Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEBRASKA STATE MEDICAID FRAUD CONTROL UNIT: 2014 ONSITE REVIEW

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EXECUTIVE SUMMARY: NEBRASKA STATE MEDICAID FRAUD CONTROL UNIT: 2014 ONSITE REVIEW
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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 conducted an onsite review in February 2014. We analyzed data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for fiscal years (FYs) 2011 through 2013; (2) a review of financial documentation for FYs 2011 through 2013; (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 a sample of case files that were open in FYs 2011 through 2013; and (7) an onsite observation of Unit operations.

WHAT WE FOUND

For FYs 2011 through 2013, the Unit reported combined civil and criminal recoveries of nearly $33 million and 22 criminal convictions. Our review identified that 91 percent of cases files contained documentation of periodic supervisory reviews and nearly all case files contained documentation of supervisory approval for opening and closing. However, the Unit did not transmit reports of nine convictions to OIG for the purpose of program exclusion, and conviction information for two cases was not transmitted in a timely manner. Additionally, the Unit's Memorandum of Understanding with the State Medicaid agency did not reflect current Federal legal requirements. Lastly, although 85 percent of Nebraska Medicaid enrollees received health care through managed care, the Unit received only three managed care referrals during the review period.

WHAT WE RECOMMEND

The Unit should work with OIG's MFCU oversight division to ensure compliance with the 12 performance standards. The Nebraska Unit concurred with all four of our recommendations.

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OBJECTIVE

To conduct an onsite review of the Nebraska 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.[1] Pursuant to Title XIX of the 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 FY 2013, combined Federal and State grant expenditures for the Units totaled $230 million.[4, 5] That year, the 50 Units employed 1,912 individuals.[6]

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.[7] 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 2013, the 50 Units collectively obtained 1,341 convictions and 879 civil settlements or judgments.[8] That year, the Units reported recoveries of approximately $2.5 billion.[9]

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

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

[3] North Dakota and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units.

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

[5] Office of Inspector General (OIG), *Medicaid Fraud Control Units Statistical Data for Fiscal Year 2013*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2013-statistical-chart.htm on March 11, 2014.

[6] Ibid.

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

[8] OIG, *Medicaid Fraud Control Units Statistical Data for Fiscal Year 2013*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2013-statistical-chart.htm on March 11, 2014.

[9] Ibid.

The Unit must be in an office of the State Attorney General, another State government office with Statewide prosecutorial authority, or operate under a formal arrangement with the State Attorney General's office.[10] Units are required to have either Statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.[11] In 44 States, the Units are located within offices of State Attorneys General; in the remaining 6 States, the Units are located in other State agencies.[12, 13] Generally, Units located outside of an Attorney General's Office must refer cases to other offices with prosecutorial authority.

Each Unit must be a single identifiable entity of State government, distinct from the State Medicaid agency and each Unit must develop a formal agreement—i.e., a Memorandum of Understanding (MOU)—that describes the Unit's relationship with that agency.[14]

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to OIG the authority to both annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.[15] All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.[16] To receive Federal reimbursement, each Unit must submit an initial application to OIG.[17] OIG reviews the application and notifies the Unit if the application is approved and the Unit is certified. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.[18]

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program

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[10] 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf on February 21, 2014.

[11] SSA § 1903(q)(1).

[12] OIG, Medicaid Fraud Control Units. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on March 11, 2014.

[13] The Unit shares 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.

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

[15] 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).

[16] SSA §§ 1903(a)(6)(B).

[17] 42 CFR § 1007.15(a).

[18] 42 CFR § 1007.15(b) and (c).

requirements.[19] OIG developed and issued 12 Performance Standards to further define the criteria it applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements.[20] 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 the 2012 Performance Standards used in this review and Appendix B for the1994 Performance Standards.

Nebraska State MFCU

The Nebraska Unit is located in the Office of Attorney General within the Nebraska Department of Justice and has Statewide criminal and civil jurisdiction to prosecute cases. At the time of our review, the Unit's nine employees were located in the State capital of Lincoln. These nine employees include: three attorneys, two investigators, two auditors, a data analyst, and a legal assistant. For FY 2013, the Unit expended a total of $770,566 in combined Federal and State funds.[21]

