

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**KANSAS STATE MEDICAID  
FRAUD CONTROL UNIT:  
2012 ONSITE REVIEW**



**Stuart Wright  
Deputy Inspector General for  
Evaluation and Inspections**

**September 2012  
OEI-07-12-00200**

**EXECUTIVE SUMMARY:  
KANSAS STATE MEDICAID FRAUD CONTROL UNIT:  
2012 ONSITE REVIEW  
OEI-07-11-00200**

**WHY WE DID THIS STUDY**

OIG oversees all Medicaid Fraud Control Units (MFCU or Unit) with respect to Federal grant compliance. As part of this oversight, OIG reviews all Units. These reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor Unit compliance with Federal grant requirements. This is a review of the Kansas Unit.

**HOW WE DID THIS STUDY**

We analyzed 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 management; (6) an onsite review of case files; and (7) an onsite review of Unit operations.

**WHAT WE FOUND**

For fiscal years (FY) 2009 through 2011, the Unit reported combined civil and criminal recoveries of nearly \$66 million and 44 convictions. The Unit increased referrals through education and outreach efforts. We found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals. However, we found opportunities for improvement and instances in which the Unit did not fully meet the performance standards. Specifically, for FYs 2009 and 2010, the Unit had several internal control weaknesses and inadequate policies and procedures related to certain expenditures. For FYs 2009 through 2011, the Unit did not report the identities of all convicted providers to OIG within 30 days of sentencing for the purpose of program exclusion. The Unit also did not establish annual training plans for its professional disciplines. Finally, case files had inconsistent documentation of supervisory approval for key stages of investigations, yet cases generally proceeded timely.

**WHAT WE RECOMMEND**

Based on these findings, the Kansas Unit should: (1) develop policies and procedures to address internal control weaknesses; (2) develop a protocol to ensure identities of convicted providers are reported to OIG; (3) establish annual training plans for professional disciplines; and (4) ensure that all case files contain opening and closing investigative memoranda, documented supervisory approval, and documented periodic supervisory reviews. The Kansas Unit concurred with all four of our recommendations.

---

## TABLE OF CONTENTS

Objective .....	1
Background .....	1
Methodology .....	4
Findings.....	7
For FYs 2009 through 2011, the Unit reported combined civil and criminal recoveries of nearly \$66 million and 44 convictions..	7
For FYs 2009 and 2010, the Unit had several internal control weaknesses and inadequate policies and procedures related to certain expenditures .....	8
The Unit did not report the identities of all convicted providers to OIG within 30 days of sentencing for the purpose of program exclusion .....	8
The Unit did not establish annual training plans for its professional disciplines .....	9
Case files had inconsistent documentation of supervisory approval for key stages of investigations, yet cases generally proceeded timely .....	10
Conclusion and Recommendations .....	11
Unit Comments and Office of Inspector General Response .....	11
Appendixes .....	13
A: Performance Standards .....	13
B: Population and Sample Distribution of Case Files Open Any Time During FYs 2009 Through 2011 .....	17
C: Investigations Opened and Closed by Provider Category for Fiscal Years 2009 Through 2011 .....	18
D: Medicaid Fraud Control Unit Referrals by Provider Category for Fiscal Years 2009 Through 2011 .....	20
E: Expanded Information on Internal Control Weaknesses and Inadequate Policies and Procedures Related to Certain Expenditures .....	21
F: Point Estimates and Confidence Intervals Based on Case File Reviews.....	24

G: Unit Comments .....	25
Acknowledgments.....	35

---

## OBJECTIVE

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

---

## BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.<sup>1</sup> Under the Medicaid statute, each State must maintain a certified Unit unless the Secretary of Health & 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.<sup>2</sup> Currently, 49 States and the District of Columbia (States) have created such Units.<sup>3</sup> In fiscal year (FY) 2011, combined Federal and State grant expenditures for the Units totaled \$208.6 million, and Units employed 1,833 individuals.<sup>4</sup>

Each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney to carry out its duties and responsibilities in an effective and efficient manner.<sup>5</sup> Unit staff review complaints provided by the State Medicaid agency and other sources and determines their potential for criminal prosecution. In FY 2011, the 50 Units collectively reported 1,230 convictions and 906 civil settlements or judgments.<sup>6</sup> That year, the Units reported recoveries of approximately \$1.7 billion.<sup>7</sup>

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.<sup>8</sup> In Kansas and 42 other States, the Units are located

---

<sup>1</sup> Social Security Act (SSA) § 1903(q)(3).

<sup>2</sup> SSA §§ 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.

<sup>3</sup> 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.

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

<sup>5</sup> SSA § 1903(q)(6) and 42 CFR § 1007.13.

<sup>6</sup> Office of Inspector General (OIG), *State Medicaid Fraud Control Units Fiscal Year 2011 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on April 16, 2012.

<sup>7</sup> Ibid.

<sup>8</sup> SSA § 1903(q)(1).

within offices of State Attorneys General; in the remaining 7 States, the Units are located in other State agencies.<sup>9</sup> Generally, Units outside of the Attorneys General offices must refer cases to other offices with prosecutorial authority.

Each Unit must be a single, identifiable entity of State government, distinct from the single State Medicaid agency, and each Unit must develop a formal agreement (i.e., a memorandum of understanding) that describes the Unit's relationship with that agency.<sup>10</sup>

### **Oversight of the MFCU Program**

The Secretary of HHS delegated to OIG the authority both to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.<sup>11</sup> All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.<sup>12</sup> To receive Federal reimbursement, each Unit must submit an application to OIG.<sup>13</sup>

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.<sup>14</sup>

Under the Medicaid statute, States must operate Units that effectively carry out their statutory functions and meet program requirements.<sup>15</sup> OIG developed and issued 12 performance standards to define the criteria it applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements.<sup>16</sup> 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 performance standards.

---

<sup>9</sup> The Units share responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States also employ a Medicaid Inspector General who conducts and coordinates fraud, waste, and abuse activities for the State agency.

<sup>10</sup> SSA § 1903(q)(2); 42 CFR §§ 1007.5 and 1007.9(d).

<sup>11</sup> 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.

<sup>12</sup> SSA § 1903(a)(6)(B).

<sup>13</sup> 42 CFR § 1007.15(a).

<sup>14</sup> 42 CFR § 1007.15(b) and (c).

<sup>15</sup> SSA § 1902(a)(61).

<sup>16</sup> 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov> on November 22, 2011. Note that OIG published revised performance standards on June 1, 2012. (See 77 Fed. Reg. 32645.) The standards referred to in this report are from 1994 and were in effect at the time of our review.

