

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ARIZONA STATE MEDICAID
FRAUD CONTROL UNIT:
2015 ONSITE REVIEW**



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**EXECUTIVE SUMMARY: ARIZONA STATE MEDICAID FRAUD CONTROL
UNIT: 2015 ONSITE REVIEW
OEI-07-15-00280**

WHY WE DID THIS STUDY

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

HOW WE DID THIS STUDY

We conducted an onsite review of the Arizona Unit in July 2015. We based our review on 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; (6) an onsite review of files for cases that were open in FYs 2012 through 2014; and (7) an onsite observation of Unit operations.

WHAT WE FOUND

The Unit was in general compliance with applicable laws, regulations, and policy transmittals; however, we identified one area for improvement. For FYs 2012 through 2014, the Arizona Unit reported 185 criminal convictions and combined criminal and civil recoveries of \$4 million. We found that almost all case files contained documentation of supervisory approval to open and close cases as well as of periodic supervisory reviews. In addition, we noted that the Unit collaborates with external stakeholders and educates the community to generate referrals. However, the Unit did not report all convictions and adverse actions to Federal partners within required timeframes. Subsequent to the period of our review, the Unit implemented processes to ensure future timely reporting.

WHAT WE RECOMMEND

We recommend that the Arizona Unit update its policies and procedures manual to include the Unit's new processes for reporting convictions and adverse actions to Federal partners within required timeframes. The Unit concurred with our recommendation.

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OBJECTIVE

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

BACKGROUND

The mission of State MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.¹ 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 Currently, 49 States and the District of Columbia (States) have created such Units.³ In fiscal year (FY) 2014, combined Federal and State grant expenditures for the Units totaled \$235 million.^{4,5} That year, the 50 Units employed 1,958 individuals.⁶

Each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.⁷ Unit staff review complaints referred to the Unit and determine their potential for criminal prosecution and/or civil action. In FY 2014, the 50 Units collectively obtained 1,318 convictions and 874 civil settlements or judgments.⁸ In addition, the Units reported recoveries of approximately \$2 billion.⁹

¹ Social Security Act (SSA) § 1903(q). 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 North Dakota and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units.

⁴ All FY references in this report are based on the Federal FY (October 1 through September 30).

⁵ Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on August 3, 2015.

⁶ Ibid.

⁷ SSA § 1903(q)(6); 42 CFR § 1007.13.

⁸ OIG, *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on August 3, 2015.

⁹ Ibid.

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.¹⁰ In Arizona and 43 other States, the Units are located 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 refer cases to other offices with prosecutorial authority.¹¹ Additionally, each Unit must be a single, identifiable entity of State government, distinct from the single State Medicaid agency and must develop a formal agreement—i.e., a memorandum of understanding (MOU)—that describes the Unit’s relationship with that agency.¹²

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.¹³ All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹⁴ To receive Federal reimbursement, each Unit must submit an initial application to OIG.¹⁵ OIG reviews the application and notifies the Unit if the application is approved and the Unit is certified. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.¹⁶ In addition to annual recertification, OIG performs periodic onsite reviews of the Units.

States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁷ To clarify the criteria that OIG applies in assessing whether a Unit is effectively carrying out these functions and meeting program requirements, OIG developed and issued 12 performance standards.¹⁸ Examples of the standards include maintaining an adequate caseload through referrals from several

¹⁰ SSA § 1903(q)(1).

¹¹ OIG, *Medicaid Fraud Control Units*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp> on February 25, 2015.

¹² SSA § 1903(q)(2); 42 CFR § 1007.9(d).

¹³ The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called Federal Financial Participation.

¹⁴ SSA § 1903(a)(6)(B).

¹⁵ 42 CFR § 1007.15(a).

¹⁶ 42 CFR § 1007.15(b) and (c).

¹⁷ SSA § 1902(a)(61).

¹⁸ 77 Fed. Reg. 32645 (June 1, 2012).

sources, maintaining a training plan for all professional disciplines, and establishing policies and procedure manuals. See Appendix A for a description of each of the 12 performance standards.