Referrals. The Unit receives referrals of Medicaid fraud and of patient abuse and neglect from the State Medicaid agency, Adult Protective Services (APS), the Attorney General's Web site, the State Long Term Care Ombudsman, and private citizens. (See Appendix D for MFCU referrals by referral source for FYs 2011 through 2013.) Unit staff follow a set of screening procedures in determining whether to open referrals as cases. For example, the Chief of Investigations screens all APS complaints and forwards them as potential cases to the Unit director for further review. For referrals made by sources other than APS (e.g., referrals from the State Medicaid agency), the legal assistant or recipient of the referral reviews the information, and, if necessary, gathers additional information or documentation necessary for preparing a case intake form. The legal assistant completes the case intake forms and gathers relevant preliminary information (e.g., following up with local law enforcement if they are involved or verifying whether the Unit or State Medicaid agency has investigated or is currently investigating the provider or suspect). The legal assistant forwards the intake forms to the Unit

[19] SSA § 1902(a)(61).

[20] OIG initially published performance standards in 1994 (59 Fed. Reg. 49080) and issued revised standards on June 1, 2012. (See 77 Fed. Reg. 32645.) Although the 1994 Performance Standards were in effect during most of the review period, we apply the 2012 performance standards where appropriate in the findings and report recommendations.

[21] OIG, *Medicaid Fraud Control Units Statistical Data for Fiscal Year 2013*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2013-statistical-chart.htm on March 11, 2014.

director for final review and then to the Chief Investigator for staff assignments. Referrals that are not related to Medicaid fraud, patient abuse, patient neglect, or misappropriation of patient funds are redirected to the proper agency.

Investigation and Prosecution. The Unit uses a team approach in the investigation and prosecution of cases of Medicaid fraud and patient abuse and neglect. Generally, teams consist of one investigator, one auditor, and one attorney. An investigator or auditor is assigned as the team leader and is responsible for coordinating case activities, such as analyzing documents, interviewing witnesses, serving subpoenas, assisting in search warrants, and preparing factual findings. The attorney assigned to the case is responsible for providing legal expertise and guidance to the investigative team, securing access to the providers' records, obtaining documentary evidence for trial, and developing a legal theory for prosecution.

Previous Review

In 2007, OIG conducted an onsite review of the Nebraska MFCU and found that the Unit did not adequately document the current status and progress made in ongoing case investigations and/or prosecutions. Further, several of the case files reviewed by OIG did not include an identifiable record to indicate that an official MFCU investigation had begun or had been formally approved. OIG also found that case files reviewed contained no formal final statement or closing report summarizing the final disposition of the cases. OIG concluded that the lack of sufficient documentation in the case files reviewed made it difficult to determine the exact status of the cases and progress made in them. OIG strongly suggested that the Unit incorporate opening, interim, and closing investigative memorandum(s) into the case file records to ensure that investigations and prosecutions of cases would not linger or falter. OIG also suggested that the Unit consider incorporating a sequential file index in each case file.

METHODOLOGY

We conducted the onsite review in February 2014. We based our review on an analysis of data from seven sources: (1) a review of policies and procedures and documentation on the Unit's operations, staffing, and caseload for FYs 2011 through 2013; (2) a review of financial documentation for FYs 2011 through 2013; (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 a sample of case files that were open at any time in FYs 2011 through 2013; and (7) an onsite

observation of Unit operations. Appendix C contains the details of our methodology.

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 2011 through 2013, the Nebraska Unit reported combined civil and criminal recoveries of nearly $33 million and 22 criminal convictions

The Unit reported combined criminal and civil recoveries of nearly $33 million for FYs 2011 through 2013. The majority of the recoveries were obtained from "global" settlements, which accounted for 91 percent of the Unit's recoveries during the period of our review.[22] See Table 1 for details regarding criminal and civil recoveries.

Table 1: Reported Nebraska MFCU Criminal and Civil Recoveries, FYs 2011–2013

Type of Recovery	FY 2011	FY 2012	FY 2013	Total Recoveries
Criminal Recoveries	$7,679	$11,268	$16,380	$35,327
Global Case Recoveries	$7,564,528	$15,411,411	$6,608,548	$29,584,487
Nonglobal Civil Recoveries	$507,516	$569,870	$1,809,037	$2,886,423
Total Recoveries	**$8,079,723**	**$15,992,549**	**$8,433,965**	**$32,506,237**

Source: OIG analysis of Unit Submitted Documentation, FYs 2011–2013.

During the review period, the Unit closed 366 investigations, obtained 54 civil settlements and judgments, charged 26 individuals, obtained 22 criminal convictions, and had 1 dismissal. See Appendix E for details on investigations opened and closed by provider category for FYs 2011 through 2013.

