Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

VIRGINIA STATE MEDICAID FRAUD CONTROL UNIT: 2015 ONSITE REVIEW

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EXECUTIVE SUMMARY: VIRGINIA STATE MEDICAID FRAUD CONTROL UNIT: 2015 ONSITE REVIEW
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WHY WE DID THIS STUDY

The Office of Inspector General (OIG) administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies the Units, and oversees the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. These reviews assess the Units' adherence to the 12 MFCU performance standards and compliance with applicable Federal statutes and regulations.

HOW WE DID THIS STUDY

We conducted an onsite review of the Virginia Unit in September 2015. We based our review on an analysis of data from seven sources: (1) policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) financial documentation for fiscal years (FYs) 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) a sample of files for cases that were open in FYs 2012 through 2014; and (7) observation of Unit operations.

WHAT WE FOUND

The Unit reported significant results and was in general compliance with applicable laws, regulations, and policy transmittals. For FYs 2012 through 2014, the Virginia Unit reported 79 criminal convictions, 46 civil judgments and settlements, and combined criminal and civil recoveries of $1.1 billion. This amounted to recovery of more than $34 for every $1 spent in the review period. The Unit also maintained proper fiscal control of its resources. We identified two practices that assisted the Unit in obtaining its results. First, the Virginia Unit's partnerships with a variety of stakeholders led to successful Medicaid fraud prosecutions and increased recoveries. Second, the Unit's use of specialty software improved its ability to process and share investigative information.

However, we identified several areas where the Unit should improve its operations. Although the Unit's active case files generally contained the required supervisory reviews, the Unit's policy did not require supervisory reviews of monitored cases. Furthermore, the Unit's policy did not define what constituted a monitored case. Also, the Unit did not report all convictions and adverse actions to Federal partners within required timeframes.

WHAT WE RECOMMEND

We recommend that the Virginia Unit revise its policy to define what constitutes a monitored case and indicate the appropriate level and frequency of supervisory review for such cases. Further, the Unit should formalize its processes to ensure that convictions

and adverse actions are consistently reported to Federal partners within required timeframes. The Unit concurred with both recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse or neglect under State law.[1] The SSA requires each State to operate a MFCU, unless the Secretary of Health and Human Services (HHS) determines that operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in a particular State and 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 MFCUs.[3]

Each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.[4] Unit staff review referrals of provider fraud and patient abuse or neglect to determine their potential for criminal prosecution and/or civil action. In fiscal year (FY) 2015, the 50 Units collectively reported 1,553 convictions, 795 civil settlements and judgments, and approximately $745 million in recoveries.[5, 6]

Units must meet a number of requirements established by the SSA and Federal regulations. For example, each Unit must:

- be a single, identifiable entity of State government, distinct from the single State Medicaid agency; [7]
- develop a formal agreement, such as a memorandum of understanding (MOU), which describes the Unit's relationship with the State Medicaid agency;[8] and

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

[2] SSA § 1902(a)(61).

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

[5] Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on April 13, 2016.

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

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

[8] 42 CFR § 1007.9(d).

- have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.[9]

MFCU Funding

Each MFCU is funded jointly by its State and the Federal government. Federal funding for the MFCUs is provided as part of the Federal Medicaid appropriation, but it is administered by OIG.[10] Each Unit receives Federal financial participation equivalent to 75 percent of its total expenditures, with State funds contributing the remaining 25 percent.[11] In FY 2015, combined Federal and State expenditures for the Units totaled $251 million, $188 million of which represented Federal funds.[12]

Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority to administer the MFCU grant program.[13] To receive Federal reimbursement, each Unit must submit an initial application to OIG for approval and be recertified each year thereafter.

In annually recertifying the Units, OIG evaluates Unit compliance with Federal requirements and adherence to performance standards. The Federal requirements for Units are contained in the SSA, regulations, and policy guidance.[14] In addition, OIG has published 12 performance standards that it uses to assess whether a Unit is effectively performing its responsibilities.[15] The standards address topics such as staffing, maintaining adequate referrals, and cooperation with Federal authorities. Appendix A contains the Performance Standards.