Arizona Medicaid Program

Arizona's State Medicaid program provides services to Medicaid enrollees through managed care.¹⁹ Through what is known as a "section 1115 waiver," Arizona was the first State to enroll the majority of its Medicaid beneficiaries statewide in mandatory managed care.^{20, 21} As of July 2011, nearly 90 percent of Medicaid beneficiaries in Arizona were enrolled in managed care. The State Medicaid agency contracts with nine MCOs and pays them a fixed amount for Medicaid enrollees.²² In FY 2014, combined Federal and State expenditures for Arizona's Medicaid program were approximately \$9.5 billion.²³

Arizona MFCU

The Arizona Unit is housed within the criminal division of the Arizona Office of the Attorney General and operates in three locations. The Unit's headquarters is located in Phoenix, Arizona's capital. The Unit operates two subunits, located in Prescott and Tucson.

At the time of our review, the Unit employed 19 staff members including the director, the special agent supervisor, 8 special agents, 4 attorneys, 1 auditor, and 4 support staff members.

Referrals. The Unit receives referrals from a variety of sources, including the State Medicaid agency, local law enforcement, Adult Protective Services, and the State Long-Term Care Ombudsman.

¹⁹ Medicaid managed care is a type of health care delivery system that provides Medicaid health benefits and services to enrollees through contracted arrangements between State Medicaid agencies and managed care organizations (MCOs). MCOs receive a set payment per member per month from the State Medicaid agency for these services.

²⁰ The only beneficiary population that is not mandatorily enrolled into managed care is the American Indian/Alaska Native population. This population may elect to remain in Arizona's fee-for-service Medicaid program, or can elect to receive health benefits through Medicaid managed care.

²¹ States must comply with Title XIX (Medicaid) and Title XXI (Children's Health Insurance Program) of the SSA. Arizona began providing Medicaid services on October 1, 1982. Since then, the Arizona Health Care Cost Containment System—Arizona's State Medicaid agency—has been exempt from specific provisions of the SSA, pursuant to a waiver under section 1115 of the SSA.

²² Centers for Medicare & Medicaid Services (CMS), *Managed Care in Arizona*. Accessed at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-State/arizona.html> on April 30, 2015.

²³ OIG, *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on August 3, 2015.

Unit referrals by referral source for FYs 2012 through 2014 can be found in Appendix B. Generally, referrals are received by the special agent supervisor by postal mail or telephone. The special agent supervisor is responsible for obtaining information about the referral and may conduct a preliminary investigation before opening a case.

Investigations and prosecutions. When a case is opened, it is assigned to a special agent and attorney for investigation and, as appropriate, for prosecution. The Unit has statewide authority to prosecute criminal cases of Medicaid fraud and patient abuse. The Unit does not pursue civil Medicaid fraud cases, which are instead prosecuted by the State Medicaid Agency's Office of Inspector General. See Appendix C for details on investigations opened and closed.

Previous OIG Onsite Review

In 2009, OIG published a report regarding its onsite review of the Arizona Unit. OIG found that the Unit was in full compliance with all applicable Federal regulations and the 12 MFCU performance standards.

METHODOLOGY

We conducted an onsite review of the Arizona Unit in July 2015.

We based our review on 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) structured interviews with the Unit's management; (6) an onsite review of files for cases that were open in FYs 2012 through 2014; and (7) onsite observation of Unit operations.

Appendix D provides a detailed methodology.

Standards

These reviews are conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Our review of the Arizona Unit found that it was generally in compliance with applicable laws, regulations, and policy transmittals. Additionally, the Unit collaborates with external stakeholders and educates the community to generate referrals. Although we found no evidence of significant noncompliance, we identified one area for improvement. Specifically, the Unit did not report all convictions and adverse actions to Federal partners within required timeframes. However, the Unit has subsequently implemented processes to ensure future timely reporting.

For FYs 2012 through 2014, the Arizona Unit reported 185 criminal convictions and combined criminal and civil recoveries of \$4 million

For FYs 2012 through 2014, the Unit reported 185 criminal convictions. Of the Unit’s 185 convictions over the 3-year period, 135 involved provider fraud, 8 involved patient abuse and neglect, and 42 involved patient funds.