Ninety-one percent of case files contained documentation of periodic supervisory reviews; nearly all case files contained documentation of supervisory approval for opening and closing

According to the 2012 Performance Standard 7(a), supervisory reviews should be conducted periodically and noted in the case file to ensure timely case completion. The Unit director reported that supervisory

[22] "Global" cases are civil false-claims actions involving the U.S. Department of Justice and other State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases.

reviews were conducted at least once a month.[23] Ninety-one percent of case files for cases open longer than 30 days contained documentation of periodic supervisory reviews. Ninety-eight percent of case files for cases open longer than 30 days contained documentation of at least one supervisory review. (See Appendix F for all estimates and 95-percent confidence intervals for projections.)

Additionally, according to the 2012 Performance Standard 5(b), Unit supervisors should approve the opening and closing of cases to ensure a continuous case flow and timely completion of cases. We found that 98 percent of all case files contained documentation of supervisory approval of opening and that 100 percent of closed case files contained documentation of supervisory approval of closing the case.

The Unit did not transmit reports of nine convictions to OIG for the purpose of program exclusion; conviction information for two cases was not transmitted in a timely manner

According to the 2012 Performance Standard 8(f), the Unit should transmit to OIG reports of all convictions for the purpose of exclusion from Federal health care programs. Specifically, this standard stipulates that convictions should be reported within 30 days of sentencing.

The Unit did not submit all conviction information to OIG for the purpose of program exclusion; of the 22 convictions that should have been sent to OIG for exclusion, 9 convictions were not submitted.[24] These nine convictions were related to patient-funds cases that involved sentencing of nonproviders. Of the 13 convictions that were transmitted, 2 were not transmitted in a timely manner. Specifically, the Unit transmitted information to OIG 229 days after sentencing for one conviction and 300 days after sentencing for the other.

[23] The Unit director reported that supervisory reviews are conducted twice a month. A formal review occurs during the Unit's monthly team meetings. All Unit staff are present during these meetings, and the status of all open cases and next steps for them are discussed and reviewed. A second informal review of each case is conducted in smaller groups, which include the Unit director, senior assistant attorney general, chief investigator, and the lead auditor or investigator assigned to the case. The Unit director reported that he maintains notes from these informal meetings, but that notes from these meetings are not maintained in the case files. For the purposes of our review, we reviewed the case files (including the electronic case file database) to determine whether at least one supervisory review was documented in the case file for each month the case was open.

[24] OIG confirmed that as of June 3, 2014 (after we collected information for our onsite review), the Unit had submitted information for all nine convictions.

The Unit's MOU with the State Medicaid agency did not reflect current Federal legal requirements

According to the 2012 Performance Standard 10(b), the Unit's MOU with the State Medicaid agency should meet current Federal legal requirements, including provisions for payment suspension on the basis of credible allegation of fraud.[25] The Unit's MOU, last updated in 2011, did not include provisions describing the process between the Unit and the State Medicaid agency for providers who were subject to a payment suspension on the basis of credible allegation of fraud. However, both the Unit director and the director of the Nebraska Medicaid Program Integrity Unit indicated that payment suspension protocols were in place between the Unit and the State Medicaid agency during the review period.

Although 85 percent of Nebraska Medicaid enrollees received health care through managed care, the Unit received only 3 managed care referrals during FYs 2011 through 2013

According to the 2012 Performance Standard 4(a), the Unit should take steps to ensure that managed care organizations (MCOs) refer cases of suspected provider fraud to the Unit. As of July 2010, 85 percent of Nebraska Medicaid enrollees received their health care services through MCOs.[26] However, in FYs 2011 through 2013, the Unit reported receiving a total of three MCO referrals—two referrals in FY 2012 and one referral in FY 2013.

For FYs 2011 through 2013, both the Unit director and the director of the Nebraska Medicaid Program Integrity Unit (PI Unit) reported that MCOs were not required to refer cases of Medicaid fraud to the Unit, but rather to the State Medicaid agency. The PI Unit director stated: "[I]f there are concerns of waste and abuse, [MCOs] share that with us, and we make a referral to the MFCU." Of the three MCO referrals received during FYs 2011 through 2013, two of the referrals were received by the State Medicaid agency and then referred to the Unit. The third MCO referral

[25] The Affordable Care Act, § 6402(h)(2), requires State Medicaid programs, as a condition of receiving FFP, to suspend payments to providers for whom there is a credible allegation of fraud, unless good cause exists to not suspend payments. One way to establish good cause is for the MFCU to inform the State Medicaid agency that the suspension would compromise or jeopardize its investigation of the provider. The Centers for Medicare and Medicaid Services (CMS) and OIG implemented this provision in revisions to 42 CFR §§ 455.23 and 1007.9(e) effective March 25, 2011 (76 Fed. Reg. 5862).

