Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ARKANSAS STATE MEDICAID FRAUD CONTROL UNIT: 2013 ONSITE REVIEW

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EXECUTIVE SUMMARY: ARKANSAS STATE MEDICAID FRAUD CONTROL UNIT: 2013 ONSITE REVIEW
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WHY WE DID THIS STUDY

The Office of Inspector General (OIG) oversees all Medicaid Fraud Control Units (MFCU or Unit) with respect to Federal grant compliance. As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. The reviews describe the Units' caseloads; assess performance in accordance with the 12 MFCU performance standards; identify any opportunities for improvement; and identify any instances of noncompliance with laws, regulations, and policy transmittals.

HOW WE DID THIS STUDY

We based our review on an analysis of data from seven sources: (1) a review of policies, procedures and documentation of the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit director and supervisors; (6) an onsite review of case files; and (7) an onsite review of Unit operations conducted in January 2013.

WHAT WE FOUND

For fiscal years (FY) 2010 through 2012, the Arkansas Unit obtained 27 criminal convictions and 43 civil settlements, and reported recoveries of nearly $42 million. Our review of compliance issues found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals. However, we identified six instances in which the Unit did not fully adhere to performance standards. Opportunities for improvement in the Unit's adherence to the performance standards include, but are not limited to, establishing policies and procedures specific to the Unit's operations, updating the Unit's memorandum of understanding with the State Medicaid agency to reflect current law, working with the State Medicaid agency to ensure an adequate number of referrals from the State Medicaid agency, including supervisory review and approval documentation in case files, ensuring indirect costs are correctly reported, and establishing and maintaining an annual training plan.

WHAT WE RECOMMEND

On the basis of these findings, we recommend specific improvements to ensure that the Arkansas Unit fully adheres to each of the performance standards for which we had findings. The Unit concurred with each of our six recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute fraud and patient abuse and neglect by Medicaid providers under State law.[1] Pursuant to Title XIX of the Social Security Act (SSA), each State must maintain a certified Unit unless the Secretary of Health and Human Services (HHS) 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.[3,4] In Federal fiscal year (FY) 2012, combined Federal and State grant expenditures for the Units totaled $217.4 million.[5]

To carry out its duties and responsibilities in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.[6] Unit staff review complaints provided by the State Medicaid agency and other sources and determine their potential for criminal prosecution and/or civil action. In FY 2012, the 50 Units collectively reported 1,337 convictions, 823 civil settlements or judgments, and recoveries of approximately $2.9 billion.[7, 8]

[1] Social Security Act (SSA) § 1903(q).

[2] Ibid., §§ 1902(a)(61) and 1903(q)(3). Regulations at 42 CFR § 1007.11(b)(1) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities.

[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] Office of Inspector General (OIG) *Medicaid Fraud Control Units.* Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on May 22, 2013.

[5] OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2012-statistical-chart.htm on March 8, 2013.

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

[7] OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2012-statistical-chart.htm on March 8, 2013.

[8] Ibid. Recoveries are defined as the amount of money that defendants are required to pay as a result of a settlement, judgment, or pre-filing settlement in criminal and civil cases and may not reflect actual collections. Recoveries may involve cases that include participation by other Federal and State agencies.

Units are required to have either Statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an office with such authority.[9] If the Unit is in a State which does not have an entity with statewide authority to criminally prosecute individuals, the Unit must have formal procedures approved by OIG to assure that cases are referred to State entities with criminal prosecutorial authority and assure that the State entities cooperate with the Unit.[10] In Arkansas and 43 other States, the Units are located within offices of State Attorneys General; in the remaining 6 States, the Units are located in other State agencies.[11] 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., MOU) that describes its relationship with that agency.[12]

Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority 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 federally funded on a 75-percent matching basis, with the States contributing the remaining 25 percent.[14] To receive Federal reimbursement, each Unit must submit an 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]

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.[17] OIG developed and issued 12 performance standards to define the criteria it applies in assessing whether a Unit is effectively carrying out statutory

[9] SSA § 1903(q)(1).