OIG also performs periodic onsite reviews of the Units, such as this review of the Virginia MFCU. During these onsite reviews, OIG evaluates Units' compliance with laws, regulations, and policies, as well as adherence to the

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[9] SSA § 1903(q)(1).

[10] SSA § 1903(a)(6)(B).

[11] Ibid.

[12] Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on April 13, 2016.

[13] The SSA authorizes the Secretary of HHS to award grants to the Units; (SSA § 1903(a)(6)(B)); the Secretary delegated this authority to the OIG.

[14] On occasion, OIG issues policy transmittals to provide guidance and instructions to MFCUs.

[15] 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf on May 22, 2015. On June 1, 2012, OIG published a revision of the performance standards at 77 Fed. Reg. 32645. Because our review covered FYs 2012 through 2014, we applied the standards published on June 1, 2012.

12 performance standards. OIG also makes observations about best practices, provides recommendations to the Units, and monitors the implementation of the recommendations. These evaluations differ from other OIG evaluations as they support OIG's direct administration of the MFCU grant program. These evaluations are subject to the same internal quality controls as other OIG evaluations, including internal peer review.

OIG provides additional oversight including the collection and dissemination of performance data, training, and technical assistance.

Virginia MFCU

The Unit, a division of the Virginia Office of the Attorney General, investigates and prosecutes cases of Medicaid fraud and patient abuse or neglect. The Unit employs 98 staff, including investigators, attorneys, and auditors.[16] The Virginia Unit has three regional offices and is the fifth-largest Unit in the nation, with total expenditures of approximately $11.1 million in combined State and Federal funds in FY 2015.[17]

The Unit is broadly organized into two groups: investigators and attorneys. Both the investigators and the attorneys are split further into civil and criminal teams. Each team is supervised by a chief investigator or chief attorney. The Unit's two chief investigators report to the Deputy Director; the Unit's two chief attorneys report to the Chief Section Counsel.

Referrals. The Unit receives referrals from a variety of sources, including the State Medicaid agency, local law enforcement, and private citizens. Once the Unit receives a referral, the Unit's assigned attorney and investigator conduct a case conference that includes a preliminary case evaluation and consultation with the lead attorney to decide whether the case should be opened. Appendix B depicts Unit referrals by referral source for FYs 2012 through 2014.

Investigations and Prosecutions. Per Unit policy, Unit management approves the opening of each case. If the case is opened, the case will be routed to one of two tracks: active or monitored. Per Unit policy, investigative resources are assigned to active cases; investigative resources are available on an ad hoc basis for monitored cases. Legal resources are assigned to both active and monitored cases. The assigned investigator(s) are responsible for all investigative activity conducted for the case, under the

[16] The Virginia Unit has some investigators specifically designated as financial investigators, who fulfill the auditor function. The Unit also employs administrative and paralegal staff.

[17] OIG, *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on February 18, 2016.

direction of the appropriate supervisor and chief. The assigned attorney oversees the investigation, and is responsible for prosecuting the case. Appendix C provides detailed statistics on investigations opened and closed.

The Unit conducts quarterly reviews of each active case. During these reviews, each case's progress is discussed, and investigative steps for the next 30, 60, and 90 days are planned. The Unit's policy requires that documentation of each quarterly review be maintained in the case file.

Previous Onsite Review

In 2009, OIG published a report on its onsite review of the Virginia Unit. OIG found that the Virginia Unit was in general compliance with all applicable Federal rules and regulations that govern the grant and the 12 performance standards.

METHODOLOGY

Data Collection and Analysis

We conducted the onsite review in September 2015. We based our review on an analysis of data from seven sources: (1) policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) financial documentation for FYs 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) a sample of files for cases that were open in FYs 2012 through 2014; and (7) observation of Unit operations. We also used these data sources to determine if any issues related to findings from the previous OIG onsite review persisted. Appendix D provides 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

Our review of the Virginia Unit found that it reported significant results and that it was generally in compliance with applicable laws, regulations, and policy transmittals. The Unit reported over $1 billion in combined criminal and civil recoveries during the review period, with less than one-third of its recoveries derived from "global" settlements.[18] The Unit recovered more than $34 for every $1 spent in the review period.

