Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MINNESOTA STATE MEDICAID FRAUD CONTROL UNIT: 2013 ONSITE REVIEW

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EXECUTIVE SUMMARY – MINNESOTA STATE MEDICAID FRAUD CONTROL UNIT: 2013 ONSITE REVIEW
OEI-06-12-00200

WHY WE DID THIS STUDY

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

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 April 2013.

WHAT WE FOUND

For fiscal years (FYs) 2010 through 2012, the Minnesota Unit obtained 62 criminal convictions and 59 civil settlements, and reported recoveries of over $64 million. Our review of compliance issues found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals. However, we found that the Unit's memorandum of understanding (MOU) with the State Medicaid agency did not reflect all current processes. In addition, the Unit's training plan did not include a minimum number of training hours. We also found that some Unit case files lacked documentation of supervisory approval and periodic review. Finally, the Unit stored some case files in a location accessible to non-Unit staff.

WHAT WE RECOMMEND

We recommend that the Minnesota Unit (1) update its MOU with the State Medicaid agency; (2) establish training hour requirements for each professional discipline; (3) include notation of supervisory approval and periodic supervisory review in all case files; and (4) secure case files. The Unit concurred with all four of our recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate fraud and patient abuse and neglect by Medicaid providers and to prosecute it 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 determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.[2] Currently, 49 States and the District of Columbia (States) have created such Units.[3] In Federal fiscal year (FY) 2012, combined Federal and State grant expenditures for the Units totaled $217.4 million.[4]

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.[5] 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.[6, 7]

Units are required to have either Statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an office with

[1] Social Security Act (SSA) § 1903(q)(3).

[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] 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.

[4] 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.

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

[6] OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/ on April 16, 2012.

[7] 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.

such authority.[8] If the Unit is located in a State that does not have an entity with statewide prosecutorial-authority, the Unit must have formal procedures approved by OIG to ensure that cases are referred to State entities with criminal prosecutorial authority and ensure that the State entities cooperate with the Unit.[9] In 44 States and the District of Columbia, the Units are located within offices of State Attorneys General; in 6 States, the Units are located in other State agencies.[10] 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., Memorandum of Understanding (MOU) that describes its relationship with that agency.[11]

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.[12] All Units are currently federally funded on a 75-percent matching basis, with the States contributing the remaining 25 percent.[13] To receive Federal reimbursement, each Unit must submit an application to OIG.[14] OIG reviews the application and notifies the Unit if it is approved and the Unit is certified. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.[15]

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.[16] OIG developed and issued 12 performance standards to define the criteria it applies in assessing whether a Unit is effectively carrying out statutory

[8] SSA § 1903(q)(1).

[9] SSA § 1903(q)(1)(B).

[10] OIG *Medicaid Fraud Control Units*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on May 21, 2013.

[11] SSA § 1903(q)(2); 42 CFR §§ 1007.5 and 1007.9(d).

[12] 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).

[13] SSA § 1903(a)(6)(B).

[14] 42 CFR § 1007.15(a).

[15] 42 CFR § 1007.15(b) and (c).

[16] SSA § 1902(a)(61).

functions and meeting program requirements.[17] Examples of criteria 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 and Appendix B for a complete list of the 2012 performance standards.

Minnesota Medicaid Program

The Minnesota Medicaid program is located within the Minnesota Department of Human Services. The Minnesota Medicaid program provides services to over 885,000 Minnesotans, 68 percent of whom are enrolled in managed care.[18] Total Minnesota Medicaid expenditures for FY 2012 were over $9 billion.[19]

Minnesota Unit

The Minnesota Unit is housed within the Minnesota Attorney General's Office (AGO), located in the State capital of St. Paul. The Unit expended a total of $1.4 million in combined State and Federal funds for FY 2012.[20] At the time of our April 2013 review, the Unit employed 13 staff members including a director, 4 attorneys, 4 investigators, 1 investigative auditor, and 3 support staff. During FY 2010 through FY 2012, provider fraud represented 87 percent of the Unit's open cases; the remaining 13 percent involved cases of patient abuse and neglect, including cases of theft of patient funds. The Unit has authority to prosecute Medicaid fraud cases, but does not have original jurisdiction to prosecute abuse and neglect cases.[21] However, county attorneys with original jurisdiction may choose to refer cases back to the Unit for prosecution.

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[17] 77 Fed Reg. 32645 (June 1, 2012). Accessed at http://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf on August 15, 2012. Previous performance standards established in 1994 are found at 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, 2013.

[18] *Mecdicaid.gov Minnesota Medicaid Statistics.* Accessed at http://www.medicaid.gov/medicaid-chip-program-information/by-state/minnesota.html on June 10, 2003.