## **Kansas State MFCU**

The Attorney General's Medicaid Fraud and Abuse Division acts as the MFCU for the State of Kansas.<sup>17</sup> It has authority to prosecute Medicaid fraud and cases of patient abuse and neglect. At the time of our review, the Unit's 15 employees were located in the State capital of Topeka.<sup>18</sup> For FY 2011, the Kansas Unit was authorized to receive \$1.2 million in Federal funds (with a State match of \$400,000), but expended just under \$1 million in Federal funds.<sup>19</sup> Total Medicaid expenditures in Kansas increased from \$2.4 billion in FY 2009 to \$2.8 billion in FY 2011.<sup>20</sup>

For FYs 2009 through 2011, the Unit received an average of 132 fraud referrals each year. The Unit also reviews every complaint received by the Kansas Department on Aging (KDOA) regarding potential abuse, neglect, or exploitation occurring in health care facilities, as well as reports from consumers or the public.<sup>21</sup> During FY 2011, the Unit reviewed 4,979 complaints that were received by KDOA.<sup>22</sup>

Upon receipt of a Medicaid fraud referral, an analyst is assigned to determine whether criminal or civil liability exists. The analyst forwards a recommendation memo to the Unit's Special Agent in Charge (SAC), who in turn forwards his or her recommendation to the Unit Director. Upon determining that a referral merits a full investigation, the SAC assigns an investigator and the Director assigns an attorney(s) and an analyst.

## **Previous Review**

In 2007, OIG conducted an onsite review of the Kansas Unit and found that: (1) the Unit lacked consistency in its investigative case files and did not have standardized policies and procedures for creating and maintaining case files; (2) the Unit did not routinely include opening, interim, or closing investigative memorandums in official files; (3) the Unit's case files did not contain an index identifying the information contained within each case file; (4) final dispositions of investigations were not noted in case files and Unit case files remained open indefinitely; (5) the Unit did not have any complaint, intake, or referral forms or documentation that identified specific complaint(s) or allegation(s) or the source of the information; and (6) the Unit initiated an open, active investigation for every complaint, referral, or

---

<sup>17</sup> *Kansas Attorney General's Medicaid Fraud and Abuse Division Annual Report 2010-11*. Accessed at <http://www.ag.ks.gov> on September 13, 2012.

<sup>18</sup> Our onsite review occurred in April 2012.

<sup>19</sup> OIG analysis of State form SF-425 for FY 2011.

<sup>20</sup> Medicaid Fraud Control Units FY2011 Statistical Chart. Accessed at <http://oig.hhs.gov/> on March 1, 2012.

<sup>21</sup> *Kansas Attorney General's Medicaid Fraud and Abuse Division Annual Report 2010-11*.

<sup>22</sup> All KDOA complaints are referred to local law enforcement and county prosecutors. The Unit determined that none of the 4,979 complaints merited further investigation.

allegation received, resulting in each investigator having approximately 61 open investigative cases, which may have been too burdensome to allow investigators to effectively and efficiently manage their caseload.

As part of the 2007 onsite review, OIG recommended that the Kansas Unit (1) develop and implement standardized policies and procedures for creating and maintaining investigative case files; (2) incorporate opening, interim, and closing investigative memorandums in case files; (3) develop and implement a case file index listing all documents contained within the case file to allow easy identification and access by staff; (4) close case files upon final adjudication of the case or determine an appropriate timeframe after final adjudication to close the official case file; (5) ensure that original complaint, intake, or referral documents are part of the official investigative case file; and (6) conduct preliminary investigations into all complaints, referrals, or allegations for a specified period and determine whether an active, open investigation should be initiated, develop minimum requirements for opening an investigative case, and prioritize investigative bases based on their merit.

The present onsite review found no evidence that issues related to findings 1, 3, 4, 5, or 6 continue to occur.

---

## METHODOLOGY

Our review covered the 3-year period of FYs 2009 through 2011. We analyzed data from seven sources: (1) a review of policies, procedures, and documentation of the Unit's operations, staffing, and caseload for FYs 2009 through 2011; (2) a review of financial documentation for FYs 2009 through 2011; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) an onsite review of case files that were open in FYs 2009 through 2011; and (7) an onsite review of Unit operations. If interview and survey respondents provided information that fell outside of our 3-year review period, we used it to explain further the results of our analyses covering FYs 2009 through 2011.

We analyzed data from all seven sources to describe the caseload and assess the performance of the Unit. We also analyzed the data to identify any opportunities for improvement and any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, and policy transmittals.<sup>23</sup>

---

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



## **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. We also reviewed the Unit's data describing how it detects, investigates, and prosecutes Medicaid cases. Data collected included the number of referrals received by the Unit and the number of investigations opened and closed.

*Review of Financial Documentation.* We reviewed Unit policies and procedures related to budgeting, accounting systems, cash management, procurement, property, and personnel to evaluate internal controls and design our tests for financial documentation. We reviewed the Unit's claimed \$3,793,846 (\$2,834,019 Federal share) in grant expenditures for FYs 2009 through 2011 to: (1) review final Federal Status Reports and the supporting documentation, (2) purposively select and review transactions within direct cost categories to determine whether costs were allowable, and (3) verify that indirect costs were accurately computed using the approved indirect cost rate. We reviewed records from the Payment Management System to identify unusual patterns of drawn-down amounts. Finally, we reviewed revenue accounts to identify program income amounts.

*Interviews With Key Stakeholders.* We conducted structured interviews with key stakeholders who were familiar with the operations of the Unit. Specifically, we interviewed the General Counsel of Social Rehabilitation Services (SRS)<sup>24</sup>; the Director of KDOA; the Assistant Chief Counsel of Kansas' Department of Health and Environment, Division of Health Care Finance (DHCF); and staff from the DHCF OIG. Additionally, we interviewed the SAC in HHS OIG's Kansas City region, as well as a Special Agent from the HHS OIG's Wichita field office. These interviews focused on the Unit's interaction with external agencies.

*Survey of Unit Staff.* We administered an electronic survey of all nonmanagerial Unit staff. We requested and received responses from 13 nonmanagerial staff members, for a 100-percent response rate. Our questions focused on operations of the Unit, opportunities for improvement, and practices that contributed to the efficiency and effectiveness of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

---

<sup>24</sup> As of February 2012, SRS is called the Department for Children and Families.

Interviews With Unit Management and Staff. We conducted structured interviews with the Unit Director and SAC (Chief Investigator). We also met with the individual who executes the budget. We asked these managers to provide us with additional information to better illustrate the Unit's operations, identify opportunities for improvement, identify practices that contributed to the efficiency and effectiveness of Unit operations and/or performance, and clarify information obtained from other data sources.

Onsite Review of Case Files. We selected a simple random sample of 100 case files from the 449 cases that were open at some point during FYs 2009 through 2011, the most recent complete FYs at the start of our review. We reviewed all of these sampled case files for documentation of supervisory approval for the opening and closing of cases, documented 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 and case development. See Appendix B for a distribution of case files from the population and sample.

Onsite Review of Unit Operations. While onsite, we reviewed the Unit's operations. Specifically, we observed intake of referrals, data analysis operations, security of data and case files, and the general functioning of the Unit.

### **Limitations**

We limited our internal control review to the Unit's procedures related to accounting, budgeting, personnel, procurement, and property and equipment.