For the same period, the Unit reported combined criminal and civil recoveries of approximately \$4 million. See Table 1 for the Unit’s yearly recoveries and expenditures. The Unit obtained 55 percent of its recoveries from “global” cases during the 3-year review period.²⁴

Table 1: Arizona MFCU Recoveries and Expenditures, FYs 2012–2014*

Type of Recovery	FY 2012	FY 2013	FY 2014	3-Year Total
Global Civil	\$462,297	\$443,797	\$1,357,762	\$2,263,856
Nonglobal Civil	\$0	\$0	\$0	\$0
Criminal	\$880,288	\$645,915	\$301,869	\$1,828,073
Total Recoveries	\$1,342,585	\$1,089,713	\$1,659,631	\$4,091,929
Total Expenditures	\$1,634,293	\$1,806,079	\$2,037,742	\$5,478,114

Source: OIG analysis of Unit-submitted documentation, 2015.

* Due to rounding, dollar figures for each category of recoveries do not always sum to the total recovery amount for that category.

²⁴ “Global” cases are civil false claims actions involving the U.S. Department of Justice and other State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases.

The Arizona Medicaid program provides and pays for services through MCOs.²⁵ Accordingly, the Unit has significant experience investigating and prosecuting matters involving managed care settings. Matters that the Unit investigates include falsified identities, double billing, falsified prescriptions, and elder abuse, which are similar to matters that might be investigated by other State MFCUs.

According to the Unit, part of the reason it has been able to successfully investigate and prosecute matters involving managed care is that the Unit does not focus on the payer involved in each case. The Unit director said, “A crime is a crime regardless of whether it occurred in a managed care or a fee-for-service setting.” As a result, the Unit does not make a distinction between managed care cases and fee-for-service cases. Rather, the Unit focuses on investigating and prosecuting the case and relies on the State Medicaid agency to calculate restitution, which is equivalent to the amount falsely billed by the provider.²⁶

Almost all case files contained documentation of supervisory approval to open and close cases as well as of periodic supervisory review

The Unit documented supervisory approval to open 100 percent of cases and to close 99 percent of closed cases. According to Performance Standard 5(b), Unit supervisors should approve the opening and closing of cases to ensure continuous case flow and timely completion of cases. Supervisory approval to open and close cases demonstrates that Unit supervisors are monitoring the intake of cases and the timeliness of case resolutions.

The Unit’s policy requires that supervisory reviews occur on a quarterly basis (i.e., every 90 days), and our review found that 94 percent of cases contained documentation indicating such review. According to Performance Standard 7(a), supervisory reviews should be conducted periodically and noted in the case file. Appendix E

²⁵ Nearly all of Arizona’s Medicaid enrollees receive services through MCOs. The only population that is not mandatorily enrolled into managed care is the American Indian/Alaska Native population.

²⁶ Once the State Medicaid agency calculates the restitution, it reports the billing information to the Unit. Using this information, the Unit pursues a restitution order against the provider as part of the resolution of its case. After the conclusion of the Unit’s case, the State Medicaid agency pursues a separate civil recoupment action, which may include civil forfeitures.

contains the point estimates and 95-percent confidence intervals for these statistics.

The Unit did not report all convictions and adverse actions to Federal partners within required timeframes; however, the Unit has subsequently implemented processes to ensure future timely reporting

The Unit did not report all convictions to OIG for the purpose of program exclusion or all adverse actions to the National Provider Data Bank (NPDB) within the required timeframes; however, the Unit has subsequently implemented new processes to ensure that future convictions and adverse actions are reported to these Federal partners within the required timeframes. According to Performance Standard 8(f), the Unit should transmit to OIG reports of all convictions for the purpose of exclusion from Federal health care programs within 30 days of sentencing. Additionally, Federal regulations require that for any adverse actions generated as a result of investigations or prosecutions of healthcare providers, Units must report the action to the NPDB within 30 days.²⁷

Eighty-one percent of the Unit's convictions were not reported to OIG for the purpose of program exclusion within the required timeframe

The Unit reported all 185 of its convictions to OIG for the purpose of program exclusion; however, 81 percent (150 of 185) of the Unit's convictions were not reported within 30 days of sentencing. Of the convictions that were not reported timely, 119 were reported over 120 days after sentencing, 8 were reported within 91 to 120 days of sentencing, and 23 were reported within 31 to 90 days of sentencing. If a Unit fails to ensure that convicted individuals are referred for

²⁷ Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. See 45 CFR § 60.5. In addition to Federal regulations, the Performance Standards also require Units to report to NPDB. Performance Standard 8(g) states that the Unit should report "qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases." 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. We reviewed the reporting of adverse actions under NPDB requirements because the HIPDB and the NPDB were merged during our review period (FYs 2012 through 2014). 78 Fed. Reg. 20473 (April 5, 2013).

exclusion, those individuals may be able to continue to submit claims and receive payments from Federal health care programs.