[19] *MFCU Statistical Data for FY 2011*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/ on January 13, 2014.

[20] 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.

[21] Minnesota Statute 388.051 provides county attorneys with original jurisdiction for prosecution of all crimes in Minnesota, unless specifically provided elsewhere. Minnesota Statute 256B.21 provides the Unit with original jurisdiction in Medicaid fraud cases.

Previous Review

In 2007, OIG conducted an onsite review of the Minnesota Unit. In that review, OIG found that the investigative case files lacked consistency and that the Unit did not have standardized policies and procedures in place for the creation and maintenance of investigative case files.[22] The review also found that Unit investigators had a high average of open cases (18 cases per investigator), making it difficult to effectively and efficiently manage the investigative process.

METHODOLOGY

We based the 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'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 in April 2013. 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.[23] 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.

Data Collection and Analysis

Review of Unit Documentation. 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 financial practices to determine compliance with applicable laws and regulations and to determine the need for additional internal controls. Prior to the onsite review, we reviewed the Unit's financial policies and procedures, its response to an internal control questionnaire, and MFCU grant-related

[22] OIG issued the 2007 review directly to the Unit and did not make the review publicly available.

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

documents such as financial status reports. During the onsite review, we reviewed a sample of the Unit's purchase and travel transactions. In addition, we reviewed a sample of time and effort records.

Interviews with Key Stakeholders. We conducted structured interviews with key stakeholders who were familiar with the Unit operations. Specifically, we interviewed staff from the Minnesota Department of Human Services, Medicaid Program Integrity Unit (hereinafter referred to as the State Medicaid agency); the Minnesota Department of Human Services, Office of Long Term Care; an HHS OIG investigator who worked closely with the Unit during the review period; three of the four largest managed care organizations that operate in Minnesota (Blue Cross Blue Shield, Health Partners, and UCare); and an Assistant United States Attorney. These interviews focused on the Unit's interaction with external agencies.

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

Interviews with Unit Management and Staff. We conducted structured interviews with the Assistant Attorney General (who serves as the Unit Director and Chief Attorney), the Deputy Attorney General, the Chief Investigator, and the Chief Auditor. 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.

Onsite Review of Case Files. We selected a statistically valid, simple random sample of 100 case files from the 267 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 issues, such as the appropriateness and timeliness of investigations. See Appendix C for point estimates and corresponding 95-percent confidence intervals.

Onsite Review of Unit Operations. 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 Minnesota Unit obtained 62 criminal convictions and 59 civil settlements, and reported recoveries of over $64 million

For FYs 2010 through 2012, the Unit filed criminal charges against 74 defendants and obtained 62 criminal convictions. Nearly 80 percent of these convictions involved provider fraud; the remaining 20 percent involved patient abuse and neglect, including theft of patient funds. The Unit was awarded nearly $3 million in criminal recoveries. See Table 1.

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

Criminal Investigations	Charges	Convictions
Fraud	60	49
Patient Abuse and Neglect	4	4
Theft of Patient Funds	10	9
Total	**74**	**62**
Criminal Recoveries Ordered		$2,976,780*

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

*Unit criminal recoveries ordered were $856,490 in FY 2010, $347,641 in FY 2011, and $1,772,648 in FY 2012.

The Unit obtained 59 civil settlements, resulting in more than $61 million in civil recoveries. Ninety-seven percent ($59 million) of settlements were from "global" settlements.[24] See Table 2.

Table 2: Unit Civil Recoveries, FYs 2010–2012

Recovery Type	FY 2010	FY 2011	FY 2012	Total Recoveries
Global	$23,101,825	$17,309,623	$18,839,389	$59,250,837
State Only	$738,166	$370,146	$707,496	$1,815,808
Total	**$23,839,991**	**$17,679,769**	**$19,546,885**	**$61,066,645**

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

[24] "Global" settlements originate from civil false claims cases involving the U.S. Department of Justice and other State MFCUs. The Federal Government often represents multiple States in global settlements, but the $59 million is the portion owed to Minnesota.

The Unit's MOU with the State Medicaid agency did not reflect all current processes

According to Performance Standard 10, the Unit should periodically review its MOU with the State Medicaid agency to ensure that the MOU reflects current law and practice. The Unit updated its MOU with the State Medicaid agency in April 2012. However, the MOU did not include language that addresses 42 CFR § 455.23, which requires payment suspension of any provider against whom there is a credible allegation of fraud (effective March 25, 2011).[25] Despite the lack of payment suspension language in the MOU, the Unit and the State Medicaid agency have a documented process for suspending payments to providers against whom there is a credible allegation of fraud. Since our onsite visit, the Unit has modified its MOU with the State Medicaid agency to address 42 CFR § 455.23.