### **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 2009 through 2011, the Unit reported combined civil and criminal recoveries of nearly \$66 million and 44 convictions**

The Unit reported combined criminal and civil recoveries of nearly \$66 million for FYs 2009 through 2011, increasing from \$19 million in FY 2009 to \$25 million in FY 2011 (see Table 1). Criminal recoveries declined from \$4.1 million in 2009 to slightly under \$1 million in 2011, while civil recoveries increased from \$15 million to \$24 million during the same period. The Unit closed 265 investigations and obtained 44 criminal convictions during the review period, along with 4 dismissals and 1 acquittal. See Appendix C for details on investigations opened and closed by provider category for FYs 2009 through 2011.

**Table 1: Kansas MFCU Recovered Funds, FYs 2009 Through 2011**

<b>Data Element Description</b>	<b>FY 2009</b>	<b>FY 2010</b>	<b>FY 2011</b>	<b>3-Year Total</b>
Reported Criminal Recoveries	\$4,102,312	\$240,193	\$926,986	\$5,269,491
Reported Civil Recoveries	\$14,856,538	\$21,551,436	\$23,910,671	\$60,318,645
<b>Total</b>	<b>\$18,958,850</b>	<b>\$21,791,629</b>	<b>\$24,837,657</b>	<b>\$65,588,136</b>

Source: OIG analysis of Kansas Unit Quarterly Statistical Reports, FYs 2009 through 2011.

### ***The Unit increased referrals through education and outreach efforts***

The Unit reported 121 referrals in FY 2009, 46 in FY 2010, and 230 in FY 2011. Referrals from private citizens to the Unit represented the largest increase in share of referrals. These referrals increased from 25 in FY 2009 to 29 in FY 2010 and to 79 in FY 2011. Unit management attributed the recent increase to the Unit's public outreach and education efforts. The Unit also reported an overall increase in referrals from State agencies (39 in FY 2009, 11 in FY 2010, and 88 in FY 2011). Unit management attributed this increase to the positive professional relationships cultivated with external stakeholder agencies. Throughout our interviews, staff from external stakeholder agencies, such as SRS, DHCF, and KDOA, were highly complimentary of the Unit staffs' willingness and ability to maintain effective communication. See Appendix D for details on referrals received by provider category for FYs 2009 through 2011.

## **For FYs 2009 and 2010, the Unit had several internal control weaknesses and inadequate policies and procedures related to certain expenditures**

According to Performance Standard 11, the Unit Director should exercise proper fiscal control over the Unit's resources. During FYs 2009 and 2010, the majority of the expenditures that the Unit claimed represented allowable, allocable, and reasonable costs in accordance with applicable Federal requirements.<sup>25</sup> However, the Unit did not always maintain adequate internal controls related to accounting, budgeting, personnel, procurement, and property and equipment. As a result, expenditures claimed for Federal reimbursement could not be reconciled with the accounting records and some expenditures claimed for vehicle costs were not properly allocated.

Contrary to Federal regulations, expenditures claimed for Federal reimbursement on the SF-269 reports in FYs 2009 and 2010 did not reconcile to the Unit's accounting records. As a result, the Unit underclaimed expenditures in FY 2009 by \$22,611 (\$18,243 Federal share) and overclaimed expenditures in FY 2010 by \$25,925 (\$19,444 Federal share). The Unit overclaimed expenditures for vehicle maintenance in FY 2011 by an estimated \$631 (\$473 Federal share). In addition, the Unit did not claim all allowable costs for fringe benefits and indirect costs. The Unit underclaimed fringe benefit expenditures in FY 2009 by an estimated \$47,982 (\$35,986 Federal share). The Unit underclaimed indirect costs in FYs 2009 and 2010 by \$16,315 (\$12,236 Federal share). The Unit did not have policies and procedures to ensure that all allowable expenditures were claimed for Federal reimbursement. A Unit official stated that policies and procedures are being put in place to ensure that all allowable expenditures are claimed in the future. See Appendix E for a comprehensive discussion of internal control weaknesses and procedures.

## **The Unit did not report the identities of all convicted providers to OIG within 30 days of sentencing for the purpose of program exclusion**

According to Performance Standard 8, Units should send to OIG, for purposes of program exclusions under section 1128 of the SSA, reports of convictions and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period.

---

<sup>25</sup> No underclaimed or overclaimed expenditures were identified for FY 2011.

During our review, we verified that between November 2008 and April 2011, the Kansas Unit failed to report 13 of 39 health care providers convicted of fraud, abuse, or neglect within 30 days of sentencing.<sup>26</sup> These individuals could potentially have received reimbursement from Medicaid and Medicare after their convictions; however, we identified no such payments.

The Unit director explained that from November 2008 through April 2011, the Unit designated an individual to handle the exclusion paperwork and submissions to the Healthcare Integrity and Protection Data Bank. That individual left in July 2011. In April 2012, during our onsite review, the failure to report the identities of convicted providers was identified and information sent to the OIG for exclusion.

### **The Unit did not establish annual training plans for its professional disciplines**

According to Performance Standard 12, the Unit should establish annual training plans for each professional discipline. The training provided under these plans should aid in the mission of the Unit and could be useful in providing a coordinated approach for the professional development of staff. At the time of our onsite review, managers reported that they had not established annual training plans for any of the three professional disciplines.<sup>27</sup> In 2007, the Unit created a training record form for each staff member to document completion of individual training. Unit management indicated that the process initially worked well, but the form fell out of use. However, the Unit has provided all staff with training opportunities to expand the skills and techniques they need to understand and perform their duties.<sup>28</sup> All new employees are provided introductory Medicaid training through the National Association of Medicaid Fraud Control Units Medicaid 101 training, and take advantage of other training related to fraud trends and financial investigation techniques as it becomes available. Unit management reported that despite cost concerns and a lack of regional training opportunities that fit the unique needs of their staff, all

---

<sup>26</sup> We included all referrals received within 30 business days as meeting the performance standard. One of the 13 health care providers not reported was referred 55 days after sentencing; the others were referred later. All referrals were made by the conclusion of the onsite review.

<sup>27</sup> 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.

<sup>28</sup> *Kansas Attorney General's Medicaid Fraud and Abuse Division Annual Report 2010-11.*

law enforcement training hours were met. The Unit's annual report also demonstrated that attorneys received necessary continuing legal education.

### **Case files had inconsistent documentation of supervisory approval for key stages of investigations, yet cases generally proceeded timely**

According to Performance Standard 6, the Unit should have a continuous case flow and cases should be completed in a reasonable time. As a part of this effort, managers should approve the opening and closing of cases and document any supervisory case reviews in the case file. Twenty-three percent of case files lacked documented supervisory approval detailing the opening of the investigation, and 16 percent of closed files were missing documented supervisory approval for closing the case. Unit management stated that Pharmaceutical Average Wholesale Price and Global Pharmaceutical cases did not have signed supervisory approval due to the nature of the cases (i.e., these cases were typically nationwide cases). Excluding these types of cases, 11 percent of opening investigations and 5 percent of closed cases lacked supervisory approval. The performance standard does not differentiate between types of cases requiring supervisory approval.