[10] SSA § 1903(q)(1)(B).

[11] Office of Inspector General (OIG) *Medicaid Fraud Control Units*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on May 22, 2013.

[12] SSA § 1903(q)(2); 42 CFR §§ 1007.5 and 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 (FFP).

[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).

functions and meeting program requirements.[18] Examples include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all professional disciplines, and establishing policy and procedure manuals to reflect the Unit's operations. See Appendix A for a complete list of the 1994 performance standards used for this review and Appendix B for a complete list of the 2012 performance standards.

Arkansas Medicaid Program

The Arkansas Medicaid program is located within the Arkansas Department of Human Services. The Arkansas Medicaid program works with more than 12,000 providers to provide services to over 700,000 Arkansas Medicaid beneficiaries. Total Arkansas Medicaid program expenditures for FY 2012 were nearly $4.4 billion.[19]

Arkansas Unit

The Arkansas Unit operates within the Arkansas Attorney General's Office, located in the State capital of Little Rock. The Unit expended a total of $2.25 million in combined Federal and State funds for FY 2012.[20] At the time of our January 2013 review, the Unit employed 22 staff members including 1 Deputy Attorney General, 5 Assistant Attorney Generals, 7 investigators, 3 support staff, 2 nurse investigators, 1 auditor, 1 case coordinator, and 1 paralegal. During our 3-year review period, 59 percent of the Unit's open cases involved cases of patient abuse and neglect, including cases of theft of patient funds. The remaining 41 percent of open cases involved fraud.

Previous Review

In 2008, OIG published an onsite review of the Arkansas Unit. In that review, OIG found no significant issues with Arkansas' adherence to the performance standards.

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[18] 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf on August 15, 2012. OIG published revised performance standards, effective June 1, 2012. See 77 FR 32645 (June 1, 2012) for the new performance standards. Accessed at http://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf on August 15, 2012. For purposes of this review covering FYs 2010–2012, we relied on the 1994 performance standards unless changes in the performance standards were significant for our review of a particular area.

[19] OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2012-statistical-chart.htm on March 8, 2013.

[20] Ibid.

METHODOLOGY

Our review covered FYs 2010 through 2012. We based our review on an analysis of data from seven sources: (1) a review of policies and procedures and documentation of the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's director and supervisors; (6) an onsite review of case files that were open in FYs 2010 through 2012; and (7) an onsite review of Unit operations. We analyzed data from all seven sources to describe the caseload; assess the performance of the Unit; identify any opportunities for improvement; and identify any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, and policy transmittals.[21] In addition, we noted any practices that appeared to benefit the Unit. We based these observations on statements from Unit staff, data analysis, and our own judgment. We did not independently verify the effectiveness of these practices, but included the information because it may be useful to other Units in their operations. We conducted the onsite review in January 2013.

Data Collection and Analysis

Unit Documentation Review. We reviewed policies, procedures, and documentation of the Unit's operations, staffing, and cases, including its annual reports, quarterly statistical reports, and responses to recertification questionnaires.

Review of Financial Documentation. We reviewed Unit policies and procedures related to budgeting, accounting systems, cash management, procurement, property, and personnel. We obtained the Unit's claimed grant expenditures for FYs 2010 through 2012 so that we could (1) reconcile final Financial Status Reports and the supporting documentation; (2) purposively select and review transactions within categories of direct costs to determine whether costs were allowable; and (3) verify that indirect costs were accurately computed using the approved indirect cost rate. Finally, we verified that the Unit does not receive program income directly from any of its cases.

Stakeholder Interviews. We conducted structured interviews with key stakeholders who were familiar with the Unit operations. Specifically, we interviewed staff from the Arkansas Department of Human Services Medicaid Program Integrity Unit (hereafter referred to as the State

[21] All relevant regulations, statutes, and policy transmittals are available online at http://oig.hhs.gov.

Medicaid agency or the State Medicaid agency Program Integrity Unit); the Arkansas Department of Human Services, Office of Long Term Care; an HHS OIG investigator who worked closely with the Unit during the review period; the United States Attorney's Office; and AdvanceMed, the Zone Program Integrity Coordinator that works with the Unit. These interviews focused on the Unit's interaction with external agencies.

