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Missouri Medicaid Fraud Control Unit: 2018 Onsite Inspection

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Report in Brief
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What OIG Found

The Missouri Medicaid Fraud Control Unit (MFCU or Unit) reported 48 indictments; 45 convictions; 43 civil settlements and judgments; and $42.1 million in recoveries for fiscal years (FYs) 2016–18. From the information we reviewed, we found that the Unit generally operated in accordance with applicable laws, regulations, and policy transmittals. However, we made four findings involving the Unit's adherence to the MFCU performance standards, one of which also involved compliance with Federal regulations:

1. Unit case files did not include all relevant facts, information, and significant documents.

2. The Unit lacked a policy requiring a specific frequency for periodic supervisory reviews.

3. The Unit did not report all convictions and adverse actions to Federal partners.

4. The Unit's training plan did not include an annual minimum number of training hours for Unit investigators.

In addition to the findings, we made a number of observations regarding Unit operations and practices. For example, we highlight an observation regarding Unit staffing and a beneficial practice that may be of interest to other MFCUs, as follows:

- The Unit experienced significant turnover among management and staff.

- The Unit created in-house training videos to assist staff in Unit investigations and trials.

What OIG Recommends

To address the four findings, we recommend that the Unit take steps to (1) ensure that Unit case files include all relevant facts, information, and significant documents; (2) revise the Unit's policies and procedures manual to include a specific frequency for conducting periodic supervisory review of Unit case files, and take steps to ensure that case files include documentation of periodic supervisory reviews; (3) ensure that the Unit consistently reports convictions and adverse actions to Federal partners; and (4) establish training-hour requirements for Unit investigators and ensure that all investigators receive annual training. The Unit concurred with all four recommendations.

Full report: oig.hhs.gov/oei/reports/oei-12-18-00490.asp

Unit Case Outcomes

FYs 2016–18

- 48 indictments
- 45 convictions
- 43 civil settlements and judgments
- $42.1 million in recoveries with $25.5 million from "global"* civil cases, $4.1 million from nonglobal civil cases, and $12.5 million from criminal cases

Unit Snapshot

The Unit is a division of the Missouri Attorney General's Office.

At the time of OIG's onsite inspection, the Unit had 21 staff located in its single office location in Jefferson City, Missouri.

*"Global" recoveries derive from civil settlements or judgments involving the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

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BACKGROUND

Objective

To examine the performance and operations of the Missouri Medicaid Fraud Control Unit

Medicaid Fraud Control Units

Medicaid Fraud Control Units (MFCUs or Units) investigate (1) Medicaid provider fraud and (2) patient abuse or neglect in facility settings, and prosecute those cases under State law or refer them to other prosecuting offices.[1, 2] Under the Social Security Act (SSA), a MFCU must be a "single, identifiable entity" of State government, "separate and distinct" from the State Medicaid agency, and employ one or more investigators, attorneys, and auditors.[3] Each State must operate a MFCU or receive a waiver.[4] Currently, 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate MFCUs.[5] Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.[6] In Federal fiscal year (FY) 2018, combined Federal and State expenditures for the Units totaled approximately $294 million.[7]

[1] SSA § 1903(q)(3). Regulations at 42 CFR § 1007.11(b)(1) clarify that the Unit's responsibilities include the review of complaints of misappropriation of patients' private funds in health care facilities.

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

[3] SSA § 1903(q).

[4] SSA § 1902(a)(61).

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

[6] SSA § 1903(a)(6). For a Unit's first 3 years of operation (currently applicable to North Dakota, Puerto Rico, and the U.S. Virgin Islands), the Federal Government contributes 90 percent of funding, and the State contributes 10 percent. Thereafter, the Federal Government contributes 75 percent, and the State contributes 25 percent.

[7] Office of Inspector General analysis of FY 2018 MFCU annual statistical reporting data. Federal FY 2018 was from October 1, 2017, through September 30, 2018.

OIG Grant Administration and Oversight of Medicaid Fraud Control Units

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.[8, 9] As part of its oversight, OIG reviews and recertifies each Unit annually and conducts periodic onsite reviews or inspections, such as this inspection.

In its recertification review, OIG examines the Unit's reapplication, case statistics, and questionnaire responses from the Unit's stakeholders. Through the recertification review, OIG assesses a Unit's performance, as measured by the Unit's adherence to published performance standards;[10] the Unit's compliance with applicable laws, regulations, and OIG policy transmittals;[11] and the Unit's case outcomes. (See Appendix A for MFCU performance standards, including performance indicators for each standard.)

OIG further assesses Unit performance by conducting onsite Unit reviews or inspections that may identify findings and make recommendations for improvement. During an onsite review or inspection, OIG also makes observations regarding Unit operations and practices, and may identify beneficial practices that may be useful to share with other Units. Finally, OIG provides training and technical assistance to Units while onsite, as appropriate, and on an ongoing basis.