Performance Standard 6 also states that supervisory reviews should be "conducted periodically and noted in the case file." The Unit's policy is to conduct a periodic supervisory review every 6 months on all open cases. Of the 42 percent of cases open longer than 6 months, 19 percent lacked documentation of periodic 6-month supervisory reviews.<sup>29</sup> See Appendix F for sample sizes and 95-percent confidence intervals associated with point estimates.

Although several of the case files lacked opening or closing approvals and supervisory reviews, only one of the cases we reviewed experienced unreasonable delays. Criminal investigations, including filing of criminal charges, seeking restitution without filing criminal charges, and closing the case without filing criminal charges or seeking restitution, were all processed timely. Criminal and civil prosecutions were also processed timely.

---

<sup>29</sup> For the purposes of this report, supervisory approval to open and close a case does not constitute a case file "review." Periodic supervisory review indicates that a supervisor reviewed a case more than once between the opening and closing of the case.

---

## CONCLUSION AND RECOMMENDATIONS

For FYs 2009 through 2011, the Unit reported combined civil and criminal recoveries of nearly \$66 million and 44 convictions. The Unit increased referrals through education and outreach efforts. Our review found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals.

However, our review found opportunities for improvement and instances in which the Unit did not fully meet the performance standards. Specifically, for FYs 2009 and 2010, the Unit had several internal control weaknesses and inadequate policies and procedures related to certain expenditures. For FYs 2009 through 2011, the Unit did not report the identities of all convicted providers to OIG within 30 days of sentencing for the purpose of program exclusion, and did not establish annual training plans. Similar to the findings from 2007, the Unit's case files lacked documentation of supervisory approval for key stages of the investigative process, although the cases were adequately developed.

Based on these findings, we recommend that the Kansas Unit:

### **Develop Policies and Procedures To Address Internal Control Weaknesses**

The Unit should ensure that expenditures claimed are reconciled to accounting records, and that expenditures are allocated and claimed in accordance with Federal regulations.

### **Develop a Protocol To Ensure Identities of Convicted Providers Are Reported to OIG**

The Unit should ensure that individuals convicted of fraud, abuse, and neglect are reported within 30 days of their sentencing.

### **Establish Annual Training Plans for Professional Disciplines**

The Unit should develop plans that indicate the type and duration of training for each professional discipline. The Unit may work with OIG to identify additional relevant training opportunities for staff.

### **Ensure That All Case Files Contain Opening and Closing Investigative Memoranda, Documented Supervisory Approval, and Documented Periodic Supervisory Reviews**

---

## UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with the four report recommendations. Regarding our first recommendation, the Unit has been working to identify and improve internal control weaknesses, including: reconciling expenditures, vehicle

costs, fringe benefits, and indirect costs. With respect to reconciling expenditures, changes have been made and implemented by the Attorney General's Office and the Unit to avoid this reporting situation in the future. Further, the Unit is working to reconcile FYs 2009 and 2010 expenditures and is working with OIG to amend its financial reporting accordingly. With respect to vehicle costs, as of June 2012, non-Unit employees are no longer permitted to use Unit vehicles for any purpose. With respect to fringe benefits, the Unit has worked closely with the Budget Division of the Attorney General's Office to develop a system of checks and balances to ensure that receipts and expenditures are properly accounted. With respect to indirect costs, efforts are underway to train current Unit and Budget Division staff to ensure that proper indirect cost rates are utilized and that all allowable expenditures are claimed for the Unit. The Unit and Budget Division staff will work closely to ensure that proper indirect costs are submitted.

Regarding our second recommendation, the Unit acknowledged that there were a number of providers for which exclusion paperwork was not submitted to OIG timely. A report will be provided to the Unit director monthly allowing for verification that each conviction is being reported in a timely fashion or that there is a satisfactory explanation for any delay.

Regarding our third recommendation, the Unit is currently working with the administration to develop a training plan that will not only serve to meet the demands of the performance standards, but may also be utilized by the Attorney General's Office for other professional staff.

Regarding our fourth recommendation, the Unit will prepare opening and closing memoranda, as well as periodic case file reviews for all Global and Average Wholesale Price cases. Opening memoranda will be created for all cases currently open. A staff member has been assigned to develop a case file review form that can be automatically generated for each case.

The full text of the Unit's comments is provided in Appendix G. We modified the number of exclusions not reported timely to the OIG from 30 to 13 based on additional documentation that the Unit provided. One of the 13 health care providers not reported was referred 55 days after sentencing; the rest were referred during our onsite review.



---

## APPENDIX A

### 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

### Population and Sample Distribution of Case Files Open Any Time During Fiscal Years 2009 Through 2011

Data Element Description	Population (number)	Sample (number)	Population (percentage)	Sample (percentage)
Fraud—Civil (Open)	29	5	6.5%	5%
Fraud—Civil (Closed)	21	5	4.7%	5%
Fraud—Criminal (Open)	76	15	16.9%	15%
Fraud—Criminal (Closed)	165	39	36.7%	39%
Fraud—Global (Open)	41	9	9.1%	9%
Fraud—Global (Closed)	37	6	8.2%	6%
Abuse—Criminal (Open)	0	0	0.0%	0%
Abuse—Criminal (Closed)	28	6	6.2%	6%
Patient Funds—Criminal (Open)	9	1	2.0%	2%
Patient Funds—Criminal (Closed)	43	14	9.6%	14%
<b>Total</b>	<b>449</b>	<b>100</b>	<b>100%</b>	<b>100%</b>

Source: Kansas Medicaid Fraud Control Unit, 2012.

## APPENDIX C

### Investigations Opened and Closed by Provider Category for Fiscal Years 2009 Through 2011

**Table C-1: Fraud Investigations**

Provider Category	FY 2009		FY 2010		FY 2011	
	Opened	Closed	Opened	Closed	Opened	Closed
<b>Facilities</b>						
Hospitals	1	0	1	2	0	0
Nursing Facilities	0	0	1	2	0	0
Other Long-Term Care Facilities	0	0	0	0	0	0
Substance Abuse Treatment Centers	1	0	1	2	1	0
Other	1	3	0	0	0	0
<b>Practitioners</b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>
Doctors of Medicine or Osteopathy	2	1	1	2	1	1
Dentists	1	2	0	1	0	0
Podiatrists	0	0	0	0	0	0
Optometrists/Opticians	0	0	0	0	0	0
Counselors/Psychologists	1	1	0	1	1	0
Chiropractors	0	0	0	0	0	0
Other	1	0	1	1	0	0
<b>Medical Support</b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>
Pharmacies	3	3	0	1	2	0
Pharmaceutical Manufacturers	38	1	34	22	15	19
Durable Medical Equipment and/or Supplies	0	0	3	3	2	2
Labs	0	0	0	0	0	0
Transportation Services	4	8	0	5	2	4
Home Health Care Agencies	5	3	8	9	5	4
Home Health Care Aides	31	22	22	26	48	38
Nurses, Physician Assistants, Nurse Practitioners, Certified Nurse Aides	1	1	7	7	1	2
Radiologists	0	0	0	0	0	0
Medical Support—Other	2	0	0	0	1	1
<b>Program Related</b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>
Managed Care	0	0	0	0	1	0
Medicaid Program Administration	0	0	0	0	0	0
Billing Company	1	2	1	1	15	0
Other	0	0	0	0	0	0
<b>Total Provider Categories</b>	<b>93</b>	<b>47</b>	<b>80</b>	<b>85</b>	<b>95</b>	<b>71</b>

Source: Kansas Medicaid Fraud Control Unit (Unit).  
FY = fiscal year.