However, we identified several areas where the Unit should improve its operations. Although the Unit's active case files generally contained the required supervisory reviews, the Unit's policy did not require supervisory reviews of "monitored cases". Furthermore, the Unit's policy did not define what constituted a monitored case. Also, the Unit did not report all convictions and adverse actions to Federal partners within required timeframes.

For FYs 2012 through 2014, the Virginia Unit reported 79 criminal convictions, 46 civil judgments and settlements, and combined criminal and civil recoveries of $1.1 billion

For FYs 2012 through 2014, the Unit reported 79 criminal convictions and 46 civil judgments and settlements. Table 1 provides details of the Unit's yearly convictions and civil judgments and settlements. Of the Unit's 79 convictions over the 3-year period, 71 involved provider fraud, and 8 involved patient abuse or neglect.

Table 1: Virginia MFCU Criminal Convictions and Civil Judgments and Settlements, FYs 2012–2014

Outcomes	FY 2012	FY 2013	FY 2014	3-Year Total
Criminal Convictions	24	21	34	79
Civil Judgments and Settlements	12	11	23	46

Source: OIG analysis of Unit-submitted documentation, 2016.

The Unit reported criminal and civil recoveries of $1.1 billion for FYs 2012 through 2014—ranging from $28 million to $1 billion over the 3 years (shown in Table 2). During the 3-year review period, "global cases" accounted for less than one-third of the Unit's recoveries.

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

The Unit's recoveries in FY 2013 were particularly high. In FY 2013, the Unit's criminal recoveries constituted nearly three-quarters of national MFCU criminal recoveries; the Unit's civil recoveries constituted nearly one-fifth of national MFCU civil recoveries. Most of the Unit's criminal and civil recoveries in FY 2013 resulted from the settlement of a single case against Abbott Laboratories.

Table 2: Virginia MFCU Recoveries and Expenditures, FYs 2012–2014

Type of Recovery	FY 2012	FY 2013	FY 2014	3-Year Total
Global Civil	$18,158,785	$304,548,889	$20,557,459	$343,265,133
Nonglobal Civil	$6,915,766	$0	$42,439,402	$49,355,168
Criminal	$3,587,917	$703,681,818	$1,725,971	$708,995,706
Total Recoveries	**$28,662,468**	**$1,008,230,707**	**$64,722,832**	**$1,101,616,007**
Total Expenditures	$9,059,666	$11,249,106	$11,757,418	$32,066,190

Source: OIG analysis of Unit-submitted documentation, 2016.

Unit policy requires supervisory review of active cases but not monitored cases; Unit policy does not define what constitutes a monitored case

Unit policy requires periodic supervisory reviews of active cases, but does not require supervisory review for monitored cases.[19] We found that 58 percent of the sampled cases were monitored cases, and only 7 percent of monitored cases had documented supervisory reviews in their respective case files. Supervisory reviews generally occurred for active cases.

For active cases, the Unit's policy requires a 30, 60, and 90-day investigation planning review and a quarterly case review meeting with senior staff. Following each quarterly case review meeting, Unit policy requires the investigator assigned to the case to complete a case review form reflecting the issues discussed and investigative steps assigned. The investigator is required to provide copies of this form to the appropriate supervisor and chief. Unit policy requires the supervisor to place the form in the case file.

For monitored cases, the Unit's policy requires periodic and continuous assessment to determine whether additional investigative effort is warrented. Unit policy does not state what constitutes a monitored case.

[19] All references to Unit policy may be found in the "Medicaid Fraud Control Unit, Virginia Office of the Attorney General Employee Manual," revised July 14, 2015. The Unit has an updated manual effective January 13, 2016.

However, the Unit director stated that the Unit applied the term monitored cases tor civil cases forwhich the Unit was not expending resources to investigate the underlying allation(s). Further, the Unit director reported that all but three of the monitored cases in our review were civil cases that were coordinated by the National Association of Medicaid Fraud Control Units (NAMFCU). These three cases involved urgent care services not rendered, improper lab testing resulting in patient harm, and transportation services not rendered.