Missouri Medicaid Fraud Control Unit

The Missouri MFCU is located in Jefferson City and is part of the Missouri Attorney General's Office. At the time of our November 2018 review, the Unit employed 5 attorneys, 1 of whom was the director; 11 investigators (including a chief investigator who served as the Unit's liaison with Federal agencies regarding joint investigations); 1 auditor; 1 data analyst; 1 program analyst; and 2 legal secretaries. During our review period of FYs 2016 through 2018, the Unit spent $6,872,579 ($1,718,145 State share).

Referrals. The chief investigator reviews all referrals received by the Unit. After a preliminary review to determine whether the allegations are within the Unit's grant authority and are supported by claims data, the chief investigator, senior investigator, and director confer to determine whether the Unit should open an investigation.

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

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

[10] MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012).

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

Investigations and Prosecutions. Unit management assigns at least one attorney and investigator to each open case. The Unit's auditor is assigned to cases involving financial records and patient funds.

The Missouri MFCU investigates and prosecutes (or refers for prosecution) cases of suspected Medicaid fraud. Additionally, the Unit may prosecute violations of State laws related to the abuse, neglect, or exploitation of adults in health care facilities.

The Unit may prosecute criminal and civil cases in State and Federal court. The Unit may prosecute criminal cases in State court by the county attorney's authority or when the county attorney declines to respond to a referral from the Unit.[12] The Unit may pursue civil cases in State court under the State false claims statute.[13] The Unit may also prosecute criminal and civil cases in Federal court. The Unit may pursue those cases in collaboration with, or by referral to, the Missouri U.S. Attorney's Offices.

Missouri Medicaid Program

MO HealthNet. The Missouri Medicaid program, MO HealthNet, provides care to 819,296 beneficiaries.[14] Missouri contracts with three managed care organizations (MCOs) to coordinate health care services for 72 percent of Missouri's Medicaid beneficiaries.[15] In FY 2018, total Missouri Medicaid expenditures were $10.7 billion.[16]

Prior OIG Report

OIG conducted a previous onsite review of the Missouri Unit in 2011. In that review, OIG found that (1) the Unit did not establish annual training plans for the professional disciplines; (2) one-third of case files were missing documented supervisory approval for the opening of investigations, but only 1 percent of the closed case files did not include documented supervisory approval for case closure; (3) only 3 percent of case files

[12] Mo. Rev. Stat. § 191.910 (2005). In addition to the report of violation, the Unit also generally provides the county prosecutor with a binder containing an investigative summary, a draft probable cause statement, potential charges, witness statements, and a list of all discoverable material and supporting evidence.

[13] Mo. Rev. Stat. § 191.905 (2017).

[14] Centers for Medicare & Medicaid Services, *May 2019 Medicaid & CHIP Enrollment Data Highlights*, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[15] Missouri Department of Social Services, *MO HealthNet Managed Care Health Plan Options,* https://dss.mo.gov/mhd/participants/mc/managed-care-health-plan-options.htm. Accessed on August 22, 2019. Beneficiaries who are aged, blind, or disabled (including beneficiaries with developmental disabilities) are not included in the managed care system and continue to receive Medicaid fee-for-service provisions through the MO HealthNet program.

[16] OIG, *MFCU Statistical Data for FY 2018*, available at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2018-statistical-chart.pdf.

contained any documentation of periodic supervisory reviews; and (4) Unit practices left case files vulnerable to unauthorized access.[17]

OIG recommended that the Unit (1) establish annual training plans for professional disciplines; (2) ensure that case files contain documented supervisory approval to open the case; (3) document periodic supervisory reviews; and (4) ensure that case files are not vulnerable to unauthorized access.

In response to the recommendations, the Unit (1) implemented a training plan for all professional disciplines; (2) developed a case opening form to ensure that case openings were approved by a Unit supervisor and documented in Unit case files; (3) developed a periodic supervisory review form to ensure that periodic supervisory reviews were documented in Unit case files; and (4) implemented policies and procedures for ensuring that all Unit case files be kept in secure locations. Based on information received from the Unit, OIG considered the recommendations implemented.

Methodology

OIG conducted the onsite inspection of the Missouri MFCU in November 2018. Our review covered the 3-year period of FYs 2016 through 2018. We based our inspection on an analysis of data and information from 7 sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's managers; (5) a review of a simple random sample of 86 case files that were open at some point during the review period; (6) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (7) observation of Unit operations. (See Appendix B for a detailed methodology.) In examining the Unit's operations and performance, we applied the published performance standards in Appendix A, but we did not assess adherence to every performance indicator for every standard.

Standards

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

[17] OIG, *Missouri State Medicaid Fraud Control Unit: 2011 Onsite Review*, available at https://oig.hhs.gov/oei/reports/oei-07-11-00750.pdf on February 1, 2019.

PERFORMANCE ASSESSMENT

In assessing the performance and operations of the Missouri Unit, OIG identified the Unit's case outcomes; found that the Unit generally complied with legal and policy requirements; and made findings and observations regarding the Unit's adherence to each of the performance standards, including highlighting a beneficial practice designed to assist staff in investigations and trials. OIG also provided recommendations to improve the Unit's operations.