---

**Table C-2: Patient Abuse, Neglect, and Funds Investigations**

Provider Category	FY 2009		FY 2010		FY 2011	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing Facility	0	1	0	1	1	0
Nondirect Care	3	2	1	3	5	3
Other Long-Term Care	0	0	0	1	0	0
Nurses/Physician's Assistant/Nurse Practitioner/ Certified Nurse Aides	12	2	3	12	0	2
Home Health Aides	0	0	0	0	1	0
Other	13	8	12	11	8	16
<b>Total</b>	<b>28</b>	<b>13</b>	<b>16</b>	<b>28</b>	<b>15</b>	<b>21</b>

Source: Kansas Unit.

## APPENDIX D

### Medicaid Fraud Control Unit Referrals by Provider Category for Fiscal Years 2009 Through 2011

Referral Source	FY 2009			FY 2010			FY 2011		
	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Funds
Kansas Department of Social and Rehabilitation Services – Surveillance and Utilization Review Unit	12	0	0	2	0	1	3	0	0
Kansas Department of Social and Rehabilitation Services – Other	14	6	3	3	0	1	39	2	2
State Survey & Certification	0	0	0	0	0	0	0	0	0
Other State Agencies	0	4	0	1	3	0	17	22	3
Licensing Board	1	0	0	0	0	0	0	0	0
Law Enforcement	2	0	9	0	0	4	5	1	3
Office of Inspector General (OIG)	0	0	0	1	0	0	1	0	0
Prosecutors	3	0	1	0	0	1	5	0	3
Providers	3	0	0	0	0	0	22	0	0
Provider Associations	0	0	0	0	0	0	3	0	0
Private Health Insurer	0	0	0	0	0	0	0	0	0
Long Term Care Ombudsman	0	0	0	0	0	0	0	0	0
Adult Protective Services	1	0	3	0	0	0	4	0	2
Private Citizens	24	0	1	26	2	1	69	3	7
MFCU Hotline	0	0	0	0	0	0	0	0	0
Other	32	2	0	0	0	0	13	1	0
<b>Total</b>	<b>92</b>	<b>12</b>	<b>17</b>	<b>33</b>	<b>5</b>	<b>8</b>	<b>181</b>	<b>29</b>	<b>20</b>
<b>Annual Total</b>	<b>121</b>			<b>46</b>			<b>230</b>		

Source: OIG analysis of Kansas Medicaid Fraud Control Unit (MFCU) Quarterly Statistical Reports, fiscal years 2009 through 2011.



---

## APPENDIX E

### **Expanded Information on Internal Control Weaknesses and Inadequate Policies and Procedures Related to Certain Expenditures**

The following material describes in detail the internal control weaknesses identified.

#### ***Expenditures Claimed for Federal Reimbursement Did Not Reconcile to the Accounting Records***

Federal regulations (45 CFR § 92.20(a)) state: Fiscal control and accounting procedures of the State ... must be sufficient to—

- (1) Permit preparation of reports required by this part and the statutes authorizing the grant, and
- (2) Permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of applicable statutes.

Federal regulations (45 CFR § 92.20(b)) require financial management systems to meet the following standards:

- (1) Financial reporting. Accurate, current, and complete disclosure of the financial results of financially assisted activities must be made in accordance with the financial reporting requirements of the grant or subgrant.
- (2) Accounting records. Grantees and subgrantees must maintain records which adequately identify the source and application of funds provided for financially-assisted activities. These records must contain information pertaining to grant or subgrant awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income.

Contrary to Federal regulations, expenditures claimed for Federal reimbursement on the SF-269 reports in fiscal years 2009 and 2010 did not reconcile to the Medicaid Fraud Control Unit's (Unit) accounting records. As a result, the Unit underclaimed expenditures in FY 2009 by \$22,611 (\$18,243 Federal share) and overclaimed expenditures in FY 2010 by \$25,925 (\$19,444 Federal share).

The Unit did not have policies and procedures in place to ensure that the expenditures claimed on the SF-269 reports reconciled to its accounting records. A Unit official stated that policies and procedures are being put in place to ensure expenditures claimed in the future reconcile to the accounting records.

### ***Expenditures Claimed for Vehicle Costs Were Not Properly Allocated***

Federal regulations at 2 CFR pt. 225, Appendix A, (C)(3)(a), state: “A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received.”

Contrary to Federal regulations, the Unit did not properly allocate vehicle maintenance costs. Specifically, the Unit allowed the State Attorney General’s Office to use the Unit’s vehicles during FY 2011; this use totaled approximately 25 percent of the mileage accumulated on these vehicles. However, the Unit claimed all the vehicle maintenance costs for Federal reimbursement instead of allocating 25 percent of the costs to the State Attorney General’s Office. As a result, the Unit overclaimed expenditures for vehicle maintenance in FY 2011 by an estimated \$631 (\$473 Federal share).

The Unit did not have policies and procedures in place to ensure that expenditures were allocated in accordance with Federal regulations. A Unit official said that the State Attorney General’s Office paid for fuel and tolls when using the Unit’s vehicles and therefore, the Unit did not believe it was necessary to allocate the costs.

### ***Expenditures for Fringe Benefits Not Claimed***

Federal regulations (45 CFR § 92.20(b)) require financial management systems to meet the following standards:

- (1) Financial reporting. Accurate, current, and complete disclosure of the financial results of financially assisted activities must be made in accordance with the financial reporting requirements of the grant or subgrant.
- (2) Accounting records. Grantees and subgrantees must maintain records which adequately identify the source and application of funds provided for financially-assisted activities. These records must contain information pertaining to grant or subgrant awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income.

Contrary to Federal regulations, the Unit did not claim all allowable fringe benefit expenditures. Specifically, the Unit did not claim expenditures for fringe benefits (employer portion of health benefits) for 3 months during FY 2009. As a result, the Unit underclaimed fringe benefit expenditures in FY 2009 by an estimated \$47,982 (\$35,986 Federal share).

The Unit did not have policies and procedures in place to ensure that all allowable expenditures were claimed for Federal reimbursement. A Unit

official stated that policies and procedures are being put in place to ensure that all allowable expenditures are claimed in the future.

### ***Expenditures for Indirect Costs Not Claimed***

Federal regulations at 2 CFR pt. 225, Appendix E (B)(7), states:

“‘Provisional rate’ means a temporary indirect cost rate applicable to a specified period which is used for funding, interim reimbursement, and reporting indirect costs on Federal awards pending the establishment of a ‘final’ rate for that period.”

With respect to the final rate, 2 CFR pt. 225, Appendix E (B)(8), states: “‘Final rate’ means an indirect cost rate applicable to a specified past period which is based on the actual allowable costs of the period. A final audited rate is not subject to adjustment.”

