Collection

Review of Unit Documentation. Prior to the onsite review, we analyzed information regarding how the Unit investigates Medicaid cases and refers them for prosecution. We gathered this information from several sources, including the Unit's quarterly statistical reports, annual reports, recertification questionnaires, policies and procedures manuals, Memorandum of Understanding with the State Medicaid agency, and the report (from 2008) on OIG's previous onsite review of the Unit. Additionally, we confirmed with the Unit director that the information we had was current as of December 2014, and as necessary, we requested any additional data or clarification.

Review of Financial Documentation. OIG's Office of Audit Services (OAS) reviewed the Unit's control over its fiscal resources to identify any internal control issues or other issues involving use of resources. OAS reviewed the Unit's financial policies and procedures; its response to an internal control questionnaire; documents (such as timecard records) to support staff time and effort during selected pay periods; and documents (such as financial status reports[36]) related to MFCU grants. Further, OAS reviewed a judgmental sample—consisting of 108 expenditure transactions totaling $2,171,737—to assess (1) expenditures that represented allowable, allocable, and reasonable costs in accordance with applicable Federal regulations; and (2) internal controls related to accounting, budgeting, personnel, procurement, property, and equipment. All selected transactions were limited to the review period of FYs 2012 through 2014. The sample included the following:

No.	Expenditure Type	Transactions	Expenditure Amount
1	Salary and benefits	12	$1,798,956
2	Rent	19	$91,795
3	Equipment	8	$121,412
4	Supplies and miscellaneous	8	$31,782
5	Travel	34	$60,472
6	Training and membership	27	$67,320
	Total	108	$2,171,737

[36] The Unit transmits financial status reports to OIG's Office of Management and Policy on a quarterly and annual basis. These reports detail Unit income and expenditures.

We also reviewed items in the Unit's inventory of supplies. Specifically, we selected a sample of 106 items from the current inventory list of 451 items (which includes items in both the Unit's Oklahoma City office and its Tulsa office) and verified the items. To ensure a variety in our inventory sample, we included expensive items such as computers and vehicles as well as less expensive items such as radios and cameras.

Interviews with Key Stakeholders. We conducted structured interviews with key stakeholders who were familiar with the operations of the Unit. Specifically, we interviewed staff from the Oklahoma Attorney General's office; the Oklahoma Health Care Authority; the Oklahoma State Department of Health; the Oklahoma Department of Human Services; the Assistant U.S. Attorneys' offices in the USAO Eastern and Western Districts of Oklahoma; and the Federal Bureau of Investigation, as well as OIG special agents and an OIG Assistant Special Agent in Charge who worked with the Unit during the review period. These interviews focused on the Unit's interaction with external agencies.

Survey of Unit Staff. We administered an electronic survey to Unit staff in the weeks leading up to the onsite review. We requested responses from 18 nonmanagerial staff members and received responses from 16 of them, an 89-percent response rate. Our questions focused on operations, opportunities for improvement, and effective practices.

Interviews with Unit Management and Staff. We conducted structured interviews with the Unit director; the deputy director; the Agent in Charge; the Special Agents in Charge for the Oklahoma City and Tulsa offices; the senior auditor; and staff from those two offices. We asked interviewees to provide information to better illustrate the Unit's operations, identify opportunities for improvement, describe effective practices, and clarify information we obtained from other data sources.

Onsite Review of Case Files. We requested that the Unit provide us with a list of cases that were open at any point during FYs 2012 through 2014. The Unit provided a list of 605 cases that were open during this period. For each case, the Unit provided us with data including the current status of the case; whether the case was criminal, civil, or global; and the date on which the case had been opened. From this list of cases, we excluded 95 cases that were categorized as "global." The remaining number of cases was 510.

From these 510 cases, we selected a statistically valid, simple random sample of 100 cases to review the case files to see whether they included documentation of supervisory approval for the opening and closing of cases and whether they included documentation of periodic supervisory review. The sample of cases for which we reviewed the case files

included 65 cases that were closed sometime in the period of FYs 2012 through 2014 and 67 cases that had been open for more than 90 days, thus necessitating periodic supervisory review. See Appendix F for point estimates and 95-percent confidence intervals.

From the initial sample of 100 cases, we selected another simple random sample of 50 cases for a more indepth review of the case files. We reviewed these case files for selected issues, such as the timeliness of investigations and case development.