[26] CMS, *Medicaid Managed Care Enrollment as of July 1, 2010*. Accessed online at http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/2010July1.pdf on March 17, 2014.

was received directly from an MCO. During our onsite review, the Unit director stated that the Unit is seeking recognition as a required recipient of referrals in the contract between the State Medicaid agency and MCOs. To facilitate this recognition, the Unit director reported that Unit staff attend quarterly meetings with the State Medicaid agency and MCOs.

CONCLUSION AND RECOMMENDATIONS

For FYs 2011 through 2013, the Unit reported combined civil and criminal recoveries of nearly $33 million. During the review period, the Unit closed 366 investigations with 26 individuals charged, obtained 54 civil settlements and judgments, obtained 22 criminal convictions, and had 1 dismissal.

Our review identified that 91 percent of cases files contained documentation of periodic supervisory reviews, and nearly all case files contained documentation of supervisory approval for opening and closing. However, the Unit did not transmit reports of nine convictions to OIG for the purpose of program exclusion, and conviction information for two cases was not transmitted in a timely manner. Additionally, the Unit's MOU with the State Medicaid agency did not reflect current Federal legal requirements because the MOU did not address payment suspension on the basis of a credible allegation of fraud. Lastly, although 85 percent of Nebraska Medicaid enrollees received health care through managed care, the Unit received only three managed care referrals during the review period.

We recommend that the Nebraska Unit:

Ensure that all open cases receive periodic supervisory review in accordance with Unit policy

The Unit should ensure that all open cases receive periodic supervisory review at least once a month throughout the duration of the case and should document these reviews in the case file, in accordance with Unit policy. Doing so will ensure that supervisory reviews are conducted periodically and noted in the case file to ensure timely case completion.

Transmit reports of all convictions to OIG for the purpose of exclusion from Federal health care programs

The Unit should ensure that all individuals convicted of fraud, abuse, and/or neglect, including individuals with convictions related to patient funds, are reported to OIG within 30 days of their sentencing.

Revise the current MOU with the State Medicaid agency to reflect current Federal legal requirements

The Unit should work with the State Medicaid agency to revise its MOU to reflect the current Federal legal requirement of payment suspension on the basis of credible allegation of fraud.

Continue to take steps to ensure that the State Medicaid agency and MCOs refer all suspected cases of fraud among managed care providers to the Unit

The Unit should continue to work with the State Medicaid agency and MCOs to ensure that all suspected cases of fraud among managed care providers are referred to the Unit. This could include the development of operational protocols focused on fraud among managed care providers and might specifically include recognition of the MFCU as a direct recipient of referrals from MCOs. Further, the Unit should work with the State Medicaid agency to obtain all necessary information that the latter receives from MCOs regarding suspected fraud in managed care.

UNIT RESPONSE AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Nebraska Unit concurred with all four of our recommendations.

The Unit concurred with our first recommendation (that it ensure that all open cases receive periodic supervisory review). The Unit stated that although a high percentage of its case files include documentation of supervisory review, as well as documentation of supervisory approval of the opening and closing of the case, it will strive to achieve 100-percent compliance for future reviews.

The Unit concurred with our second recommendation (that it transmit reports of all convictions to OIG for the purpose of exclusion). The Unit stated that the nine convictions that were not submitted to OIG were related to matters other than health care fraud, specifically, the theft of patient funds by nonproviders. The Unit stated that its interpretation of existing law and regulations had been that convictions of nonproviders did not need to be reported to OIG for the purpose of program exclusion. The Unit stated that, since learning that OIG interprets law and regulations to include nonproviders, it has referred all nine convictions to OIG for the purpose of program exclusion. The Unit also indicated that in the future, it will refer all convictions to OIG for exclusion within 30 days of sentencing.

The Unit concurred with our third recommendation (that it revise the current MOU with the State Medicaid agency to reflect current Federal legal requirements). The Unit acknowledged that the current MOU does not address a protocol for the suspension of payment to providers on the basis of credible allegation of fraud. The Unit stated that an addendum to the current MOU will be drafted to formally add a payment suspension protocol. The Unit anticipated that this addendum would be added by the end of 2014.