The Unit reported that staff turnover contributed to the Unit's not submitting records of convictions to OIG for the purpose of program exclusion. The Unit said that it notified OIG of this issue in December 2013 and worked with OIG for approximately 6 months to submit all records of convictions.

Seventy percent of the Unit's adverse actions were not reported to the NPDB within the required timeframe

The Unit reported all 109 adverse actions to the NPDB; however, 70 percent (76 of 109) were not reported within 30 days of the action. Of the adverse actions that were not reported timely, 66 were reported over 90 days after the action; 4 were reported within 61 to 90 days of the action; and 6 were reported within 31 to 60 days of the action. The Unit said that—as with reporting convictions to OIG for program exclusion—staff turnover contributed to these delays.

The Unit has implemented new processes to ensure future timely reporting to Federal partners

In May 2015, the Unit implemented new processes to ensure that convictions are reported to OIG and adverse actions are reported to the NPDB within the required timeframes. Such processes include (1) providing a memorandum to Unit support staff outlining a timeline for reporting convictions and adverse actions, (2) creating a “tickler” calendar to remind staff to collect and prepare conviction information for submission to OIG and report adverse actions to the NPDB, (3) providing staff with a copy of OIG's presentation on the exclusion program and the Health Resources and Services Administration's presentation on NPDB reporting, (4) including conviction and adverse action reporting as part of the Unit's checklist for case closing, and (5) an ongoing reminder at each staff meeting to report convictions and adverse actions within the required timeframes.

Other observation: The Unit collaborates with external stakeholders and educates the community to generate referrals

The Unit collaborates with the State Medicaid agency and MCOs to ensure that they provide quality referrals to the Unit. The Unit director reported that Unit staff attend quarterly compliance-officer meetings held between the State Medicaid agency and the MCOs. These meetings are led by the State Medicaid agency and include

representation from all of the State's contracted MCOs. The Unit director said that these meetings give the Unit an opportunity to provide guidance as to what constitutes a quality referral and the types of referrals that will result in opening a case for investigation. For FYs 2012 through 2014, the Unit reported that it opened 19 cases for criminal investigation as a result of referrals provided by the State Medicaid agency. Of these 19 cases, 13 involved referrals originating from MCOs.

To help generate referrals, the Unit also educates the community about the Unit's role in investigating and prosecuting cases of Medicaid fraud and patient abuse. The actions the Unit takes to educate the community include providing training to Adult Protective Services and distributing MFCU manuals regarding fraud and elder abuse to law enforcement and community advocacy organizations. The Unit director reported that providing training connects the Unit to the community, and as a result, helps generate cases.

CONCLUSION AND RECOMMENDATION

For FYs 2012 through 2014, the Arizona Unit reported 185 criminal convictions, 4 civil judgments and settlements, and combined criminal and civil recoveries of \$4 million.

Our review found that the Unit was in general compliance with applicable laws, regulations, and policy transmittals. However, we identified one area for improvement in the Unit's operations. Specifically, we found that for FYs 2012 through 2014, the Unit did not report all convictions and adverse actions to Federal partners within required timeframes. Subsequent to the period of review, the Unit implemented processes to ensure future timely reporting.

We recommend that the Arizona Unit:

Update its policies and procedures manual to include the Unit's new processes for reporting convictions and adverse actions to Federal partners within required timeframes

The Unit has implemented new processes to ensure that convictions are reported to OIG and adverse actions are reported to the NPDB within the required timeframes. The Unit should update its policies and procedures manual to include the new processes to ensure that convictions are reported to OIG within 30 days and that adverse actions are reported to the NPDB within 30 days.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Arizona Unit concurred with our recommendation. The Unit stated that it has already implemented processes to ensure that convictions are reported to OIG within 30 days of sentencing and adverse actions are reported to the NPDB within 30 days of the final action. The full text of the Unit's comments is provided in Appendix F.

APPENDIX A

2012 Performance Standards²⁸

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.