Onsite Review of Unit Operations. During our December 2014 onsite review, we observed the Unit's workspace and operations. We visited the Unit's Oklahoma City and Tulsa offices and meeting spaces, and we reviewed the following: the process for receiving referrals, the electronic case management system, the security of case files, the location of selected equipment, and the general functioning of the Unit. We also verified that the Unit referred convicted individuals to OIG for program exclusion and that the Unit reported adverse actions to the NPDB.

Data Analysis

We analyzed data from the sources described above to identify any opportunities for improvement and any instances in which the Unit did not meet the performance standards or was not operating in accordance with laws, regulations, and/or policy transmittals.[37]

[37] All relevant regulations, statutes, and policy transmittals are available online at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/.

APPENDIX D

Fiscal Control Review Findings, FYs 2012 Through 2014

Table D-1: Unallowable Expenditures

Findings	Total	Federal Share	Federal Requirements
Claimed Expenditures	**$6,040,516**	**$4,530,386**	
Accepted Expenditures	**$6,009,212**	**$4,506,908**	
Incorrectly Claimed Expenditures	**$31,304**	**$23,478**	
• Overreported expenditures: Claimed expenditures on FFP reports were not supported.	$20,770	$15,577	A-87 Att. A, (C)(1)(j)
• Methodology for Oklahoma City rent allocation: Square footage and price per square foot were not supported by the Oklahoma City lease agreements.	$1,280	$960	A-87 Att. A, (C)(3)(a)
• Methodology for Tulsa rent allocation: Rent space allocation used 15 employees instead of 11 employees, causing the Unit to pay higher rent amounts.	$4,214	$3,161	A-87 Att. A, (C)(3)(a)
• Unsupported postage expense: The Unit did not maintain postage usage reports for a postage machine in the Attorney General's office.	$3,000	$2,250	A-87 Att. A, (C)(1)(j)
• Lack of supporting documentation: A gasoline fee and a training fee lacked proper supporting documentation verifying allowability.	$1,090	$818	A-87 Att. A, (C)(1)(j)
• Duplicated expenditure: The Unit mistakenly twice claimed a training registration payment for one employee.	$950	$712	A-87 Att. A, (C)(1)(a)

Source: OIG analysis of Unit expenditures, FYs 2012 through 2014.

Table D-2: Identified Cost Recoveries Related to Criminal Judgements and Sentences

Finding	Total	Federal Share	Federal Requirement
Incorrectly retained investigative cost recoveries related to criminal judgments and sentencing	$167,944	$107,492	State Fraud Policy Transmittal No. 10-01

Source: OIG analysis of Unit expenditures, FYs 2012 through 2014.

Table D-3: Employee Salaries

Finding	Total	Federal Share	Federal Requirement
Four employees who performed non-MFCU related activities	Unable to determine	Unable to determine	A-87 Att. B, (8)(h)(4) & (5)

Source: OIG analysis of Unit expenditures, FYs 2012 through 2014.

Table D-4: Federal Requirements

OMB Circular A-87 Requirements	
Attachment A	
(c)(1)(a) and (j)	To be allowable under Federal awards, costs must be necessary and reasonable for proper and efficient performance and administration of the Federal award and must be adequately documented.

Table D-4: Federal Requirements (Continued)

Attachment B	
(c)(3)(a)	A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received.
(8)(h)(3)	Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having first-hand knowledge of the work performed by the employee.
(8)(h)(4)	Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation. Such documentary support will be required where employees work on an unallowable activity and a direct or indirect cost activity.
(8)(h)(5)	Personnel activity reports or equivalent documentation must (a) reflect an after the fact distribution of the actual activity of each employee, (b) account for the total activity for which each employee is compensated, (c) be prepared at least monthly and must coincide with one or more pay periods, and (d) be signed by the employee.
State Fraud Policy Transmittal Number 10-01, Program Income	
CMS should be paid the Federal Medical Assistance Percentage (FMAP) proportionate share of a MFCU's total recovery, without deducting legal expenses and other administrative costs.	

APPENDIX E

Investigations Opened and Closed by Provider Category and Case Type, FYs 2012 Through 2014

Table E-1: Annual Opened and Closed Investigations

Case Type	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Provider Fraud	76	45	54	31	83	32
Patient Abuse and Neglect	80	56	85	73	55	68
Total	**156**	**101**	**139**	**104**	**138**	**100**

Source: Oklahoma MFCU response to OIG data request.