The Unit's training plan did not include a minimum number of training hours

Performance Standard 12 states that the Unit should maintain a training plan that indicates an annual minimum number of training hours for each professional discipline and should ensure that professional staff satisfy continuing education standards. We found that the Unit had a training plan for each professional discipline, but the plan did not specify a minimum number of training hours. Nonetheless, Unit professional staff satisfied continuing education standards by attending training on health care, investigative issues, and legal issues sponsored by the Department of Veterans Affairs, the National White Collar Crime Center, and legal education entities.[26] Since our onsite visit, the Unit has updated its training plan to include an annual minimum number of training hours for each professional discipline.

[25] 42 CFR § 455.23. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/45523.asp on June 12, 2013.

[26] Although we reviewed training records, we did not evaluate each staff member'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 a minimum number of training hours does not suggest that professional staff are unqualified.

Some Unit case files lacked documentation of supervisory reviews and approvals

Performance Standard 6 states that Unit supervisors should periodically conduct reviews of ongoing investigations and should note the reviews in the case file. During our onsite review, the Unit Director reported meeting at least monthly with investigators and attorneys to discuss and review all open case files and provided documentation of these reviews. However, these supervisory reviews were not documented in 58 percent of the case files that were open for longer than 30 days and instead were stored in the Unit Director's office. See Appendix C for point estimates and corresponding 95-percent confidence intervals.

Performance Standard 6 also states that managers should approve the opening and closing of cases, and the Unit's policies and procedures state that these approvals should be documented in case files. We found that case files lacked documentation of supervisory approval for 19 percent of case openings and 23 percent of case closings. The Unit Director explained that there was supervisory approval for case openings and closings in each case, but in some cases the Unit Director or Chief Investigator did not sign the memo for the opening or closing. See Appendix C for point estimates and corresponding 95-percent confidence intervals.

The Unit stored some case files in a location accessible to non-Unit staff

According to Performance Standard 1, the Unit should conform to all applicable statutes, regulations, and policy transmittals. Federal regulations and OIG policy require Units to prevent the misuse of information under the Unit's control by safeguarding the privacy rights of witnesses, victims, and informants.[27] During our onsite review, we observed that some case files were stored in unlocked file cabinets in a hallway that is inaccessible to the public, but in proximity to non-Unit staff in the Minnesota Attorney General's Office. Unit officials reported that they promptly moved the file cabinets to a locked storage room accessible only to Unit staff.

[27] 42 CFR § 1007.11(f); OIG State Fraud Policy Transmittal 99-02, *Public Disclosure Requests and Safeguarding of Privacy Rights* (December 22, 1999).

Other observation: The Unit helped to pass legislation that strengthens background checks for guardians and conservators of Medicaid beneficiaries

The Unit worked with two Minnesota Deputy Attorneys General to research and draft legislation that strengthens Minnesota's background check processes for guardians (appointed persons who make personal decisions for Medicaid beneficiaries) and conservators (appointed persons who make financial decisions for Medicaid beneficiaries). Effective May 2013, the expanded background checks include requirements that the guardian or conservator must disclose things such as whether they have ever been denied a professional license by the State, whether they have ever filed for bankruptcy, or whether they have ever had a restraining order filed against them. Additionally, the new legislation requires that the court conduct background checks of guardians and conservators every 2 years rather than every 4 years.[28]

Other observation: The Unit does not issue mobile phones to its investigators

Notably, the Unit does not issue mobile phones to Unit investigators for use while in the field, as is standard among the other MFCUs and other law enforcement offices. The Unit Director explained that the Unit's parent agency, the Minnesota AGO, also does not issue mobile phones to any staff. Therefore, when conducting field investigations, Unit staff may either use their personal mobile phones or the mobile phones of others, such as OIG agents jointly investigating a case. When using personal mobile phones, Unit staff call the Unit operator to route the call to the appropriate individual using a State office phone number, thereby masking the caller identification of the personal mobile phone.

[28] Minnesota Statute 524.5-188. Accessed at https://www.revisor.mn.gov/statutes/?id=524.5-118 on November 8, 2013.

CONCLUSION AND RECOMMENDATIONS

For FYs 2010 through 2012, the Minnesota Unit obtained 62 criminal convictions and 59 civil settlements, and reported recoveries of over $64 million. Unit staff reported working with the Minnesota Attorney General to draft legislation that strengthened background checks for guardians and conservators of Medicaid beneficiaries.

Our review of compliance issues found no evidence of significant noncompliance with applicable laws or regulations. However, we found four opportunities for improvement in the Unit's adherence to the performance standards. As a result, we recommend that the Minnesota Unit:

Update its MOU with the State Medicaid Agency

The Unit should update its MOU with the State Medicaid agency to include language that sufficiently addresses 42 CFR § 455.23 regarding provider payment suspension.