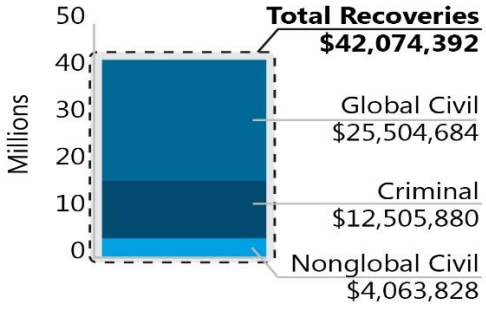
CASE OUTCOMES

Observations

The Unit reported 48 indictments; 45 convictions; and 43 civil settlements and judgments for FYs 2016 through 2018. Of the 45 convictions, 41 convictions involved provider fraud and 4 involved patient abuse or neglect.

The Unit reported total recoveries of $42.1 million for FYs 2016 through 2018. (See Exhibit 1 for the sources of those recoveries.)

Exhibit 1: The Unit reported combined civil and criminal recoveries of $42.1 million (FYs 2016–18).



Source: OIG analysis of Unit statistical data from FYs 2016–18.

Note: "Global" civil recoveries derive from civil settlements or judgments in "global" cases, which are cases that involve the U.S. Department of Justice and a group of State MFCUs and that are facilitated by the National Association of Medicaid Fraud Control Units.

STANDARD 1	A Unit conforms with all applicable statutes, regulations, and policy directives.

Observation

From the information we reviewed, the Missouri Unit generally complied with applicable laws, regulations, and policy transmittals. However, we identified one compliance concern related to the Unit's reporting of adverse actions to Federal partners, as explained under Performance Standard 8 below.

STANDARD 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.

Observations

The Unit's staff levels were low in relation to the State's Medicaid program expenditures. The Missouri Unit employed 22 staff at the end of FY 2018. In FY 2018, Missouri's State Medicaid expenditures were $10.7 billion. OIG observed that the size of the Unit was low compared to all other Units, as measured by Medicaid program expenditures.[18] Despite the low number of Unit staff, OIG did not specifically observe that the number of staff negatively affected Unit operations.

OIG also observed that the Unit's staffing level remained generally consistent during the review period, with 24 staff at the end of FYs 2016 and 2017 and 22 staff at the end of FY 2018. Those numbers were generally consistent with, but slightly less than, the numbers of staff approved in the Unit's budget.

The Unit experienced significant turnover among management and staff. Although total staff levels remained relatively consistent during the review period, the Unit experienced significant staff turnover. During the 3-year review period, 22 employees left the Unit, including the director and deputy director.

Two Unit managers attributed the high turnover to the low salaries available to Missouri State employees, explaining that many experienced staff left the Unit for more competitive salaries in the private sector. One manager described the turnover as "beyond the MFCU's control."

Unit managers spoke to us about the challenges associated with the high turnover. One manager stated that because of the turnover, Unit management assigned more cases to the Unit's more experienced

[18] Although 22 staff were on board at the end of FY 2018, the Missouri Unit was approved for 28 staff. Both the Unit's actual staff level and approved staff level were low compared to State Medicaid expenditures.

investigators because the Unit's newer investigators were not yet prepared to investigate complicated Medicaid cases. For example, the Unit's chief investigator had to divert his attention from supervisory duties to focus his time on two cases assigned to him during the review period. The manager also stated that once some Unit employees were sufficiently trained in Unit work, they often left the Unit for other agencies or offices. Further, the manager reported that the turnover affected the timeliness of Unit investigations. Another manager said that the turnover affected the Unit's relationship with Federal partners because it was difficult for Federal investigators to establish relationships with Unit investigators when they so frequently left the Unit.

STANDARD 3	A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.

Observation

The Unit maintained written policies and procedures. The Unit maintained a Medicaid Fraud Control Unit Procedures Manual that was available to Unit staff on the shared network drive. The manual contained specific guidelines for Unit operations and casework. The manual was updated in 2018.

STANDARD 4	A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

Observation

The Unit took steps to maintain an adequate volume and quality of referrals. To encourage incoming referrals, the Unit engaged in several outreach and collaborative efforts with prosecutors and law enforcement agencies across the State. For example, the Unit:

- Participated in a working group with the State Medicaid agency and the Missouri MCOs. The working group provided Unit managers with an opportunity to discuss potential case referrals arising in managed care settings with the State Medicaid agency and MCOs.
- Attended quarterly Law Enforcement Intelligence Sharing meetings coordinated by the U.S. Attorney's Office for the Western District of Missouri. These meetings allowed the Unit to share health care fraud information with local, State, and Federal law enforcement officers and to encourage these agencies to contact the Unit with information related to Medicaid fraud.
- Participated in health care task force groups in the Eastern and Western Districts of Missouri. The Unit exchanged information about emerging areas of fraud and recent fraud investigations with other members of

the task force groups, such as Assistant U.S. Attorneys, Federal Bureau of Investigation agents, OIG agents, and State Medicaid agency staff.