Contrary to Federal regulations, the Unit did not claim all allowable indirect costs. Specifically, the Unit used the provisional rate of 16.2 percent and did not change to the final rate of 18.3 percent during FYs 2009 and 2010. As a result, the Unit underclaimed indirect costs in FYs 2009 and 2010 by \$16,315 (\$12,236 Federal share).

The Unit did not have policies and procedures in place to ensure that all allowable expenditures were claimed for Federal reimbursement. A Unit official stated that policies and procedures are being put in place to ensure that all allowable expenditures are claimed in the future.

### ***Internal Control Weaknesses***

Although the Unit’s internal controls were adequate to ensure that the majority of the expenditures that the Unit claimed and that we reviewed for this audit period were claimed correctly, we noted some internal control weaknesses and inadequate policies and procedures as described throughout the report. These could result in the Unit’s reporting incorrect expenditures for Federal reimbursement.

---

## APPENDIX F

### Point Estimates and Confidence Intervals Based on Case File Reviews

We calculated confidence intervals for key data points for the case file reviews. The sample sizes, point estimates, and 95-percent confidence intervals are given for the each of the following:

**Table F-1: Confidence Intervals for Case File Review Data**

<b>Data Element Description</b>	<b>Sample Size</b>	<b>Point Estimate (percentage)</b>	<b>95-Percent Confidence Interval</b>
Case files missing supervisory approval for the opening of investigations	100	23.0	16.4–31.2
Case files missing documented supervisory approval for the closing of investigations	70	15.7	9.5–25.0
Case files missing documented periodic supervisory reviews (for cases open longer than 6 months)	42	19.1	10.6–31.2
Case files missing supervisory approval for the opening of investigations (excluding Global and Average Wholesale Price cases)	76	10.5	5.8–18.5
Case files missing documented supervisory approval for the closing of investigations (excluding Global and Average Wholesale Price cases)	59	5.1	1.9–13.2

Source: Office of Inspector General analysis of Medicaid Fraud Control Unit case files, 2012.

---

## APPENDIX G

### Unit Comments



STATE OF KANSAS  
OFFICE OF THE ATTORNEY GENERAL

**DEREK SCHMIDT**  
ATTORNEY GENERAL

MEMORIAL HALL  
120 SW 10TH AVE., 2ND FLOOR  
TOPEKA, KS 66612-1597  
(785) 296-2215 • FAX (785) 296-6296  
WWW.KSAG.ORG

August 31, 2012

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

RE: Kansas State Medicaid Fraud Control Unit: 2012 Onsite Review  
(OEI-07-12-00200)

Dear Mr. Wright,

On behalf of the Kansas Attorney General and the Kansas Medicaid Fraud Control Unit (MFCU), we thank you for the opportunity to respond to draft report of the Kansas State Medicaid Fraud Control Unit: 2012 Onsite Review. As is true with many of the Medicaid Fraud Control Units, we have undergone a change in administration during the period of time covered by the onsite review. Therefore, we in the MFCU have taken this review as an opportunity to evaluate the operational guidelines that were in place prior to the current administration, as well as those guidelines and policies that have been put in place since the change in the administration. We would also like to extend our thanks to the staff conducting the review. We found them to be very professional and helpful throughout the course of the onsite review. Of particular assistance was their willingness to not only provide constructive criticism, but to also communicate and allow for dialogue throughout the process.

In accordance with the request of HHS-OIG, we are taking this opportunity to respond to the recommendations set forth in the draft report, including whether we concur or disagree with the recommendations, as well as explain the actions that have been implemented to-date and those actions that are in currently in the process of being implemented. We also include an analysis of the circumstances that lead to the recommendation.

***Develop Policies and Procedures to Address Internal Control Weaknesses***

*The Unit should ensure that expenditures claimed are reconciled to accounting records, and that expenditures are allocated and claimed in accordance with Federal regulations.*

**Response:**

We concur with the recommendation and would note that even prior to the onsite review, efforts were underway to identify and improve internal control weaknesses in this area.

The MFCU and the Attorney General acknowledge the importance of having proper policies and procedures in place as noted in the draft report. There were four (4) primary areas of concern within this section of the draft report. This response will attempt to address each of those.

**Reconciling Expenditures:**

**Analysis:**

Although not stated directly in the report, we appreciate the review team's candor throughout the onsite review, and the assurance that no major concerns were identified in this area, other than failure to reconcile the SF-269 reports filed by the MFCU to the MFCU's accounting records. The internal control weaknesses identified through the onsite review had previously been identified by the Attorney General's Office and the MFCU and work had begun to rectify those concerns prior to the onsite review.

The MFCU has conducted a comprehensive review of the expenditures for FYs 2009 and 2010 since the completion of the onsite review. All expenditures and receipts were reconciled to the statewide accounting system and all expenditures by the MFCU for those years were found to be proper. It is important to note that during this time period, beginning in FY 2009, the State of Kansas changed accounting systems from STARS to SMART. The result was a migration from one system to an entirely new and different system. While this does not explain or excuse the lack of reconciling by the MFCU, this transition did pose some difficulties that may have contributed to the reporting that occurred. We believe that certain expenditures may have crossed federal, as well as state, fiscal years leading to an under reporting of expenditures on federal reports in one year and an over reporting in the next year. In any event, as discussed below, changes have been implemented by the Attorney General's Office and the MFCU that will avoid this reporting situation in the future. With the recently implemented changes the MFCU now works closely with the Attorney General's Budget Division staff to ensure that all MFCU expenditures are reconciled with the State accounting system and that the federal reports are accurate.

**Plan:**

As mentioned in the draft report the MFCU has already initiated the process of developing, or reinstating in some circumstances, policies and procedures to ensure that expenditures reconcile to accounting records. In fact, absent from the draft report was any mention of the reports and accounting records for FY 2011. The FY 2011 expenditures were reconciled to the MFCU accounting records and the SF-269 reports were accurate, serving to demonstrate the effectiveness of the changes that have been instituted by the MFCU and the Attorney General's Office. Following is a description of the system and controls that have been put in place by the MFCU and Attorney General's Office budget staff.

The State of Kansas operates under the SMART accounting system, the controlling accounting system for all state agencies, including the Attorney General's Office. This system controls all funds appropriated to and expended by the Attorney General's Office, including, but not limited to, federal grant funds. SMART is an on-line general ledger system that accounts for all revenues, expenditures and encumbrances, and includes comparison to funds appropriated.

Through SMART the MFCU is able to verify accounting of funds relating to the federal grant. In addition, the MFCU has created a system of accounting records that are utilized as checks and balances against the SMART system. It is important to note that all of the information input into the accounting records is supplied through the SMART system.

All requests for federal funds, all federal reports and the annual MFCU budget are prepared by MFCU staff, reviewed by the MFCU Director and Budget Division of the Attorney General's Office, and signed upon completion by the MFCU Director.