Establish training hour requirements for each professional discipline

The Unit should include an annual minimum number of training hours for attorneys, auditors, director, and investigators in the Unit training plan.

Include notation of periodic supervisory reviews and approval in all case files

The Unit should ensure that all appropriate documentation is located in the case files. Specifically, supervisory reviews and supervisory approval for opening and closing cases should be documented and located in the case file.

Secure case files

The Unit should store all case files and other documentation containing personally identifiable information in a locked room or in locked storage cabinets.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with the four report recommendations.

Regarding the first recommendation, the Unit reported that it had long utilized a documented process for suspending payments to providers against whom there are credible allegations of fraud. The Unit reported that it has updated its MOU with the Minnesota Department of Human Services to reflect this process.

Regarding the second recommendation, the Unit explained that Unit attorneys satisfy a minimum of 45 credit hours of professional training every 3 years and that nonattorney Unit staff receive regular training from a number of sources. The Unit reported that it has updated its training plan to specify a minimum number of training hours that Unit professionals must receive.

Regarding the third recommendation, the Unit explained that the Unit Director regularly reviews the status of all open investigations. The Unit reported that in the past, the Unit Director had maintained these records in his office, but that following our onsite visit, he began placing a record of reviews in case files. Additionally, the Unit reported that the Director has begun documenting approval of case opening and closing in case files.

Regarding the fourth recommendation, the Unit reported that it has moved the contents of file cabinets to locked rooms within the Unit office.

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

APPENDIX A

Performance Standards for Medicaid Fraud Control Units

[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 Review of Case Files

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Cases open longer than 30 days and not containing documentation indicating at least one supervisory review	91	58.2%	47.4%	68.5%
Cases in which reviewers did not find evidence that the supervisor approved opening case	100	19.0%	11.8%	28.1%
Cases in which reviewers did not find evidence that the supervisor approved closing case	70	22.9%	13.7%	34.4%

Source: OIG analysis of MFCU case files, 2013.

APPENDIX D

Unit Comments

STATE OF MINNESOTA
OFFICE OF THE ATTORNEY GENERAL

LORI SWANSON
ATTORNEY GENERAL

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February 25, 2014

Mr. Stuart Wright
Deputy Inspector General for Evaluation and Inspections
Office of Inspector General
United States Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

Re: Minnesota State Medicaid Fraud Control Unit:
Onsite Review, OEI-06-13-00200

Dear Mr. Wright:

Thank you for your report entitled *Minnesota State Medicaid Fraud Control Unit: 2013 Onsite Review, OEI-6-3-00200*. We appreciate the thorough review undertaken by your staff. We concur with the four recommendations in the Report, which we have already implemented as follows:

Finding: The Unit's MOU with the State Medicaid agency did not reflect all current processes.

Response: The Minnesota Medicaid Fraud Control Unit ("Unit") and the Minnesota Department of Human Services ("DHS") have long utilized a documented process for suspending payments to providers against whom there are credible allegations of fraud. The Unit has updated its Memorandum of Understanding with DHS to reflect this process.

Finding: The Unit's training plan did not include a minimum number of training hours.

Response: Under Minnesota law, attorneys in the Unit satisfied a minimum of 45 credit hours of professional training every three years. In addition, non-attorney Unit professionals received regular training from a number of sources, such as DHS, the National Association of Medicaid Fraud Control Units, the Minnesota Department of Public Safety, the Office of Inspector General, the National White Collar Crime Center, and the Midwest Insurance Fraud Prevention Association. The Unit has now updated its training plan to specify a minimum number of training hours that Unit professionals must receive.

Finding: Some Unit case files lacked documentation of supervisory reviews and approvals.

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Response: As Unit Director, I regularly review the status of all open investigations. In the past, I maintained records of my reviews in my office, rather than in the individual case files. I have now begun to place a record of my reviews both in the case files and in my office. I also orally approved the opening and closing of all cases. I have now begun to document my approval of case openings and closings in the individual case files.

Finding: The Unit stored some case files in a location accessible to non-Unit staff.

Response: The Unit stored some case files in file cabinets that were inaccessible to the public but in proximity to other attorneys and professionals within the Office. All attorneys and staff in the Office are held to the highest standards of confidentiality and security, and I am not aware of any instance in which a non-Unit attorney or staff member accessed the MFCU file cabinets. Last spring, the Unit moved the contents of the file cabinets to locked rooms within the Office.

I thank you again for your office's thorough and professional review. If you have any questions, please contact me.

Sincerely,

/S/

CHUCK ROEHRDANZ
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Assistant Attorney General
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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 and Ben Gaddis served as the lead analyst. Office of Investigations staff who provided support include Curt Muller 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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