Unit Staff Survey. We administered an electronic survey to Unit nonmanagerial staff. Our questions focused on operations, opportunities for improvement, and effective practices.

Unit Director, Supervisor, and Staff Interviews. We conducted structured interviews with the Deputy Attorney General (who serves as the Unit director), the Assistant Deputy Attorney General, the Chief Investigator, the Chief Auditor, and the Chief Deputy Attorney (the supervisor of the Unit director). We asked respondents to provide any additional information to better illustrate the Unit's operations, identify opportunities for improvement and effective practices, and clarify information we obtained from other data sources.

Case File Review. We selected a statistically valid, simple random sample of 100 case files from the 288 cases open at some point during FYs 2010 through 2012. We reviewed all 100 of these sampled case files for the following issues: documentation of supervisory approval for the opening and closing of cases, periodic supervisory reviews, timeliness of case development, and the Unit's processes for monitoring the status and outcomes of cases. From these 100 case files, we selected a further random sample of 50 files for a more in-depth review of selected issues, such as the timeliness of investigations. See Appendix C for point estimates and corresponding 95-percent confidence intervals.

Unit Operations Review. We reviewed the Unit's operations during our onsite visit. Specifically, we reviewed the process for receiving referrals, electronic case management, security of case files, and general functioning of the Unit.

Standards

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

FINDINGS

For FYs 2010 through 2012, the Arkansas Unit obtained 27 criminal convictions and 43 civil settlements, and reported recoveries of nearly $42 million

For FYs 2010 through 2012, the Unit filed criminal charges against 47 defendants and obtained 27 criminal convictions. Over half (18 of 27) of these convictions involved patient abuse and neglect including theft of patient funds, while the remaining 9 convictions involved fraud. Additionally, the Unit obtained just over $639,000 in criminal restitution. See Table 1.

Table 1: Unit Criminal Charges, Convictions, and Recoveries, FYs 2010–2012

Criminal Investigations	Charges	Convictions
Fraud	15	9
Patient Abuse and Neglect	32	18
Total	**47**	**27**
Criminal Recoveries Obtained		$639,026

Source: OIG analysis of Unit data and quarterly statistical reports, FYs 2010 through 2012, 2013.

The Unit obtained 43 civil settlements, resulting in more than $41 million in civil recoveries. Eighty-seven percent (about $36 million) of these settlements were recoveries from global settlements.[22] See Table 2.

Table 2: Unit Civil Recoveries, FYs 2010–2012

Recovery Type	FY 2010	FY 2011	FY 2012	Total Recoveries
Global	$10,176,871	$10,238,681	$15,400,578	$35,816,130
State Only	$1,434,742	$23,661	$3,745,347	$5,203,750
Total	**$11,611,613**	**$10,262,342**	**$19,145,925**	**$41,019,880**

Source: OIG analysis of Unit data and quarterly statistical reports, FYs 2010 through 2012, 2013.

The Unit did not have policies and procedures specific to its operations

According to Performance Standard 3, the Unit should establish policies and procedures for its operations. The Unit used the Arkansas Office of the Attorney General handbook as guidance for administrative policies, such as those relating to hiring employees and employee benefits. However, at the time of our review, the Unit did not have policies and

[22] Global settlements originate from civil false claims cases involving the Federal Department of Justice and other State MFCUs.

procedures specific to its operations such as the investigation and prosecution of Medicaid fraud and patient abuse and neglect. During our onsite review, the Unit director indicated that the Unit was in the process of creating a MFCU-specific operations manual.

The Unit's MOU with the State Medicaid agency had not been updated to reflect current law

According to Performance Standard 10, the Unit should periodically review its MOU with the single State Medicaid agency to ensure it reflects current law and practice. The Unit last updated its MOU with the State Medicaid agency in 2010. However, at the time of our January 2013 review, the MOU did not include a law that went into effect in 2011. Specifically, the MOU did not include language to address 42 CFR § 455.23, the regulation requiring payment suspension of any provider against whom there is a credible allegation of fraud (effective March 25, 2011).[23] The Unit director reported that he had sent the agency language regarding this new regulation to incorporate into the existing MOU in the months prior to our onsite review.