The Unit received a steady number of referrals, amounting to 1,335 total referrals during the review period. Of the 1,335 total referrals, 814 involved allegations of fraud, and the Unit opened 232 of these as active investigations. The primary sources of fraud referrals to the Unit during the review period were private citizens, the State Medicaid agency, and providers. The remaining 521 referrals received during the review period involved allegations of patient abuse or neglect. The Unit opened 46 of these as active investigations. The primary sources of patient abuse or neglect referrals to the Unit during the review period were private citizens, the State survey and certification agency, and other law enforcement. Appendix C identifies Unit referrals by source for FYs 2016 through 2018.

STANDARD 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.

Observations

The Unit took steps to maintain a continuous case flow and to complete cases within an appropriate timeframe. To maintain a continuous case flow and complete cases within an appropriate timeframe, the Unit director met monthly with the Unit attorneys, as a group, to review the status of cases. Additionally, the Unit director met monthly with the Deputy Attorney General for Criminal Litigation to set and update Unit priorities and to discuss the progression of the Unit's priority cases.

All case files contained documentation of supervisory approval to open the cases, and all closed case files contained documentation of supervisory approval to close the cases. While examining the Unit's case flow, we also reviewed case files for documentation of supervisory approval to open and close cases. According to Performance Standard 5(b), supervisors should approve the opening and closing of all investigations. Our review found that all case files contained supervisory approval of case opening, and all closed case files contained supervisory approval of case closing.[19]

[19] See Appendix D for further details on point estimates of the case file reviews.

STANDARD 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.

Observation

The Unit's caseload included both fraud cases and patient abuse or neglect cases, covering a broad mix of provider types. Of the 523 cases that were open during our review period, 88 percent (461 cases) involved provider fraud and 12 percent (62 cases) involved patient abuse or neglect. During the review period, the Unit's cases covered 45 provider types, including medical doctors, home health care providers, pharmaceutical manufacturers, and residential and nonresidential facilities.

STANDARD 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.

Findings

Unit case files did not include all relevant facts, information, and significant documents. According to Performance Standard 7(b) and (c), case files should include all relevant facts, information, and significant documents. The Unit used a case management system that it developed in house to record information about the Unit's investigations and to track Unit performance data. While reviewing the Unit's case files, OIG found it difficult to locate documents such as interview notes and investigative summaries in Unit case files. OIG was unable to locate interview summaries in 21 percent of the Unit's case files. OIG found that important documents that should have been contained in the case file were instead stored in other locations, such as investigators' email files or electronically in folders on the Unit's shared drive.

Additionally, instead of creating a single case file for cases with multiple defendants, in some cases, the Unit created an individual case file for each defendant. This practice of relying on multiple case files (instead of, for example, creating a single file for a case with subfiles for each of the defendants) made it difficult to locate all significant documents in the sampled case files. For example, OIG found that in cases involving multiple defendants, some documents were stored in only one defendant's case file and not in the case files for the other defendants.[20]

The Unit lacked a policy requiring a specific frequency for periodic supervisory reviews. According to Performance Standard 7(a), reviews by supervisors should be conducted periodically, consistent with the Unit's

[20] Unit management explained that they were in the process of revising the Unit's case-numbering conventions to identify multiple defendants involved in the same cases.

policies and procedures, and should be noted in the case file. The Unit's procedures manual stated: "Investigative teams will periodically meet with the Senior Investigator, Chief Investigator, Deputy Director and/or Director to discuss the status of open cases. These supervisory case reviews will be documented regularly."

The Unit's procedures manual did not include a specific frequency for periodic supervisory case reviews, which made it difficult for OIG to determine whether the Unit complied with its policy. To assess whether the Unit was complying with its policy, we asked the Unit director how the periodic supervisory review requirement was applied. The Unit director informed OIG that supervisors reviewed the Unit's case files "approximately quarterly." Because the Unit's policy lacked a specific frequency for periodic supervisory reviews and because the Unit director informed OIG that Unit supervisors conducted the reviews "approximately quarterly," we chose to review Unit case files open longer than 90 days to determine whether they contained documentation of quarterly supervisory reviews. We found that 43 percent of case files open longer than 90 days lacked documentation of one or more periodic supervisory reviews. Some case files contained no documentation of supervisory reviews or contained gaps of 2 years or more with no supervisory reviews documented in the file.[21]

Periodic supervisory reviews provide supervisors and investigators the opportunity to discuss the status of and next steps for Unit investigations. The reviews also serve as tools for supervisors to hold investigators accountable for their case file documentation as investigations progress. The lack of a specific frequency for these reviews may make it difficult for managers to ensure that these discussions are occurring regularly and that cases are completed timely. Additionally, ensuring that case files are reviewed at regular intervals can help Unit managers and staff ensure that cases progress timely even if there is turnover in the staff assigned to investigations (see pages 6–7).