All MFCU purchases are subject to review and approval by the Budget Division of the Attorney General's Office. This generally includes the Budget Director and may involve the Chief of Staff, depending upon the purchase. Daily purchases are initiated through a Purchase Requisition (PR). The PR must be approved by the MFCU Director and then submitted to the Budget Director for final authorization. Once the purchase is made and an invoice received, the invoice and backup or supplemental documentation are reviewed and approved by the MFCU Director. The approved invoice is then submitted to the Accountant in the Budget Division who matches the invoice with the PR. Final payment is then subject to approval by Budget Division staff.

For purchases over \$5,000, the Budget Director, or other member of the Budget Division, must approve the purchase request, subject to review and approval by the Kansas Division of Purchasing. The Division of

Purchasing will verify whether a contract is in place allowing for the purchase of the item or if the purchase has to be submitted through the bid process.

All out-of-state travel must be pre-approved by the MFCU Director, subject to final approval by the Chief Deputy Attorney General or the Chief of Staff.

An agency audit of expenditures made by the Attorney General's Office, including the MFCU, is conducted by the Kansas Department of Administration every 3 years. Further, daily auditing occurs on each receipt and expense of the Attorney General's Office, including the MFCU, by the Budget Division. The Kansas Department of Administration may, and does, conduct a daily audit of purchases made by the Attorney General's Office, including the MFCU.

At the conclusion of each month a report of all expenditures by the MFCU is generated from SMART and is reviewed first by the Budget Division and then by the MFCU. After reviewing and confirming the expenditures, the information is then transferred to an accounting record maintained by the MFCU, separate and apart from SMART. This accounting record is then reconciled against the SMART ledger for accuracy. Once reviewed for accuracy by the MFCU, the accounting record is sent to the Budget Division for further review and changes as necessary. At the conclusion of each quarter, the accounting record, having been reconciled on a monthly basis, is utilized to prepare the appropriate SF-269 form. The final SF-269 form is then submitted to the Budget Division for comparison against the SMART figures. Once approved by the Budget Division, the MFCU Director signs and submits the SF-269 to HHS-OIG.

These steps are very similar to the protocols that were in place prior to changes instituted in 2009. Based upon a thorough review of the process and procedures, additional auditing procedures have been added to further ensure accurate reporting.

Vehicle Costs:

**Analysis:**

In FY 2011 a request was made to HHS-OIG by the MFCU to allow other federal grant recipients in the Attorney General's Office to utilize MFCU vehicles for official grant business. This was addressed to HHS-OIG and the decision was made to allow this usage to occur. Efforts were made to track all usage by non-MFCU staff and all costs associated with non-MFCU travel were absorbed by the Attorney General's Office. However, procedures were not instituted to require an allocation of maintenance costs of the vehicles. All maintenance of the vehicles was handled by the MFCU.



**Plan:**

As of June of 2012, non-MFCU employees are no longer permitted to utilize MFCU vehicles for any purpose. All maintenance costs for FY 2012 will be computed based upon the percentage of non-MFCU staff use and the MFCU will be reimbursed by the Attorney General's Office for maintenance expenditures paid by the MFCU by the close of the federal fiscal year.

Fringe Benefits:

**Analysis:**

During the time period in question the State of Kansas transitioned to the new SMART accounting system. We believe that in the transition to the new statewide accounting system that an error occurred in the coding of fringe benefits that was not immediately identified. We would also note that this issue has not reoccurred since the new accounting system was fully implemented.

**Plan:**

As was discussed in the section relating to reconciling expenditures, the MFCU has worked closely with the Budget Division of the Attorney General's Office to develop a system of checks and balances to ensure that receipts and expenditures are properly accounted for. While we are unable to identify exactly why this occurred in FY 2009, we feel certain that the internal controls that are now in place will permit us to catch these types of mistakes and prevent them from occurring again.

Indirect Costs:

**Analysis:**

Obviously it is not the intent of the MFCU to under claim indirect costs expenditures. The indirect cost claims were handled by the Attorney General's budget staff beginning in 2009 and continuing until October of 2011. Prior to that period of time all indirect costs were handled by MFCU staff. As with the accounting procedures outlined above, the indirect costs are now being handled jointly by the MFCU and the Budget Division.

**Plan:**

All MFCU employees familiar with the indirect cost policies and procedures prior to 2009 are no longer with the MFCU. Efforts are underway to train current MFCU and Budget Division staff to ensure that proper indirect cost rates are utilized and that all allowable expenditures are claimed for the MFCU. As with the accounting reconciliation processes described above, staff from the MFCU and the Budget Division will work

closely together on this issue to insure that proper indirect cost rates are submitted and that all allowable reimbursements are obtained

***Develop a Protocol to Ensure Identities of Convicted Providers Are Reported to OIG***

*The Unit should ensure that individuals convicted of fraud, abuse, and neglect are reported within 30 days of their conviction.*

**Response:**

We concur with the recommendation that convicted providers must be reported within the time period set forth in Performance Standard 8. We acknowledge that there were a number of providers for which exclusion paperwork was not submitted to HHS-OIG in a timely fashion. However, an internal review of the files reviewed by the onsite review team revealed that the number of health care providers that were identified as not having been timely reported was actually less than was indicated in the draft report. For those that were mistakenly overlooked and not reported by the MFCU, we appreciate the efforts of the review team in identifying those discrepancies and the appropriate policy changes have been instituted.

**Analysis:**

Performance Standard 8 calls for the report of conviction to occur “within 30 days or other reasonable time period.” Moreover, it also calls for the report to include “copies of Judgment and Sentence or other acceptable documentation...” Finally, once a recommendation for exclusion has been submitted to HHS-OIG, it is no longer within the control of the MFCU as to when that exclusion takes effect. These factors are relevant to our analysis of this area of concern.

It appears that the determination of timeliness of this reporting was based, at least in part, on the date of sentencing and the date that HHS-OIG reports that the exclusion took effect. That being said, the MFCUs have little to no control over the exclusion process once the information has been submitted to HHS-OIG. We only have the ability to control how quickly the information gets processed and sent out from the MFCU once a conviction is obtained. Even then, some factors may come into play that are outside of the control of the MFCU.

The MFCU acknowledges that there were 12 case files out of the 30 identified by the review team for which exclusions had not been submitted to HHS-OIG in a timely fashion. As was noted in the draft report there had been a change of staff in July of 2011 and the employee given those responsibilities had not been properly trained on the process. Upon being trained, approximately 6 months later, the individual began the task of completing and submitting the exclusion paperwork to HHS-OIG. During that period of time some cases were not reported until they were brought to the attention of the MFCU during the onsite review.

As for the remaining 18 cases, a review of the records indicated that documentation was in fact submitted to HHS-OIG for exclusion consideration, and in many cases, within a reasonable period of time. In fact, for some of the identified cases the exclusion report was submitted within 30 days of sentencing.

With regards to those cases not submitted within 30 days of sentencing, there are a number of factors outside of the control of the MFCU that may preclude being able to submit the exclusion. For example, once a sentencing is complete the Journal Entry has to be prepared and circulated to the parties and the judge for filing with the Court. This can lead to delays outside of the control of the MFCU. Once the Journal Entry is received by the MFCU every effort is made to complete the exclusion documentation for submission to HHS-OIG. This is just one example of the types of delays that may prevent the MFCU from submitting within 30 days. It is important to note that we have not verified that there was such a reason for each instance outside of 30 days. This example is offered merely for analysis purposes and to explain that, despite the best efforts of the MFCUs, it may not be possible to meet the 30 day deadline in every instance.