The Unit concurred with our fourth recommendation (that it continue to take steps to ensure that the State Medicaid agency and MCOs refer all suspected cases of fraud among managed care providers). The Unit stated that contracts between the State Medicaid agency and the MCOs did not identify the Unit as a stakeholder in pursuing fraud among managed care providers. The Unit also stated that it is attempting to resolve the issue as the contracts come up for renewal or revision. Further, the Unit stated that it participates in quarterly meetings between Medicaid staff and MCOs.

The full text of the Unit's comments is provided in Appendix G.

APPENDIX A

2012 Revised Performance Standards[27]

1. A unit conforms with all applicable statutes, regulations, and policy directives, including:

a. Section 1903(q) of the Social Security Act, containing the basic requirements for operation of a MFCU;

b. Regulations for operation of a MFCU contained in 42 CFR part 1007;

c. Grant administration requirements at 45 CFR part 92 and Federal cost principles at 2 CFR part 225;

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

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

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 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 CMS.

d. Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.

e. The MOU incorporates by reference the CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit.

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

a. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.

b. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.

c. The Unit maintains an effective time and attendance system and personnel activity records.

d. The Unit applies generally accepted accounting principles in its control of Unit funding.

e. The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.

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

a. The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.

b. The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.

c. Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.

d. The Unit participates in MFCU related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.

e. The Unit participates in cross training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

APPENDIX B

1994 Performance Standards[28]

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 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?

[28] 59 Fed. Reg. 49080, Sept. 26, 1994.

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 State Medicaid agency and other sources.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit work with the 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 State Medicaid 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 MOU with the 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 add to the mission of the Unit?

APPENDIX C

Detailed Methodology

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

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information from several sources regarding the Unit's investigation and referral for prosecution of Medicaid cases. Specifically, we collected and analyzed information about the number of referrals the Unit received, the number of investigations the Unit opened and closed, the outcomes of those investigations, and the Unit's case mix. We also collected and analyzed information about the number of cases that the Unit referred for prosecution and the outcomes of those prosecutions. We gathered this information from several sources, including the Unit's quarterly statistical reports, annual reports, recertification questionnaire, policy and procedures manuals, MOU with the State Medicaid agency, and the report from the previous OIG onsite review (in 2007). Additionally, we confirmed with the Unit director that the information we had was current as of January 2014, and as necessary, requested any additional data or clarification.

Review of Unit Financial Documentation. We reviewed the Unit's control over its fiscal resources to identify any internal control issues or other issues involving use of resources. Prior to the onsite review, we reviewed the Unit's financial policies and procedures; its response to an internal control questionnaire; and documents (such as financial status reports) related to MFCU grants. During the onsite review, we reviewed a sample of the Unit's purchase and travel transactions. In addition, we reviewed vehicle records, the supply inventory, and a sample of time and effort records.

Interviews with Key Stakeholders. In January 2014, we interviewed key stakeholders, such as officials in the United States Attorneys' Offices, the Attorney General's Office, and other agencies that interacted with the Unit (Adult Protective Services, Medicaid Program Integrity Unit, Office of the State Long Term Care Ombudsman, and Professional Licensure Division). We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities, and we identified opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Survey of Unit Staff. In January 2014, we conducted an online survey of all nonmanagerial Unit staff within each professional discipline (i.e., investigators, auditors, and attorneys) as well as support staff. The response rate was 100 percent. Our questions focused on operations of the Unit, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Onsite Interviews with Unit Management. We conducted structured interviews with the Unit's management in February 2014. We interviewed the Unit director (who also served as the Unit's lead attorney) as well as the chief investigator and auditor. We asked these individuals to provide information related to: (1) the Unit's operations, (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance, (3) opportunities for the Unit to improve its operations and/or performance, and (4) clarification regarding information obtained from other data sources.

Onsite Review of Case Files and Other Documentation. The Unit provided a list of 460 cases that were open at any point during FYs 2011through 2013. We excluded 77 cases that the Unit had categorized as "global." We then selected a simple random sample of 100 cases from the remaining 383 cases. This sample of 100 cases included 92 cases that were open longer than 30 days and 88 cases that were closed at some point during the review period. We reviewed all 100 sampled case files.[29] Using the results of our review of the sampled case files, we estimated proportions for all 383 case files, for the subpopulation of cases open longer than 30 days, and cases closed during the review period. These estimates and the 95-percent confidence intervals are shown in Appendix F. From the initial sample of 100 case files, we selected a further simple random sample of 50 files for a more in-depth review of selected issues, such as the timeliness of investigations and case development. We did not estimate any population or subpopulation proportions from this additional sample of 50 case files.