²⁸ 77 Fed. Reg. 32646, (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 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 <i>CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit</i> .
11. A UNIT EXERCISES PROPER FISCAL CONTROL OVER UNIT RESOURCES.
A. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.
B. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.
C. The Unit maintains an effective time and attendance system and personnel activity records.
D. The Unit applies generally accepted accounting principles in its control of Unit funding.
E. The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.
12. A UNIT CONDUCTS TRAINING THAT AIDS IN THE MISSION OF THE UNIT.
A. The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.
B. The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.
C. Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.
D. The Unit participates in MFCU-related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.
E. The Unit participates in cross-training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

APPENDIX B

Arizona State Medicaid Fraud Control Unit Referrals by Referral Source for FYs 2012 Through 2014

Referral Source	FY 2012			FY 2013			FY 2014		
	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Funds
Medicaid agency – PI/SURS ²⁹	5	0	2	7	0	0	6	1	1
Medicaid agency – other	0	0	0	0	0	0	2	1	0
Managed care organizations	0	0	0	0	0	0	0	0	0
State survey and certification agency	3	2	4	3	1	4	3	2	1
Other State agencies	0	1	0	1	0	1	4	4	1
Licensing board	2	1	1	3	1	0	1	0	0
Law enforcement	40	6	8	19	4	14	27	6	3
Office of Inspector General	4	0	0	11	1	3	7	0	1
Prosecutors	11	0	1	20	0	0	4	0	0
Providers	4	2	1	8	1	1	4	0	2
Provider associations	0	0	0	0	0	0	0	0	0
Private health insurer	0	0	0	0	0	0	0	0	0
Long-term-care ombudsman	0	0	0	0	0	0	0	0	0
Adult protective services	2	0	1	0	0	0	0	5	3
Private citizens	2	1	1	0	0	0	4	2	1
MFCU hotline	0	0	0	0	0	0	0	0	0
Self-generated	0	0	0	0	0	0	0	0	1
Other	5	1	0	2	2	0	11	0	1
Total	78	14	19	74	10	23	73	21	15
Annual Total	111			107			109		

Source: OIG analysis of Unit-submitted documentation, 2015.

²⁹ The abbreviation “PI” stands for program integrity; the abbreviation “SURS” stands for Surveillance and Utilization Review Subsystem.

APPENDIX C

Investigations Opened and Closed By Provider Category for FYs 2012 Through 2014

Table C-1: Fraud Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Facilities						
Hospitals	0	0	2	0	0	0
Nursing facilities	0	0	1	0	1	0
Other long-term-care facilities	1	1	3	0	6	2
Substance abuse treatment centers	0	0	0	0	0	0
Other	3	1	4	0	3	2
Subtotal	4	2	10	0	10	4
Practitioners						
Doctors of medicine or osteopathy	5	5	8	3	11	10
Dentists	1	0	3	0	0	0
Podiatrists	0	0	0	1	0	1
Optometrists/opticians	0	1	0	0	0	0
Counselors/psychologists	0	3	0	0	0	0
Chiropractors	0	0	0	0	0	0
Other	3	1	10	2	2	4
Subtotal	9	10	21	6	13	15
Medical Support						
Pharmacies	2	2	1	1	3	0
Pharmaceutical manufacturers	10	3	9	0	2	0
Suppliers of durable medical equipment and/or supplies	0	0	1	0	1	0
Laboratories	0	0	0	0	0	0
Transportation services	0	1	1	0	2	1
Home health care agencies	3	1	0	0	3	0
Home health care aides	5	2	10	3	9	14
Nurses, physician assistants, nurse practitioners, certified nurse aides	6	4	6	1	3	6
Radiologists	2	0	0	0	1	1
Medical support—other	27	16	21	9	23	40
Subtotal	55	29	49	14	47	62

Table C-1 (Continued): Fraud Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Managed care organizations	0	1	0	0	0	0
Medicaid program administration	0	0	0	0	1	0
Billing company	0	0	0	0	0	0
Other	1	0	1	0	2	0
Subtotal	1	1	1	0	3	0
Total Provider Categories	69	42	81	20	73	81

Source: OIG analysis of Unit-submitted documentation, 2015.