Table E-2: Investigations of Patient Abuse and Neglect

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing Facilities	31	16	15	19	11	18
Other Long-Term-Care Facilities	0	1	0	0	1	0
Nurses/Physician's Assistants/Nurse Practitioners/Certified Nurse Aides	49	37	69	53	42	50
Home Health Aides	0	1	1	1	0	0
Other	0	1	0	0	1	0
Total	**80**	**56**	**85**	**73**	**55**	**68**

Source: Oklahoma MFCU response to OIG data request.

Table E-3: Investigations of Provider Fraud

Provider Category	FY 2012		FY 2013		FY 2014	
Facilities	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Hospitals	1	0	0	1	2	0
Nursing Facilities	1	1	0	1	1	0
Other Long-Term-Care Facilities	0	1	0	0	0	0
Substance Abuse Treatment Centers	0	0	0	0	0	0
Other Facilities	5	0	1	3	1	3
Practitioners	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Doctors of Medicine or Osteopathy	7	4	1	3	3	1
Dentists	1	5	3	0	1	1
Podiatrists	0	0	0	0	0	0
Optometrist/Opticians	3	0	0	2	0	0
Counselors/Psychologists	24	9	21	12	49	20
Chiropractors	0	0	0	0	0	0
Other Practitioners	0	0	0	0	0	0
Medical Support	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Pharmacies	4	2	2	0	4	2
Pharmaceutical Manufacturers	12	11	20	1	13	0
Suppliers of Durable Medical Equipment	3	2	1	1	2	1
Laboratories	1	0	1	0	2	0
Transportation Services	0	0	0	0	0	0
Home Health Care Agencies	0	1	2	1	0	0
Home Health Care Aides	4	3	0	0	0	1
Nurses/Physician's Assistants/Nurse Practitioners/Certified Nurse Aides	1	0	0	2	1	0
Radiologists	0	1	0	0	1	0
Other Medical Support	3	2	1	2	1	1
Program Related	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Managed Care	1	1	0	0	0	0
Medicaid Program Administration	5	2	1	2	2	2
Billing Company	0	0	0	0	0	0
Other Program Related	0	0	0	0	0	0
All Fraud Investigations	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Total	**76**	**45**	**54**	**31**	**83**	**32**

Source: Oklahoma Unit response to OIG data request.

APPENDIX F

Point Estimates and Confidence Intervals Based on Review of Case Files

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Case files containing documentation of supervisory approval for opening	100	100.0%	96.7%	100.0%
Case files containing documentation of supervisory approval for closing	65	100.0%	94.9%	100.0%
Case files with no documentation of periodic supervisory review*	67	41.8%	29.8%	54.5%

Source: OIG analysis of Unit case files, 2014.

*We excluded from this analysis 4 sampled cases that were closed within 90 days of opening, 8 sampled cases that did not receive periodic supervisory review because of extenuating circumstances outside of the Unit's control, and 21 sampled cases that were open less than 90 days.

APPENDIX G

Unit Comments

OFFICE OF ATTORNEY GENERAL
STATE OF OKLAHOMA

March 4, 2016

Ms. Suzanne Murrin
Deputy Inspector General for Evaluation and Inspection
Room 5660
Cohen Building
330 Independence Ave SW
Washington, DC 20201

RE: Oklahoma State Medicaid Fraud Control Unit
2014 Onsite Review, OEI-06-14-00630

Ms. Murrin:

We are in receipt of the above referenced letter dated December 10, 2015. We appreciate the opportunity to address and respond to the findings contained therein. Additionally, we would like to express our appreciation to your audit/onsite review staff. They were professional and courteous during the course of this review process. We especially appreciate your recognition of the Unit's hard work over the past five years, noting that the Unit recovered nearly $66 million for the Medicaid program while expending only $6.009 million. In other words, for every dollar spent on the Unit's operations, $10.97 was returned to the Medicaid Program.

Following is our responses to each individual recommendation. We believe that the Unit has taken measures to comply with the recommendations. As noted below, in some cases the Unit took corrective action prior to the arrival of the onsite review team.

Recommendation Number One: **Continue efforts to facilitate receiving an adequate number of referrals from the PIU [Oklahoma Health Care Authority Program Integrity Unit].**

Response: The Unit concurs with this finding and recommendation. The Unit continues to encourage referrals from the PIU, while independently identifying potential referrals and referral sources. At the Unit's monthly meeting with the PIU, the Unit makes suggestions for referral sources and criteria for possible referrals.