Although the Unit worked with the State Medicaid agency, the Unit accepted only 10 fraud referrals over our 3-year review period

According to Performance Standard 4, the Unit should take steps to ensure that it maintains an adequate workload through referrals from the single state agency and other sources. The State Medicaid agency Program Integrity Unit director and the Unit director both reported a working relationship that included communication and joint participation on healthcare fraud task forces. The two entities described meeting at least monthly to discuss potential fraud referrals from the State Medicaid agency to the Unit. Upon discussing a potential referral, the Unit would determine whether to take the referrals as a case. During the 3-year review period, the Unit accepted only 10 fraud referrals from the State Medicaid agency. Although the performance standard does not specify how many referrals constitute an adequate number, both entities agreed that 10 was a relatively small number for a 3-year period given the size of the State program and the number of participants and providers.

[23] 42 CFR §455.23. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/45523.asp on February 28, 2013.

The Unit's case files lacked evidence of supervisory review and approval

According to Performance Standard 6, the Unit should have a continuous case flow and cases should be completed in a reasonable time. Performance Standard 6 further specifies that Unit supervisors should approve the opening and closing of cases, conduct periodic case reviews, and note their reviews in the case file. Our review of 100 case files found that case files often lacked documentation that a supervisor reviewed the case file and occasionally lacked documentation that a supervisor approved the opening of the case. See Appendix C for point estimates and corresponding 95-percent confidence intervals.

Documentation of supervisory reviews. Supervisors should periodically conduct case reviews and note their reviews in the case files. Sixty-four percent of case files did not contain documentation indicating any supervisory reviews. Of these case files, 17 percent may not have received a supervisory review because they were open less than 90 days. However, 83 percent of case files were open for longer than 90 days and did not contain evidence of a supervisory review. The Unit director noted that investigators and attorneys email weekly case updates to their supervisors, which has served as the Unit's process for supervisory review of case files. However, these weekly emails did not include a supervisory review of the case files and were not documented in the case files.

Thirty-six percent of case files that contained evidence of a supervisory review. Most of these case files (92 percent) contained evidence of one supervisory review, and 8 percent contained evidence of more than one supervisory review of the case.

Documentation of supervisory approval. Supervisors should approve the opening and closing of investigative cases. Fourteen percent of the case files lacked documentation indicating supervisory approval to open the case. Four percent of case files lacked documentation indicating supervisory approval to close the case.

The Unit incorrectly reported indirect costs

According to Performance Standard 11, the Unit director should exercise proper fiscal control over the unit resources, such as maintaining an equipment inventory and applying accepted accounting principles in its control of Unit funding. We found that the Unit incorrectly reported

indirect costs.[24] Aside from cost reporting, we did not identify any deficiencies with internal controls related to accounting; budgeting; personnel; procurement; and property and equipment.

The Unit did not maintain an annual training plan

According to Performance Standard 12, the Unit should maintain an annual training plan for all professional disciplines. Specifically, the Unit should have a training plan that includes a minimum number of training hours and the Unit should make funds available for training. The Unit should also ensure that professional staff meet continuing education standards and that the training supports the Unit's mission. Although Unit staff regularly attended training paid for by the Unit, such as courses covering medical records laws in Arkansas and the National Association of Medicaid Fraud Control Units annual training, the Unit did not have a training plan and did not track Unit staff attainment of continuing education hours.[25]

The Unit reported beneficial outreach activities

The Unit engaged in outreach activities that built relationships with stakeholders and aided in the mission of the Unit. For example, the Unit director reported that veteran Unit staff were often asked to lead training relevant to Unit work, such as a training session by Unit investigators conducted for the Office of Long Term Care. The Office of Long Term Care representative reported that Unit investigators trained nursing home surveyors on topics such as how to interview beneficiaries and how to develop a potential referral.