[21] As part of OIG's 2011 onsite review of the Unit, OIG also made a finding related to the Unit's periodic supervisory reviews. Specifically, only 3 percent of the Unit's case files contained any documentation of periodic supervisory reviews. OIG recommended that the Unit ensure that case files contain documented periodic supervisory reviews. In response to OIG's recommendation, in 2012, the Unit developed a periodic supervisory review form on which the Unit director could note case details and an expected timeframe for completion. The forms were to be signed by the director, shared with the attorney and lead investigator of the case, and filed in the Unit's case files.

STANDARD 8	A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.

Observation

The Unit investigated many cases jointly with OIG and actively participated in cases with the U.S. Attorney's Office. During the review period, the Unit jointly investigated with OIG a total of 31 cases. The Unit actively participated in cases with prosecutors from the Missouri U.S. Attorney's Office; some of these cases also involved OIG. The Unit director is cross-designated as a Special Assistant U.S. Attorney and may prosecute cases in Missouri Federal District Court.

Finding

The Unit did not report all convictions and adverse actions to Federal partners. According to Performance Standard 8(f), Units should transmit to OIG—within 30 days of sentencing—reports of all convictions so that convicted individuals can be excluded from Federal health care programs.[22] Although the Unit had procedures in place for reporting convictions to OIG, the Unit did not report 24 of its 45 convictions to OIG. Additionally, of the Unit's reported convictions, it reported two to OIG more than 30 days after sentencing.

Federal regulations require Units to report final adverse actions against health care practitioners, providers, or suppliers to the National Practitioner Data Bank (NPDB) within 30 calendar days of the date of the action.[23] Performance Standard 8(g) also states that the Unit should report qualifying cases to the NPDB.[24] Although the Unit had procedures in place for reporting adverse actions to the NPDB, the Unit did not report 24 of its 46 adverse actions to the NPDB.[25] Additionally, the Unit reported five of its adverse actions to the NPDB more than 30 days after sentencing. Unit management explained that 23 of the 24 unreported convictions involved joint cases with OIG and reported that the Unit has never

[22] Effective May 21, 2019, 42 CFR § 1007.11(g) requires the Unit to transmit information on convictions within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court. Convictions include those obtained either by Unit prosecutors or non-Unit prosecutors in any case investigated by the Unit.

[23] 45 CFR § 60.5. Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(g)(1).

[24] 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 HIPDB and the NPDB merged in 2013; therefore, we reviewed the reporting of adverse actions under NPDB requirements. See 78 Fed. Reg. 20473 (April 5, 2013).

[25] Of the 24 adverse actions that the Unit did not report to the NPDB, 23 involved convictions that the Unit did not report to OIG.

submitted reports of convictions for joint cases. Although this may appear to be an understandable error, Performance Standard 8(f) makes no exception for joint cases with OIG, and OIG has provided guidance that Units should report all convictions to OIG. OIG has explained that receiving reports of convictions in joint cases reduces the risk of system error and ensures that OIG has a complete and accurate record of all convicted parties, including full names and current addresses.

STANDARD 9	A Unit makes statutory or programmatic recommendations, when warranted, to the State government.

Observation

The Unit made written recommendations to the State Medicaid agency. The Unit informed the State Medicaid agency of potential program deficiencies that the Unit had identified through MFCU investigations. During our review period, the Unit recommended (among other items) that the State Medicaid agency (1) require Medicaid provider applicants and their billing agents to attend Medicaid billing training prior to enrollment in the Medicaid program and annually thereafter; and (2) assign each personal care and home health provider a unique identification number and require that the number be included on each claim submitted to the State Medicaid agency.[26] As a way to follow up on recommendations, the Unit, at the end of the fiscal year, transmitted a list of unimplemented recommendations to the State Medicaid agency.

STANDARD 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.

Observation

The Unit's MOU with the State Medicaid agency reflected current practice, policy, and legal requirements. The Missouri Office of the Attorney General and the Missouri Department of Social Services had a current MOU, executed June 2015. The MOU reflected all policy and legal requirements as well as the current practices between the parties.

[26] At the time of OIG's inspection, the State Medicaid agency had not implemented these recommendations. However, the State was developing a request for proposal for an electronic visit verification (EVV) system that would receive EVV data from Medicaid personal care service providers. The EVV system would be used to verify the delivery of personal care services through telephone timekeeping; web or phone-based applications that use the Global Positioning System; or other electronic alternatives to paper timesheets. As part of the EVV system, individual personal care attendants would be assigned a unique identifier.

STANDARD 11	A Unit exercises proper fiscal control over its resources.

Observation

In our limited review, we identified no deficiencies in the Unit's fiscal control of its resources. From the responses to a detailed fiscal controls questionnaire and from follow-up with Unit management, we identified no issues related to the Unit's budget process, accounting system, cash management, procurement, electronic data security, property, or personnel. In our inventory review, we located all 30 of the 30 sampled inventory items.

STANDARD 12	A Unit conducts training that aids in the mission of the Unit.