313 N.E. 21ST STREET • OKLAHOMA CITY, OK 73105 • (405) 521-3921 • FAX: (405) 521-6246

Recommendation Number Two: Ensure supervisors conduct and document periodic case file reviews.

Response: The Unit concurs with findings and recommendation in this area. The Unit took measures to ensure supervisory oversight approximately one year before the onsite review took place. As noted in the draft report, the Unit implemented a new system of oversight for case reviews. A team of supervisory staff including the Unit Director, Unit Agent in Charge, Unit Deputy Director who also serves as the civil prosecutor, the lead criminal prosecutor for each location (Oklahoma City and Tulsa) and the Unit Auditor/Analyst meet once a week. The agents cycle two at a time through the panel meetings at least every 90 days. During their week at panel, two agents present their cases for review and discussion with panel members. This allows the agents to receive feedback for adjustments to their investigative plan. It also allows supervisors to review case progress.

Recommendation Number Three: Implement processes to ensure that convictions and adverse actions are reported to Federal partners within required timeframes.

Response: The Unit concurs with this finding and recommendation. The Unit refers to the two reporting systems for Oklahoma, OSCN and OCDR to find if Judgment and Sentences have been prepared by the Court staff and are available for retrieval. As noted in the final draft report, the ability to report exclusions to our Federal partners within 30 days is often outside the control of the Unit. Every effort is made to timely report fully and accurately all convictions.

Recommendation Number Four: Work with OIG to repay FFP claimed for unallowable expenditures to the Federal government.

Response: The Unit concurs with this recommendation. The Unit will work with OIG to repay all FFP for unallowable expenditures and believes this amount to have already been paid by the State. The Unit will work with OIG to ensure proper credits are applied.

Recommendation Number Five: Work with the State Medicaid Agency to ensure the Federal share of identified investigative cost recoveries related to criminal judgments are returned to the Federal government.

Response: The Unit concurs with the findings and recommendation. The Unit has already taken measures to transfer the identified investigative costs to the Medicaid Agency with correspondence indicating that these funds are to be repaid to CMS. In order to facilitate future payments to CMS for these cost recoveries, the Unit has implemented a policy in which the Federal share of investigative and legal costs recovered from criminal defendants is reconciled and transferred to the State Medicaid Agency once a month. A document will be sent simultaneously which will provide notification to the Medicaid Agency of the total amount recovered, the FMAP percentage used to determine the federal share and the total state share.

Recommendation Number Six: Claim FFP [Federal Financial Participation] only for MFCU-related activities and work with OIG to determine the Federal share of employee salaries to return to the Federal government for non-MFCU activities.

Response: The Unit concurs with this recommendation and implemented policies and procedures to record all non-MFCU related activities in the case management software. Each quarter any off-grant related expenses are deducted from FFP and reported properly on the Federal Financial Report (FFR). The Unit believes that it has already complied with this finding. All prior non-grant related activities were calculated and removed from any FFP in the final 2014 FFR. All non-grant related activities are currently recorded collaterally with the activities, calculated using the current rate of pay, deducted from the Unit's expenses and properly recorded on all quarterly and final FFR.

The staff of Oklahoma Medicaid Fraud Control Unit continue in their dedication of detection, investigation and prosecution of providers who commit Medicaid Fraud as well as those that abuse, neglect and exploit our most vulnerable adults. Once again, we appreciate the OIG staff and their professionalism in conducting this onsite review.

/S/

Mykel Fry
Assistant Attorney General
Director, Medicaid Fraud Control Unit

ACKNOWLEDGMENTS

This report was prepared under the direction of Kevin Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and Ruth Ann Dorrill, Deputy Regional Inspector General; and in consultation with Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Maria Balderas, of the Dallas regional office, served as the project leader for the study. Other Office of Evaluation and Inspections staff who conducted the review include Lyndsay Patty. Other Medicaid Fraud Policy and Oversight Division staff who participated in the review include Susan Burbach. Office of Investigations staff also participated in the review. Office of Audit Services staff who conducted a financial review include Miquel Darcey, Warren Lundy, and Keith Peters. Other central office staff who contributed to this review include Lonie Kim, Kevin Farber, and Christine Moritz.

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of individuals served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and individuals. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.