[24] 2 CFR § 255 Appendix E, (B)(2) states that the indirect cost rate is a device for determining in a reasonable manner the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of the indirect costs to a direct cost base.

[25] Although we reviewed training records, we did not evaluate the staff's professional qualifications. Rather, we applied the performance standards to evaluate whether the Unit maintained a formal training plan for each professional discipline and assessed training opportunities specific to Unit operations. We recognize that attorneys, investigators, and auditors receive professional and law enforcement training, and that the lack of an annual training plan does not suggest that professional staff are unqualified.

CONCLUSION AND RECOMMENDATIONS

For FYs 2010 through 2012, the Arkansas Unit obtained 27 criminal convictions and 43 civil settlements, and reported recoveries of nearly $42 million. Unit staff and stakeholders reported beneficial outreach activities.

Our review of compliance issues found no evidence of significant noncompliance with applicable laws or regulations. However, we identified six instances in which the Unit did not fully adhere to Performance Standards. We recommend that the Arkansas Unit:

Establish Policies and Procedures Specific To Unit Operations

The Unit's policies and procedures should include provisions relating to Unit organization, statutory authorities, investigative and litigation processes. The policies and procedures should also include case management processes such as periodic supervisory review of case files.

Update Its MOU With The State Medicaid Agency

The Unit should update its MOU with the State Medicaid agency to reflect current law. Specifically, the entities should add language to address 42 CFR § 455.23, the regulation that allows for suspending provider payments based on a credible allegation of fraud.

Work With The State Medicaid Agency To Ensure An Adequate Number of Referrals from the State Medicaid Agency

Given that the Unit received only 10 fraud referrals from the State Medicaid agency over a 3-year period, the Unit should work with the State Medicaid agency to ensure it receives an adequate number of referrals.

Ensure That All Case Files Contain Evidence of Supervisory Approvals and Reviews

Unit supervisors should approve the opening and closing of all cases, review all cases periodically, and document these activities in the case files.

Ensure Indirect Costs Are Correctly Reported

The Unit should work with its parent agency, the Arkansas Attorney General's Office, to ensure indirect costs are correctly reported.

Establish an Annual Training Plan

The Unit should establish an annual training plan consistent with the terms in the performance standard. The training plan should include a minimum number of hours training requirement for all professional disciplines and a system to ensure professional staff meet continuing education standards.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with all of our six recommendations.

Regarding our first recommendation, the Unit stated that it has drafted a MFCU-specific policies and procedures handbook that outlines Medicaid fraud investigations, criminal prosecutions, abuse and neglect investigations, and litigation or settlements. The Unit indicated the handbook would be completed soon.

Regarding our second recommendation, the Unit stated that it has updated its MOU with the State Medicaid agency and included language that addressed 42 CFR § 455.23, a regulation that became effective in March 2011 and allows for suspending provider payments based on a credible allegation of fraud. The Unit noted that although the prior MOU did not contain language specific to 42 CFR § 455.23, both parties of the MOU had been operating under the new regulation since it became effective.

Regarding our third recommendation, the Unit stated that it has begun to redouble its efforts to ensure that the State agency refers meritorious cases to the Unit. The Unit also noted that since our onsite review, the Arkansas legislature created the Office of the Medicaid Inspector General, with which the Unit will pursue referrals.

Regarding our fourth recommendation, the Unit stated that it will develop an intake form or checklist to ensure that supervisory approval of the opening of cases is documented in the case file. Additionally, the Unit developed a form, to be kept in the case file, to ensure that all cases have a supervisory review every 90 days.

Regarding our fifth recommendation, the Unit stated that it met with OIG grantee oversight representatives to clarify reporting procedures and attended a Web seminar on indirect costs.

Regarding our sixth recommendation, the Unit stated that the Unit director is establishing a formal written plan that will be included in the MFCU-specific handbook of policies and procedures.

The full text of the Unit's comments is provided in Appendix D. We did not make any changes to the report based on the Unit's comments.