Finding

The Unit's training plan did not include an annual minimum number of training hours for Unit investigators, and some investigators did not receive annual training. According to Performance Standard 12(a), Units should maintain a training plan for each professional discipline that includes an annual minimum number of training hours. The Unit's training plan required Unit attorneys and auditors to complete an annual minimum number of training hours; however, it did not include an annual minimum number of training hours for Unit investigators. The training plan did require Unit investigators to complete general training or interview training.

Observation

Beneficial Practice

The Unit created in-house training videos to assist staff in Unit investigations and trials. The Unit's chief auditor created in-house training videos for Unit investigators and attorneys. The chief auditor designed the videos to train Unit staff on helpful techniques that Unit staff had developed during Unit investigations. One staff member explained that each of these training videos emerged from Unit investigations that concluded with successful trials.

The videos contained step-by-step tutorials for creating and using investigative and trial tools. For example, one training video instructed staff how to use Google Maps to visualize a defendant's movements and to approximate travel times during time periods involved in investigations. Another training video showed staff how to use time studies to plot hours and days worked by providers to visualize overlaps in providers' reported employment. A Unit staff member commented that Unit staff used these training videos to develop investigative tools to use during case development and to create exhibits for trial.

CONCLUSION AND RECOMMENDATIONS

From the information we reviewed, we determined that the Missouri Unit complied with applicable legal requirements and generally adhered to performance standards, but we identified four areas in which the Unit should improve its adherence to standards. We found that the Unit's case files did not include all relevant facts, information, and significant case documents, and that the Unit's case files lacked consistent documentation of periodic supervisory reviews. Additionally, we found that the Unit did not report all convictions and adverse actions to Federal partners. Finally, we found that the Unit's training plan did not include an annual minimum number of training hours for Unit investigators.

We also made observations regarding Unit operations and practices, including a beneficial practice employed by the Unit that may serve as a model for other Units: The Unit created in-house training videos to assist staff in Unit investigations and trials.

We recommend that to address the four findings, the Missouri Unit:

Take steps to ensure that Unit case files include all relevant facts, information, and significant documents

The Unit should take steps to ensure that case files include all relevant facts; information; and significant documents, such as interview summaries. For example, the Unit could incorporate into its policy manual a requirement that staff include all relevant facts, information, and significant documents in Unit case files. The Unit could also provide training to staff regarding the importance of storing all relevant case information in the case files rather than in email or separately on the Unit's network drive.

Revise the Unit's policies and procedures manual to include a specific frequency for conducting periodic supervisory reviews of Unit case files, and take steps to ensure that case files include documentation of periodic supervisory reviews

The Unit should revise its policies and procedures manual to include a specific frequency for conducting periodic supervisory reviews. Additionally, the Unit should take steps to ensure that periodic supervisory reviews of cases files are documented in the Unit's case files.

Take steps to ensure that the Unit consistently reports all convictions and adverse actions to Federal partners

The Unit should take steps to ensure that it consistently reports all convictions obtained in any case investigated by the Unit to OIG within 30 days of sentencing and adverse actions to the NPDB within 30 days of

the action, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court. The Unit could inform staff that all convictions, including those obtained in joint cases with OIG, must be reported to Federal partners. Additionally, the Unit could implement automated reminders that alert Unit staff about when to report convictions and adverse actions to Federal partners.

Establish training-hour requirements for Unit investigators and ensure that all investigators receive annual training

The Unit should revise its training plan to include an annual minimum number of training hours for Unit investigators. Additionally, the Unit should ensure that all Unit investigators receive annual training.

UNIT COMMENTS AND OIG RESPONSE

The Missouri Unit concurred with all four of our recommendations.

First, the Unit concurred with our recommendation to take steps to ensure that Unit case files include all relevant facts, information, and significant documents. The Unit stated that it has implemented document management software and standardized the Unit's electronic case files.

Second, the Unit concurred with our recommendation to revise the Unit's policies and procedures manual to include a specific frequency for conducting periodic supervisory reviews of Unit case files and to take steps to ensure that case files include documentation of periodic supervisory reviews. The Unit stated that it now records and maintains documentation of periodic supervisory reviews electronically. Additionally, the Unit stated that it updated its policy and procedure manual to require quarterly periodic supervisory reviews.

Third, the Unit concurred with our recommendation to take steps to ensure that the Unit consistently reports all convictions and adverse actions to Federal partners. The Unit stated that it updated its electronic case management system to ensure that all convictions are reported timely.

Finally, the Unit concurred with our recommendation to establish training-hour requirements for Unit investigators and ensure that all investigators receive annual training. The Unit stated that its training plan now requires Unit investigators to obtain at least 13 hours of training annually.

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

APPENDIX A: Medicaid Fraud Control Unit Performance Standards[27]

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;[28]

D) OIG policy transmittals as maintained on the OIG website; 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 Unite 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.

[27] 77 Fed. Reg. 32645 (June 1, 2012).

[28] For FYs 2016 and later, grant administration requirements are found at 45 CFR pt. 75.

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.

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 providers 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.

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.