Onsite Review of Unit Operations. During our February 2014 onsite visit, we reviewed the Unit's workspace and operations. Specifically, we visited the Unit headquarters in Lincoln. While onsite, we observed the

[29] One case file did not contain documentation for the reviewer to determine whether the supervisor approved the opening of the case. As a result, this case was excluded from our analysis for this specific data point, and projections for this data point are projected to 99 case files rather than 100.

Unit's offices and meeting spaces, security of data and case files, location of select equipment, and the general functioning of the Unit.

Data Analysis

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

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

APPENDIX D

Medicaid Fraud Control Unit Referrals by Referral Source for FYs 2011 Through 2013

	FY 2011			FY 2012			FY 2013		
Referral Source	**Fraud**	**Abuse & Neglect**	**Patient Funds**	**Fraud**	**Abuse & Neglect**	**Patient Funds**	**Fraud**	**Abuse & Neglect**	**Patient Funds**
Medicaid Agency – (Office of Quality Assurance) – PI/SURS[31]	18	0	0	22	0	1	18	0	0
Medicaid Agency – Attorney General	0	0	1	1	0	0	6	0	0
State Survey & Certification	0	0	0	0	0	0	0	0	0
Other State Agencies	3	0	0	0	0	0	0	0	0
Licensing Board	0	0	1	1	0	0	0	0	0
Law Enforcement	0	0	0	0	0	1	0	0	0
Office of Inspector General	1	0	0	1	1	0	2	0	0
Prosecutors	0	0	0	0	0	0	0	0	0
Providers	1	0	3	6	0	1	0	0	1
Provider Associations	0	0	0	0	0	0	0	0	0
Private Health Insurer	0	0	0	0	0	0	0	0	0
Long Term Care Ombudsman	0	0	0	0	0	0	0	0	1
Adult Protective Services	3	41	27	8	17	16	6	4	33
Private Citizens	5	0	0	8	2	2	4	0	1
MFCU Hotline	0	0	0	2	0	0	1	0	0
Other	12	0	2	15	0	3	11	0	0
Total	**41**	**41**	**33**	**62**	**20**	**22**	**47**	**4**	**36**
Annual Total			**115**			**105**			**87**

Source: OIG analysis of Unit-submitted documentation, FYs 2011-2013.

[31] "PI" = "program integrity"; "SURS" = "Surveillance and Utilization Review Subsystem."

APPENDIX E

Investigations Opened and Closed By Provider Category for FYs 2011 Through 2013

Table E-1: Fraud Investigations

Provider Category	FY 2011		FY 2012		FY 2013	
Facilities	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Hospitals	2	3	4	1	1	1
Nursing Facilities	1	1	1	2	1	1
Other Long-Term Care Facilities	0	0	0	0	1	0
Substance Abuse Treatment Centers	0	0	0	0	1	1
Other	2	1	3	4	0	0
Subtotal	**5**	**5**	**8**	**7**	**4**	**3**
Practitioners	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Doctors of Medicine or Osteopathy	3	0	2	3	2	4
Dentists	2	1	2	3	0	2
Podiatrists	0	0	1	0	0	1
Optometrists/Opticians	0	0	0	0	0	0
Counselors/Psychologists	0	7	9	4	6	9
Chiropractors	2	0	2	2	0	0
Other	1	1	2	3	0	0
Subtotal	**8**	**9**	**18**	**15**	**8**	**16**
Medical Support	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Pharmacies	3	2	4	4	2	2
Pharmaceutical Manufacturers	9	10	8	9	13	14
Suppliers of Durable Medical Equipment and/or Supplies	4	2	1	3	4	3
Laboratories	0	1	0	0	0	0
Transportation Services	0	0	0	1	0	1
Home Health Care Agencies	0	1	6	4	2	1
Home Health Care Aides	14	7	19	14	14	22
Nurses, Physician Assistants, Nurse Practitioners, Certified Nurse Aides	0	0	0	0	0	0
Radiologists	0	0	0	0	0	0
Medical Support—Other	0	0	1	0	1	0
Subtotal	**30**	**23**	**39**	**35**	**36**	**43**

Table E-1 (Continued): Fraud Investigations

Program Related	Opened	Closed	Opened	Closed	Opened	Closed
Managed Care	0	0	1	1	0	0
Medicaid Program Administration	0	0	0	0	0	0
Billing Company	0	0	0	0	0	0
Other	0	0	0	0	1	1
Subtotal	**0**	**0**	**1**	**1**	**1**	**1**
Total Provider Categories	**43**	**37**	**66**	**58**	**49**	**63**

Source: OIG analysis of Unit-submitted documentation, FYs 2011–2013.