APPENDIX A

1994 Performance Standards

[59 Fed. Reg. 49080, Sept. 26, 1994]

1. **A Unit will be in conformance with all applicable statutes, regulations and policy transmittals.** In meeting this standard, the Unit must meet, but is not limited to, the following requirements:

    a. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.

    b. The Unit must be separate and distinct from the single State Medicaid agency.

    c. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.

    d. The Unit must submit annual reports, with appropriate certifications, on a timely basis.

    e. The Unit must submit quarterly reports on a timely basis.

    f. The Unit must comply with the Americans with Disabilities Act, the Equal Employment opportunity requirements, the Drug Free workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.

2. **A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.** In meeting this standard, the following performance indicators will be considered:

    a. Does the Unit employ the number of staff that was included in the Unit's budget as approved by the OIG?

    b. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?

    c. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?

    d. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?

3. **A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.** In meeting this standard, the following performance indicators will be considered:

    a. Does the Unit have policy and procedure manuals?

b. Is an adequate, computerized case management and tracking system in place?

4. **A Unit should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit work with the single State Medicaid agency to ensure adequate fraud referrals?

   b. Does the Unit work with other agencies to encourage fraud referrals?

   c. Does the Unit generate any of its own fraud cases?

   d. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?

5. **A Unit's case mix, when possible, should cover all significant provider types.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit seek to have a mix of cases among all types of providers in the State?

   b. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?

   c. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?

   d. Are there any special Unit initiatives targeting specific provider types that affect case mix?

   e. Does the Unit consider civil and administrative remedies when appropriate?

6. **A Unit should have a continuous case flow, and cases should be completed in a reasonable time.** In meeting this standard, the following performance indicators will be considered:

   a. Is each stage of an investigation and prosecution completed in an appropriate time frame?

   b. Are supervisors approving the opening and closing of investigations?

   c. Are supervisory reviews conducted periodically and noted in the case file?

7. **A Unit should have a process for monitoring the outcome of cases.** In meeting this standard, the following performance indicators will be considered:

    a. The number, age, and type of cases in inventory.

    b. The number of referrals to other agencies for prosecution.

    c. The number of arrests and indictments.

    d. The number of convictions.

    e. The amount of overpayments identified.

    f. The amount of fines and restitution ordered.

    g. The amount of civil recoveries.

    h. The numbers of administrative sanctions imposed.

8. **A Unit will cooperate with the OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud.** In meeting this standard, the following performance indicators will be considered:

    a. Does the Unit communicate effectively with the OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?

    b. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?

    c. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?

    d. Does the Unit transmit to the OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

9. **A Unit should make statutory or programmatic recommendations, when necessary, to the State government.** In meeting this standard, the following performance indicators will be considered:

    a. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?

b. Does the Unit provide program recommendations to single State agency when appropriate?

c. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?

10. **A Unit should periodically review its memorandum of understanding (MOU) with the single State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice.** In meeting this standard, the following performance indicators will be considered:

    a. Is the MOU more than 5 years old?

    b. Does the MOU meet Federal legal requirements?

    c. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?

    d. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?

11. **The Unit director should exercise proper fiscal control over the Unit resources.** In meeting this standard, the following performance indicators will be considered:

    a. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?

    b. Does the Unit maintain an equipment inventory?

    c. Does the Unit apply generally accepted accounting principles in its control of Unit funding?

12. **A Unit should maintain an annual training plan for all professional disciplines.** In meeting this standard, the following performance indicators will be considered:

    a. Does the Unit have a training plan in place and funds available to fully implement the plan?

    b. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?

    c. Are continuing education standards met for professional staff?

    d. Does the training undertaken by staff aid to the mission of the Unit?

APPENDIX B

2012 Performance Standards

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

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.

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.

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, cases involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.

c. The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.

d. For cases that require the granting of ''extended jurisdiction'' to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.

e. For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.

f. The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.

g. The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.

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

a. The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.

b. The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies

responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.