Table C-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing facilities	1	1	3	0	0	3
Other long-term-care facilities	1	0	3		8	4
Nurses, physician assistants, nurse practitioners, certified nurse aides	4	0	1	0	1	3
Home health aides	5	0	2	0	9	7
Other	3	0	1	2	3	1
Total	14	1	10	2	21	18

Source: OIG analysis of Unit-submitted documentation, 2015.

Table C-3: Patient Funds Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nondirect care	2	0	1	0	1	0
Nurses, physician assistants, nurse practitioners, certified nurse aides	3	1	4	0	1	1
Home health aides	0	0	0	0	2	0
Other	14	8	18	3	11	12
Total	19	9	23	3	15	13

Source: OIG analysis of Unit-submitted documentation, 2015.

APPENDIX D

Detailed Methodology

Data collected from the seven sources below was used to describe the caseload and assess the performance of the Arizona MFCU.

Data Collection

Review of Unit Documentation. We collected information for FYs 2012 through 2014 regarding the Unit's investigation of Medicaid cases, including information about the number of referrals the Unit received, the number of investigations the Unit opened and closed, the outcomes of those investigations, and the Unit's case mix. We also collected and analyzed information about the number of cases that the Unit referred for prosecution and the outcomes of those prosecutions.

We gathered information from several sources, including the Unit's quarterly statistical reports; annual reports; recertification questionnaire; policies and procedures manual; and MOU with the State Medicaid agency. Additionally, we confirmed with the Unit director that the information we had was current as of June 2015.

Review of Unit Financial Documentation. We reviewed the Unit's control over its fiscal resources to identify any internal control issues or other issues involving use of resources. Prior to the onsite review, we reviewed the Unit's financial policies and procedures; its response to an internal control questionnaire; and documents (such as financial status reports) related to MFCU grants.

We reviewed three purposive samples to assess the Unit's internal control of fiscal resources. All three samples were limited to the review period of FYs 2012 through FY 2014. The three samples included the following:

1. To assess the Unit's expenditures, we selected a purposive sample of 24 items from the Unit's 1,316 expenditure transactions. We selected routine and nonroutine transactions representing a variety of budget categories and payment amounts.
2. To assess the Unit's travel expenditures, we selected a purposive sample of 24 items from the Unit's 153 travel transactions. We selected a variety of travel expenditure categories related to both in-State and out-of-State travel, such as hotel stays, airfare, and conference expenses.
3. To assess employees' "time and effort"—i.e., their work hours spent on various MFCU tasks—we selected a sample

of three pay periods, one from each fiscal year. We then requested and reviewed documentation (e.g., time card records) to support the time and effort of the MFCU staff during the selected pay periods.

We also reviewed a purposive sample of the Unit's supply inventory, including vehicles. Specifically, we selected and verified a purposive sample of 23 items from the current inventory list of 82 items maintained in the Unit's Phoenix office. 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. In June 2015, we interviewed key stakeholders, including officials in the United States Attorneys' Offices, the State Attorney General's Office, and other State agencies that interacted with the Unit (e.g., the Medicaid Program Integrity Unit, the Office of the State Long-Term Care Ombudsman, and Adult Protective Services). Additionally, we interviewed two managed care health plans that interact with the Unit. We also interviewed supervisors from OIG's Region IX offices who work regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities, and we identified opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Survey of Unit Staff. In June 2015, we conducted an online survey of all 17 nonmanagerial Unit staff within each professional discipline (e.g., investigators, auditors, and attorneys) as well as support staff. The response rate was 100 percent. Our questions focused on operations of the Unit, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Onsite Interviews with Unit Management. We conducted structured interviews with the Unit's management in July 2015. We interviewed the Unit director and the special agent supervisor. We asked these individuals to provide information related to (1) the Unit's 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, and (4) clarification regarding information 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 480 cases that were open during this period. For each of these 480 cases, the Unit provided data including the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened. From this list of cases, we excluded 68 cases that were categorized as “global” and 1 case that had been closed prior to the period of our review and thus should not have been included in the list. The remaining number of cases was 411.

From these 411 cases, we selected a simple random sample of 100 cases for review. From the initial sample of 100 case files, we selected a simple random sample of 50 files for a more indepth review of selected issues, such as the timeliness of investigations and case development.