**Plan:**

As was noted in the draft report, all convicted providers identified as having not been reported to HHS-OIG have now been reported to HHS-OIG for exclusion consideration. The Case Closing Summary which is a document required for every MFCU case that has been concluded has a section to be utilized for indicating if the exclusion paperwork has been completed and submitted to HHS-OIG. Cases being submitted to the Director of the MFCU for closure must have this section completed prior to receiving approval to close the case. Moreover, the MFCU case management system has a similar section that must be completed. A report will be provided to the MFCU Director monthly allowing for verification that each conviction is being reported in a timely fashion or that there is a satisfactory explanation for any delay. This will allow the MFCU to track all closed cases and make sure that the exclusion report has been submitted in a timely fashion.

***Establish Annual Training Plans for Professional Disciplines***

*The Unit should develop plans that indicate the type and duration of training for each professional discipline. The Unit may work with OIG to identify additional relevant training opportunities for staff.*

**Response:**

We concur with the recommendation.

**Analysis:**

The MFCU has been and remains committed to training of staff. Prior to and during the review period many attempts were made to develop an effective training plan. As was mentioned in the draft report, the MFCU at one point had implemented a series of

forms to be utilized in both planning for training opportunities and for reporting training that had been received. These forms were found to be ineffective in large part because of the ever-changing training opportunities and uncertainty as to available programs. Despite not having a written training plan, the professional staff of the MFCU, as was noted in the draft report, has always been provided with opportunities to expand their skills and techniques in order to perform their job functions. Each year a report of all training received by the MFCU staff is included in the annual report submitted to HHS-OIG. MFCU staff have consistently satisfied all training requirements of their respective professions.

It was also noted in the draft report that each new employee to the MFCU is provided introductory training through the National Association of Medicaid Fraud Control Units (NAMFCU) and has further NAMFCU training opportunities made available to them as resources permit. Furthermore, each staff is encouraged to seek out training opportunities that are relevant to their duties and responsibilities and submit those to management for consideration. While this process has been utilized for a number of years, there has not been any effort to formalize the process or put it into written form, as was recognized through the Onsite Review

**Plan:**

The MFCU is currently working with the administration to develop a training plan that will not only serve to meet the demands of the federal performance standards for MFCUs, but that may also be utilized by the Attorney General's Office for other professional staff. This will include the development of written protocol for identifying and requesting training opportunities. Concentrated efforts will be made to monitor all training requests and completed trainings, making sure that each professional staff member of the MFCU receives effective training satisfactory to meet all training requirements and to perform their job duties. Work will continue throughout the remainder of 2012 in developing the written training plan for the MFCU.

*Ensure That All Case Files Contain Opening and Closing Investigative Memoranda, Documented Supervisory Approval, and Documented Periodic Supervisory Reviews*

**Response:**

We concur with the recommendation.

**Analysis:**

Subsequent to the most recent review completed by HHS-OIG in April of 2007 staff from the MFCU visited a neighboring State's MFCU at the suggestion of the reviewers. From that visit a system was established for preparing and including opening and closing memorandum, as well as periodic case file reviews. A concentrated effort was made to ensure that each referral received by the MFCU had the appropriate

documentation included with it, whether or not that referral was opened as a formal investigation. The policy is that each case file that is opened shall have a "Case Opening Form (MFCU-100)" and that each case that is closed shall have a "Case Closing Form (MFCU 101)". Moreover, before a case may be opened or closed these forms must be reviewed and approved by the Director of the MFCU. In addition, throughout the period of time that a case is open a "Case File Review Form (MFCU 103)" is to be completed by the appropriate staff in July and December of each year and must also be approved by the Director. The review forms notify the Director of the status of the case, detailing what activity has occurred during the past six months and what actions are going to be taken in the next six months. This not only permits the Director to evaluate the case as it is progressing, it also serves to require the staff to touch and think about each case. With the large case loads that staff are required to maintain, it can be easy to lose sight of a particular case if it has not been reviewed in a while. This requires that review to take place.

During the review period there were certain types of cases that were simply opened without completing the appropriate documentation. As was noted in the draft report this included the Global case files and those files associated with the pharmaceutical Average Wholesale Pricing (AWP) litigation. These cases were also not subject to having the case file reviews completed. This was due to the nature of the cases and the fact that staff were not always required to be actively engaged in these cases. It is recognized that, while these cases may be handled differently by the MFCU, this does not negate the need for proper documentation.

Finally, it needs to be noted that the Director took the opportunity to review each and every file that was reviewed during this process prior to arrival of the Onsite Review team. It was noted by the Director that certain files that were going to be subject to review were missing one or more of the required documents. At that point efforts were made to rectify the situation for future reviews, as is set forth in the paragraph below.

**Plan:**

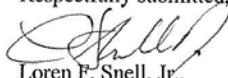
Action was taken immediately to respond to the issue identified by the reviewers. As relates to the Global and AWP cases, each case that is opened by the MFCU, regardless of the type of case, and regardless of the level of direct involvement by staff, will have an opening form, a closing form and the periodic review forms. The appropriate staff for completing these forms have been identified and instructed accordingly. Furthermore, where possible, opening forms will be created for all open cases, regardless of the type of case, in order to make sure that all cases currently open by the MFCU are in compliance.

The case management system utilized by the MFCU has the capability of producing certain documents on demand, referred to as "hot docs." A staff member has been assigned the task of developing a Case File Review form "hot doc" that can be automatically generated for each open case, thereby making this process easier and less time consuming for staff.

Conclusion:

Again, the Kansas Medicaid Fraud and Abuse Division of the Attorney General's Office offers our appreciation for the effort and dedication of the staff conducting the onsite review. We have reviewed and concur with each of the recommendations. As was noted during the review process the MFCU has either already implemented or will implement the appropriate action steps to rectify the concerns addressed by the draft report. As was noted in the draft report, the Kansas MFCU has achieved tremendous results during the three year period of review as we have navigated through a number of changes. We recognize the vital role we play in protecting the integrity of the state's Medicaid program and see this as an opportunity to continue to improve the level of service that we offer.

Respectfully submitted,



Loren F. Snell, Jr.,  
Deputy Attorney General  
Director, Medicaid Fraud and Abuse Division

---

## ACKNOWLEDGMENTS

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Brian T. Whitley served as the team leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Michael J. Brown, Susan Burbach, Teresa Dailey, and Julie Dusold Culbertson. Office of Audit Services staff who conducted the study include Ann Lowe, Ryan Moul, and Julie Wiser. Office of Investigations staff who conducted the study include Randall House. Central office staff who provided support include Kevin Farber, Debra Roush, Richard Stern, and Jason Weinstock.

# Office of Inspector General

<http://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## **Office of Audit Services**

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

## **Office of Evaluation and Inspections**

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

## **Office of Investigations**

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

## **Office of Counsel to the Inspector General**

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