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.

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 dollar amount of overpayments identified.
6) 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.
7) The number of criminal convictions and the number of civil judgments.
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, case 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 Centers for Medicare & Medicaid Services (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*.

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: Detailed Methodology

Data Collection and Analysis

We collected and analyzed data from the seven sources below to identify any opportunities for improvement and instances in which the Unit did not adhere to the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.[29] We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards.

Review of Unit Documentation. Prior to the onsite inspection, we reviewed the recertification analysis for FYs 2016 through 2018, which involved examining the Unit's recertification materials, including (1) the annual reports; (2) Unit Director's recertification questionnaires; (3) the Unit's memorandum of understanding (MOU) with the State Medicaid agency; (4) the Program Integrity Director's questionnaires; and (5) the OIG Special Agent in Charge's questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes and referrals included in its FY 2016–18 annual statistical reports. Appendix C lists Unit referrals by source for FYs 2016 through 2018. We also examined the 2011 OIG onsite review recommendations and the Unit's implementation of those recommendations.

As part of our review of Unit staff levels, we assessed the Unit's staff levels using a simple linear regression model to compare Medicaid expenditures to both actual and approved staff.

Review of Unit Financial Documentation. We conducted a limited review of the Unit's control over its fiscal resources. Prior to the onsite review, we analyzed the Unit's responses to an internal controls questionnaire and conducted a desk review of the Unit's quarterly financial reports. We followed up with Unit officials to clarify issues identified in the internal controls questionnaire. We also selected a purposive sample of 30 items from the current inventory list of 187 items maintained in the Unit's office and verified those items onsite.

Interviews with Key Stakeholders. In October and November 2018, we interviewed key stakeholders, including officials in the Missouri State Medicaid Program Integrity Unit; the Missouri Department of Health and Senior Services; and the U.S. Attorneys' Offices. We also interviewed the agents from OIG's Office of Investigations who work regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with

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

the stakeholders as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Onsite Interviews with Unit Management. We conducted structured onsite interviews with the Unit's management in November 2018. We interviewed the Unit director, deputy director, senior investigator, and chief auditor. Prior to our onsite visit, we also interviewed the Unit's chief investigator. We asked these individuals to provide information related to (1) Unit operations; (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; (3) opportunities for the Unit to improve its operations and/or performance; (4) clarification regarding information obtained from other data sources; and (5) the Unit's training and technical assistance needs.

Onsite Review of Case Files. To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2016 through 2018 and to include the status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened and closed, if applicable. The total number of cases was 456.

We excluded all global cases from our review of the Unit's case files because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs.[30] We excluded 50 global cases, leaving 406 case files.

We then selected a simple random sample of 86 case files from the population of 406 case files. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with an absolute precision of +/- 10 percent at the 95-percent confidence level. We reviewed the 86 case files for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals. During the onsite review of the sampled cases, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation. Through our case file review, we also determined that 7 of the 86 sampled cases were global cases that the Unit had mistakenly labeled as nonglobal on the list that it provided to OIG. We excluded these case files from our analysis.

Review of Unit Submissions to OIG and the National Practitioner Data Bank. We also reviewed all convictions submitted to OIG for program exclusion during the review period and all adverse actions submitted to the

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

National Practitioner Data Bank (NPDB) during the review period. We reviewed whether the Unit submitted information on all sentenced individuals to OIG for program exclusion and all adverse actions to the NPDB for FYs 2016 through 2018. We also assessed the timeliness of the submissions to OIG and the NPDB.

Onsite Review of Unit Operations. During the onsite inspection, we observed the Unit's workspace and operations of the Unit's office in Jefferson City, Missouri. 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.

APPENDIX C: Unit Referrals by Source for Fiscal Years 2016 Through 2018

	FY 2016		FY 2017		FY 2018		Grand Total	
Referral Source	Fraud	Abuse & Neglect[1]	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect
Adult Protective Services	0	0	1	1	0	0	1	1
Anonymous	7	0	6	0	10	0	23	0
Office of Inspector General	12	1	18	5	8	1	38	7
Licensing Board	0	0	2	0	1	0	3	0
Local Prosecutor	0	0	0	0	0	0	0	0
Long Term Care Ombudsman	0	0	0	0	0	0	0	0
Managed Care Organizations	25	0	7	0	0	0	32	0
Medicaid Agency Other	3	0	9	1	1	0	13	1
Medicaid Agency SURS or PI Unit[2]	54	1	72	1	67	0	193	2
Other	15	1	4	2	9	2	28	5
Law Enforcement	9	3	21	3	15	1	45	7
Private Citizen	84	112	88	120	104	154	276	386
Private Health Insurer	0	0	1	0	0	0	1	0
Provider	50	0	35	3	53	1	138	4
Provider Association	0	0	0	0	0	0	0	0
Other State Agency	8	3	9	1	1	1	18	5
State Survey and Certification	3	35	0	40	2	28	5	103
Total	270	156	273	177	271	188	814	521
Annual Total	426		450		459		1335	

Source: OIG analysis of Unit Annual Statistical Reports, FYs 2016–18.