One case in our sample of 100 was not reviewed. This case was mislabeled by the Unit as a criminal fraud case; however, it was a global case and therefore ineligible to be in the sample. After excluding the ineligible case, we reviewed 99 case files total, of which 86 were for closed cases and 96 were for cases that had been open for longer than 90 days.

Because there was 1 ineligible case in the 100 sampled cases, it is possible that there could be other ineligible cases in the population. Therefore, we estimated the number of cases in the population based on the eligible sample, as shown in Table D-1. We estimated (1) the total number of eligible cases, (2) the number of eligible closed cases, and (3) the number of eligible cases that were open longer than 90 days.

Table D-1: Estimates of the Population of Eligible Cases

Estimate Description	Sampled Cases	Population of Eligible Cases	95-Percent Confidence Interval
Total eligible cases	99	407	390–410
Eligible closed cases	86	353	323–376
Eligible cases open longer than 90 days	96	395	373–406

Source: OIG analysis of Arizona MFCU case files, 2015.

Using the results of our review of the sampled cases, we reported one estimate for each of the above eligible populations. The point

estimates and their 95-percent confidence intervals are in Appendix E.

Onsite Review of Unit Operations. During our July 2015 onsite visit, we reviewed the Unit's workspace and operations. Specifically, we visited the Unit headquarters in the State capital. While onsite, we observed the Unit's offices and meeting spaces; security of data and case files; location of select equipment; and the general functioning of the Unit.

Data Analysis

We analyzed data to identify any opportunities for improvement and any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.³⁰

³⁰ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu>.

APPENDIX E

Point Estimates and 95-Percent Confidence Intervals Based on Reviews of Case Files

Estimate	Sample Size*	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of case files that included documentation of supervisory approval for opening	99*	100.0%	96.6%	100.0%
Percentage of closed case files that included documentation of supervisory approval for closing	86	98.8%	94.3%	99.7%
Percentage of files for cases that were open longer than 90 days that included documentation of periodic supervisory review	96	93.8%	87.6%	97.5%

*One sampled case file was ineligible to be in the sample. This case was mislabeled as a criminal fraud case; however, it was a global case.

Source: OIG analysis of Arizona MFCU case files, 2015.

APPENDIX F

Unit Comments



MARK BRNOVICH
ATTORNEY GENERAL

OFFICE OF THE ARIZONA ATTORNEY GENERAL
CRIMINAL DIVISION

November 30, 2015

Jordan R. Clementi, J.D.
Program Analyst
Office of Inspector General
Office of Evaluations and Inspections
US. Department of Health and Human Services
1201 Walnut Street, Suite 934
Kansas City, MO 64106

Re: Arizona Medicaid Fraud Control Unit Onsite Review

Dear Ms. Clementi:

The Arizona Medicaid Fraud Control Unit is in full agreement with the HHS –OIG 2015 Onsite Review Preliminary Report including the single area you identified for improvement. As noted in your report, we have already implemented the processes to ensure that in every case where a defendant we have charged has been found guilty of a crime, notification will be transmitted to both HHS-OIG and the National Practitioner Data Bank within 30 days of sentencing.

I will be sharing your final report with all of the staff of the MFCU because it was their hard work and dedication which truly is the basis for your findings and observations as detailed in your report. We are particularly proud of the significant number of defendants our Unit prosecutes and convicts. Your Executive Summary noted that our Unit convicted a total of 185 offenders for FYs 2012 through 2014. On this crucial metric, our Unit has consistently been a top nationwide performer. In fact, for the three year audit period, our Unit as compared to the other 49 MFCU's, had the second highest number of convictions when comparing Unit size.

I would like to express my heartfelt appreciation for the professional work your audit group performed during the onsite review. You can be assured of our continued cooperation with your agency and our continued commitment to deliver the highest standard of service for our citizens.

1275 WEST WASHINGTON, PHOENIX, AZ 85007 • 602.542.3881 • WWW.AZAG.GOV

Sincerely,

/S/

Steven J. Duplissis, J.D.
Director and Chief Counsel
Health Care Fraud and Abuse Section
SJD:as

#4750229

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Rae Hutchison served as the project leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Dennis Tharp. Office of Investigations staff also participated in the review. Central office staff who provided support include Jordan R. Clementi, Kevin Farber, Lonie Kim, and Christine Moritz.

Office of Inspector General

<http://oig.hhs.gov>

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