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

a. The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.

b. The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR 455.23, "Suspension of payments in cases of fraud."

c. The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the 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 C

Point Estimates and Confidence Intervals Based on Case File Reviews

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Cases in which reviewers did not find evidence that the supervisor approved opening case	100	14.0%	7.9%	22.4%
Cases in which reviewers did not find evidence that the supervisor approved closing case	67	4.5%	0.9%	12.5%
Cases not containing documentation indicating at least one supervisory review	100	64.0%	53.8%	73.4%
Open for less than 90 days	64	17.2%	8.9%	28.7%
Open for longer than 90 days	64	82.8%	71.3%	91.1%
Cases not containing documentation indicating at least one periodic supervisory review	100	36.0%	26.6%	46.2%
Contained only one supervisory review	36	91.7%	77.5%	98.3%
Contained more than one supervisory review	36	8.3%	1.8%	22.5%

Source: Office of Inspector General analysis of Medicaid Fraud Control Unit case files, 2013.

APPENDIX D

Unit Comments

STATE OF ARKANSAS
OFFICE OF THE ATTORNEY GENERAL

Dustin McDaniel
Attorney General

Jeanette L. Hamilton
Senior Assistant Attorney General
Medicaid Fraud Control Unit
Direct Dial: 501-682-8123

August 9, 2013

Mr. Stuart Wright
Deputy Inspector General for Evaluation and Inspection
Office of Inspector General
Department of Health and Human Services
Washington, DC 20201

Re: Arkansas State Medicaid Fraud Control Unit (OEI-06-12-00720)

Dear Mr. Wright:

We are in receipt of your letter dated July 10, 2013, enclosing the Arkansas State Medicaid Fraud Control Unit ("MFCU") HHS-OIG Onsite Review, OEI-06-12-00720. We appreciate the opportunity to respond to the Onsite Review and we wish to thank you for the professionalism of the Audit Team during the audit.

We particularly appreciate the recognition in the Review of the achievements of the Arkansas MFCU. Our growing number of criminal convictions and substantial civil settlements and recoveries are the result of a solid team effort by our staff and the staff of Arkansas Department of Human Services, our single state agency. The MFCU's outreach activities throughout the State have always been a priority and will continue to be a focus of our Unit. We welcome the opportunity to improve areas of our operation and have already begun the process of implementing suggested modifications and improvements to these areas.

The following are our comments on your findings, as requested by the OIG-HHS.

The Unit did not have policies and procedures specific to its operations. The Unit used the Arkansas Office of the Attorney General handbook as guidance for administrative policies. However, at the time of our review, the Unit did not have policies and procedures specific to its operations.

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Response:
We concur with the OIG-HHS finding that there were no policies and procedures in place specific to the operation of the MFCU at the time of the onsite review. Immediately after the audit, we began drafting a MFCU-specific policies and procedures handbook, outlining the steps and phases of Medicaid fraud investigations, criminal prosecutions and long term care resident abuse and neglect investigations and litigation or settlements. The draft manual is expected to be completed very soon.

The Unit's MOU should be updated to reflect current law. Specifically, the MOU did not include language to address 42 CFR §455.23, the regulation requiring payment suspension of any provider against whom there is a credible allegation of fraud (effective March 25, 2011).

Response:
We concur with the OIG-HHS finding that during the time period of the review, the MOU did not include language to address 42 CFR §455.23. However, both the MFCU and the single state agency were well aware of this regulation from its effective date and were aware that it needed to be incorporated into the MOU. From the effective date forward, the parties operated as if the language had been made a part of the MOU and all discussions of potential referrals included discussion of whether there was a credible allegation of fraud requiring suspension.

After receipt of the draft report of the Onsite Review, the Unit was able to obtain the signature of the DHS Director of Medical Services to a new draft MOU incorporating the relevant language. Because Jay Shue, the MFCU Director during the review period, left the Unit on July 1, 2013, to assume the position of state Medicaid Inspector General, we anticipate that there will be a new MOU, reflecting the new arrangement and changes in the relationship between the Unit and the Medicaid Integrity Program since the creation of the Office of Medicaid Inspector General. We are actively working on a new draft and anticipate completion as soon as the parties have had an opportunity to discuss and determine which portions of the current MOU require revisions and additions.