[1] The category of patient abuse and neglect referrals includes referrals regarding misappropriation of patients' private funds.

[2] The abbreviation "PI" stands for program integrity; the abbreviation "SURS" stands for Surveillance and Utilization Review Subsystem.

APPENDIX D: Point Estimates and 95-Percent Confidence Intervals of Case File Reviews

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases Closed at the Time of Our Review	81	65.4%	55.2%	74.6%
Percentage of All Cases That Had Supervisory Approval To Open	81	100%	95.8%	100%
Percentage of All Closed Cases That Had Supervisory Approval To Close	53	100%	94.0%	100%
Percentage of All Cases Opened Longer Than 90 Days	80	95.0%	88.4%	98.4%
Percentage of All Case Files (1) Opened Longer Than 90 Days and (2) Lacked Periodic Supervisory Review	76	43.4%	33.1%	54.0%
Percentage of Applicable Case Files That Lacked Documented Interview Summaries	47	21.3%	11.3%	34.2%

Source: OIG analysis of Missouri MFCU case files, 2019.

APPENDIX E: Unit Comments

ATTORNEY GENERAL OF MISSOURI
ERIC SCHMITT

January 10, 2020

Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections
Cohen Building, Room 5660
330 Independence Avenue, SW
Washington, D.C. 20201

RE: Missouri Medicaid Fraud Control Unit 2018 Onsite Inspection Report

Dear Ms. Murrin:

The Missouri Medicaid Fraud Control Unit (MFCU) is grateful to have received HHS-OIG's 2018 Onsite Inspection Report (Report). During the onsite audit, it was a privilege to meet with and candidly discuss the MFCU's accomplishments and areas for improvement with career professionals in the field of health care fraud and abuse investigation and prosecution.

We were happy to find, as you wrote in the Report's conclusion, that the MFCU met all of the performance standards. Further, I want to thank you for acknowledging the MFCU's commitment to in-house training by noting that our in-house training is a best practice that would be beneficial to other state MFCUs.

While noting some of the challenges that the MFCU faced during the audit period (October 1, 2016 – September 30, 2018), your Report also noted our successes over the course of the three audited years; namely, 48 indictments, 45 convictions, and $42 million in recoveries. Those successes have only increased. In Federal Fiscal Year 2019, MFCU investigations and prosecutions resulted in 29 indictments, 24 convictions, 14 civil resolutions, and more than $28 million in recoveries.

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HHS-OIG requested that MFCU respond with comments to the Report. MFCU is happy to take this opportunity to provide HHS-OIG with responses to the Report's recommendations. MFCU concurs with each recommendation and we have implemented each recommendation, as is set forth below.

- We concur with your recommendation that MFCU ensure all significant documents and relevant information are stored in the case file. In 2017, under a new administration, MFCU assessed its file management needs and determined it would be beneficial to transition from paper files to electronic storage. In turn, MFCU obtained document management software that, though not implemented throughout the majority of the audit period, is now fully implemented. Today, MFCU's case files are electronic and standardized through software.

- We concur with your recommendation that MFCU specify the frequency for conducting periodic case reviews and that MFCU take steps to ensure that case review documentation is retained in the case file. MFCU no longer records its case reviews on paper and it no longer retains its case reviews outside of the case file. MFCU now records and maintains its case reviews electronically in the case file. In addition, MFCU has updated its policy and procedure manual to specify quarterly case reviews.

- We concur with your recommendation that MFCU report all convictions and adverse actions to Federal partners. MFCU previously did not report convictions and adverse actions to HHS-OIG when HHS-OIG and MFCU conducted joint investigations. MFCU now reports all adverse actions to HHS-OIG, including adverse actions that resulted from joint investigations with HHS-OIG. In addition, MFCU has made changes to its case management system to ensure that all convictions are reported timely.

- We concur with your recommendation that MFCU revise its training plan to include an annual minimum number of training hours for our investigators. On average, MFCU investigators received more than 13 hours of training during the audit period. We have updated our training plan by requiring our investigators to obtain at least 13 hours of training annually.

We continue to appreciate the collaborative relationship we share with HHS-OIG in our joint investigations and prosecutions. That appreciation extends to your audit team's diligent on-site review and subsequent recommendations.

Respectfully Submitted,

/s/ Shannon T. Kempf

Shannon T. Kempf
Assistant Attorney General
Director, Medicaid Fraud Control Unit

CC: Keith Peters, Program Analyst
Jordan Clementi, Program Analyst

ACKNOWLEDGMENTS

Jordan Clementi of the Medicaid Fraud Policy and Oversight Division served as the team leader for this inspection. Keith Peters of the Medicaid Fraud Policy and Oversight Division also participated in the inspection. Two agents from the Office of Investigations also participated in the inspection. Office of Evaluation and Inspections staff who provided support include Kevin Farber, Ben Gaddis, and Christine Moritz.

This report was prepared under the direction of Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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