Table E-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2011		FY 2012		FY 2013	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing Facility	20	28	5	5	0	2
Other Long-Term Care	6	9	1	1	0	1
Nurses/Physician's Assistant/Nurse Practitioner/Certified Nurse Aide	6	10	6	3	4	7
Home Health Aide	1	1	1	2	0	0
Other	8	12	7	6	0	2
Total	**41**	**60**	**20**	**17**	**4**	**12**

Source: OIG analysis of Unit-submitted documentation, FYs 2011-2013.

Table E-3: Patient Funds Investigations

Provider Category	FY 2011		FY 2012		FY 2013	
	Opened	Closed	Opened	Closed	Opened	Closed
Nondirect Care	0	1	1	0	0	1
Nurses/Physician's Assistant/Nurse Practitioner/Certified Nurse Aide	0	0	3	1	0	1
Home Health Aide	0	0	0	0	0	0
Other	34	46	20	34	36	35
Total	**34**	**47**	**24**	**35**	**36**	**37**

Source: OIG analysis of Unit-submitted documentation, FYs 2011-2013.

APPENDIX F

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

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of cases files that were open longer than 30 days containing documentation of periodic supervisory review	92	91.3%	84.8%	95.2%
Total cases files that were open longer than 30 days containing documentation of periodic supervisory review	92	322	298	335
Percentage of cases files that were open longer than 30 days containing documentation of at least one supervisory review	92	97.8%	93.0%	99.3%
Total cases files that were open longer than 30 days containing documentation of at least one supervisory review	92	345	327	350
Percentage of case files containing documentation of supervisory approval for opening	99*	98.0%	93.4%	99.4%
Total case files containing documentation of supervisory approval for opening	99*	372	354	377
Percentage of closed case files containing documentation of supervisory approval for closing	88	100.0%	96.3%	100.0%
Total closed case files containing documentation of supervisory approval for closing	88	327	315	327

Source: OIG analysis of Nebraska Unit case files, 2014.
*One case file did not contain documentation for the reviewer to determine whether the supervisor approved the opening of the case. As a result, this case was excluded from our analysis for this data point.

APPENDIX G

Unit Comments

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June 2, 2014

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Acting Deputy Inspector General for Evaluations and Inspections
U.S. Department of Health and Human Services
Office of Inspector General
Room 5660, Cohen Building
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RE: Nebraska State Medicaid Fraud Control Unit 2014 Onsite Review (OEI-07-14-00060)

Dear Mr. Ritchie,

We are in receipt of your letter of May 6, 2014 and enclosing the *Nebraska State Medicaid Fraud Control Unit: 2014 Onsite Review,* OEI-07-14-00060. We appreciate the opportunity to respond to the findings of the Onsite Review and we are grateful for the professionalism and courtesies shown by the members of the audit team who conducted the review.

The audit team's review before, during and after the onsite visit, provided us with a great deal of constructive guidance regarding the Unit's functions. We appreciate the team's many positive comments as well as their suggestions on how we can improve our operations. Preparation for the onsite review also provided the staff of the Nebraska Medicaid Fraud and Patient Abuse Unit with a unique opportunity to internally review our policies, procedures and best practices and identify areas for improvement.

Your letter requests that we respond to the recommendations contained in the Onsite Review report, indicating whether we concur with the report's individual recommendations and with reasons for not concurring with any such recommendations. We respond to each recommendation below, including what actions we intend to take, any alternative actions to those recommended and a timeline for taking such actions.

1

Recommendation 1:
Ensure that all open cases receive periodic supervisory review in accordance with Unit policy.
The Unit should ensure that all open cases receive periodic supervisory review at least once a month throughout the duration of the case and should document these reviews in the case file, in accordance with Unit policy. Doing so will ensure that supervisory reviews are conducted periodically and noted in the case file to ensure timely completion.