The Unit accepted only 10 fraud referrals over the three-year period of FY 2010-2012. Although Performance Standard 4 does not specify how many referrals constitute an adequate number, both entities agreed that 10 was a relatively small number for a 3-year period given the size of the State program and the number of participants and providers.

Response:
We concur that the Unit accepted only 10 fraud referrals from the single state agency during the three-year period of FY 2010-2012, and we agree that 10 is a relatively small number for a 3-year time period. However, we have always strived to maintain open lines of communication with our single state agency and have accepted all referrals that meet the appropriate legal standard and that we believe will be successful. We discussed in our exit conference that our Unit has begun to redouble our efforts at ensuring the single state agency refer meritorious cases to our office. During the last session of the Arkansas General Assembly, the Arkansas legislature created the Office of the Medicaid Inspector General. Governor Mike Beebe appointed Jay Shue, who was the Director of the Medicaid Fraud Control Unit when appointed. We will continue to pursue these cases with the Office of Medicaid Inspector General.

The Unit's case files lacked evidence of supervisory review and approval. Our review of 100 case files found that case files often lacked documentation that a supervisor reviewed the case file and occasionally lacked documentation that a supervisor approved opening the case.

Response:
We concur that supervisory approval of case openings was not always documented in global case files. However, every MFCU case and investigation is regularly discussed with a supervisor and all discussions and supervisory actions are kept in a chronological narrative in our case tracking system. In the future we agree that for the sake of uniformity, we will develop an intake/file opening form or checklist that will be used in all global cases, as well as fraud and resident abuse and neglect cases. Further, we have developed a new form to ensure that all open cases have supervisory review every ninety days. This form will stay in the case file and will show that the assigned attorney/investigator met with their supervisor and will reflect any instructions given. We plan to conduct supervisory reviews at the end of every March, June, September and December and we will begin this process in September, 2013.

The Unit incorrectly reported indirect costs. The Unit was found to have incorrectly reported indirect costs.

Response:
We concur that the Unit incorrectly reported indirect costs. On July 2, 2013, the Unit Deputy and the Attorney General's Chief Fiscal Officer had a telephone conference with Alexis Crowley on this issue and we agreed that regarding form SF 425, box 11F, we are to report only the amount we are actually expending, as opposed to the amount earned, and that we will continue to report indirect costs in this manner going forward. On July 17, 2013, the Unit Deputy and AG Chief Financial Officer attended the Indirect Costs Rates Training webinar, which provided further clarification of reporting of indirect costs generally.

The Unit did not maintain an annual training plan. Specifically, the Unit should have a training plan that includes a minimum number of hours and should make funds available for training. The Unit should also ensure professional staff meet continuing education standards and that training aids the mission of the Unit.

Response:
We concur with this recommendation. While the Unit has always had training goals and expectations for professional staff and has always kept track of staff training, we agree that there is no formal written training plan for each professional discipline within the Unit. The Unit has always arranged for each newly-hired professional to attend the introductory training course offered through the National Association of Medicaid Fraud Control Units (NAMFCU). Every effort is made to offer all professional staff at least one training opportunity per year. The Unit director is in the process of establishing a formal written plan to be included in the MFCU policies and procedures handbook.

Conclusion:

The Arkansas Medicaid Fraud Control Unit appreciates the efforts of HHS-OIG and especially appreciates the opportunity to continue with our most effective processes and procedures, and to improve in others. We concur with your recommendations and will implement necessary changes as set forth above in a manner consistent with the mission and goals of the Unit.

Sincerely,

/S/

Jeanette L. Hamilton
Deputy Attorney General

ACKNOWLEDGMENTS

This report was prepared under the direction of Kevin Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office; Blaine Collins, Deputy Regional Inspector General; and Ruth Ann Dorrill, Deputy Regional Inspector General.

Lyndsay Patty served as the Team Leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Ben Gaddis. Office of Investigations staff who provided support include Kory Inkhen and Jason Weinstock. Central office staff who provided support include Susan Burbach, Kevin Farber, Christine Moritz, Richard Stern, and Sherri Weinstein.

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