Response:

We concur. As noted in the OIG report, 91% of all case files opened longer than 30 days contained documentation of a supervisory review and 98% of case files that were open longer than 30 days contained documentation of at least one supervisory review. Additionally OIG found that 98% of all case files contained documentation of supervisory approval of opening and 100% of all closed files contained documentation of supervisory approval of closing the case. While we are proud to have achieved such high percentages for opening, closing and supervisory reviews, we will strive to achieve 100% compliance in the future.

Recommendation 2:
Transmit reports of all convictions to OIG for the purpose of exclusion from Federal health care programs.
The Unit should ensure that all individuals convicted of fraud, abuse and/or neglect, including individuals with convictions related to patient funds, are reported to OIG within 30 days of their sentencing.

Response:

We concur. Twenty-two convictions were obtained in the files that were reviewed by OIG. Nine of those cases related to non-health care fraud matters, namely the theft of patient funds by non-providers. Our interpretation of existing law and regulations was that convictions of non-providers did not need to be reported to OIG for exclusion purposes. After learning that OIG broadly interpreted existing law and regulation to include non-providers, we asked OIG to identify the nine non-providers who were not referred for exclusion. OIG initially identified eight of the non-providers and those individuals were referred for exclusion within 48 hours of their identification. As noted in footnote 24 of the OIG on-site report, those eight providers are now on the OIG exclusion list. The ninth non-provider was recently identified and has been referred for exclusion as well. In the future, all convictions will be referred to OIG for exclusion within 30 days of sentencing.

Recommendation 3:
The Unit's MOU with the State Medicaid agency did not reflect current Federal legal requirements.
The Unit should work with the State Medicaid agency to revise its MOU to reflect current Federal legal requirement of payment suspension on the basis of credible allegation of fraud.

Response:

We concur. The Unit's MOU with the State Medicaid agency was last updated in 2011. In March, 2011, 42 CFR §§ 455.23 and 1007.9(e) were revised by the Centers for Medicare and Medicaid Services (CMS) to require that payments to providers be suspended whenever a credible allegation of fraud was found to exist. Thereafter in 2012, MFCU Performance Standard 10(b) was revised to provide that the MOU meet "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.'" The 2011 MOU between the Unit and the State Medicaid agency does not address a protocol for payment suspension. However, as the on-site report correctly notes, "both the Unit director and the director of the Nebraska Medicaid Program Integrity Unit indicated that payment suspension protocols were in place between the Unit and the State Medicaid agency during the review period." In order to comply with MFCU Performance Standard 10(b), an addendum to the current MOU will be drafted to formally add the protocol for payment suspension based on a credible allegation of fraud. It is anticipated that this will be completed by the end of the calendar year.

Recommendation 4:
Continue to take steps to ensure that the State Medicaid agency and MCOs refer all suspected cases of fraud among managed care providers to the Unit.
The Unit should continue to work with the State Medicaid agency and MCOs to ensure that all suspected cases of fraud among managed care providers are referred to the Unit. This could include the development of operational protocols focused on fraud among managed care providers and might specifically include recognition of the MFCU as a direct recipient of referrals from MCOs. Further, the Unit should work with the State Medicaid agency to obtain all necessary information that the State Medicaid agency receives from MCOs related to suspected fraud in managed care.

Response:

We concur. Medicaid managed care is relatively new to Nebraska and is quickly spreading throughout the state. Early contracts between the State Medicaid agency and the MCOs did not identify the MFCU as a stakeholder in pursuing provider fraud within the managed care setting. The MFCU is attempting to rectify that problem as the

contracts come up for renewal or revision. In the meantime, the MFCU participates in quarterly meetings between Medicaid staff and the various MCOs. MFCU Performance Standard 4(a) requires that an MFCU "take 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." We will ensure that this performance standard is met in the future.

The Nebraska Medicaid Fraud and Patient Abuse Unit appreciates the OIG's efforts during the on-site review process. We especially appreciate the many positive findings contained in the report, which is not typically found in the customary audit-based reporting format. We look forward to our continued good working relationship with OIG and all of our federal and state partners in fighting fraud within Nebraska's Medicaid program.

Sincerely yours,

JON BRUNING
Attorney General

/S/

D. Mark Collins
Assistant Attorney General
Director, Medicaid Fraud and Patient Abuse Unit

ACKNOWLEDGMENTS

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

Rae Hutchison served as the team leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Michael P. Barrett, Susan Burbach, and Jordan R. Clementi. Office of Investigations staff who conducted the study include Kelly Earl. Central office staff who provided support include Christine Moritz and Sherri Weinstein.

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