Unit management reported to us that, in practice, Unit staff reevaluate the status of monitored cases during the life of the case, as more information regarding the allegations is identified. Yet, for the two cases the Unit changed from an active to monitored status, we could not find documentation in the case files indicating how or why the status changed.

Unlike active cases, the Unit's policy has no set periodicity schedule of supervisory review or formal review forms for monitored cases. The Unit's policy states that the assigned counsel is responsible for making these assessments and that investigative resources are available for monitored cases on an ad hoc basis.

The Unit did not report all convictions and adverse actions to Federal partners within required timeframes

The Unit did not report all convictions to OIG for the purpose of program exclusion or all adverse actions to the National Practitioner Data Bank (NPDB) within the required timeframes. The Unit reported delays in receiving sentencing documentation from courts and a lack of clarity regarding what documentation OIG required as the reasons for the late reporting.

The Unit did not report half of all convictions to OIG within required timeframes

The Unit did not report 42 of its 79 convictions to OIG within 30 days of sentencing, as required by Federal regulations. Table 4 shows how many days after sentencing these convictions were reported to OIG. Performance Standard 8(f) states that the Unit should transmit to OIG reports of all convictions for the purpose of exclusion from Federal health care programs within 30 days of sentencing. Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in improper payments to providers by Medicare or other Federal health care programs or possible harm to beneficiaries.

The Unit's management explained that delays in obtaining certified sentencing documents made it difficult to report all convictions to OIG within the required timeframe. Within the Unit, one administrative staff

person was responsible for reporting convictions to OIG. Her understanding was that OIG required certified sentencing documents to report convictions for exclusion; however, she had not received formal guidance on this issue for several years. Additionally, in 2012 and 2013, the Unit reported convictions to OIG quarterly; and in 2014, the Unit reported convictions to OIG monthly.

In Summer 2015, OIG issued guidance clarifying that sentencing documents do not need to be certified to report a conviction to OIG. The Unit is now aware of the reporting requirements, and it is reporting convictions to OIG as soon as they are received.

Table 4: Number of Convictions Reported to OIG After Required Timeframe

Federal Partner Reported To	Convictions Reported Within 31 to 60 Days After Sentencing	Convictions Reported Within 61 to 90 Days After Sentencing	Convictions Reported More Than 90 Days After Sentencing	Total Convictions Reported More Than 30 Days After Sentencing
OIG	23	9	10	42

Source: OIG analysis of Unit convictions and dates reported to OIG and NPDB, 2016.

The Unit did not report half of all adverse actions to NPDB within required timeframes

The Unit did not report 41 convictions to NPDB within 30 days of the adverse action. Table 5 shows how many days after the action these convictions were reported to NPDB. Federal regulations require that Units report any adverse actions generated as a result of investigations or prosecutions of healthcare providers to the NPDB within 30 calendar days of the date on which the final adverse action was taken.[20] Performance Standard 8(g) also states that the Unit should report qualifying cases to NPDB.[21] The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions. If a Unit fails to ensure that adverse actions are reported to the NPDB, individuals may be able to find new healthcare employment with an organization that is not aware of their adverse actions.

[20] 45 CFR § 60.5.

[21] Performance Standard 8(g) states that the Unit should report "qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases." The HIPDB and the NPDB were merged during our review period (FYs 2012 through 2014); therefore, we reviewed the reporting of adverse actions under NPDB requirements. 78 Fed. Reg. 20473 (April 5, 2013). Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(g)(1) and 45 CFR § 60.3.

Table 5: Number of Convictions Reported to NPDB After Required Timeframes

Federal Partner Reported To	Convictions Reported Within 31 to 60 Days After the Action	Convictions Reported Within 61 to 90 Days After the Action	Convictions Reported More Than 90 Days After the Action	Total Convictions Reported More Than 30 Days After the Action
NPDB	22	9	10	41

Source: OIG analysis of Unit convictions and dates reported to OIG and NPDB, 2016.

The staff person responsible for reporting the Unit's convictions and adverse actions explained that reports cannot be entered into NPDB without certain information found only in the sentencing documents, such as duration of probation. The Unit has an informal process for following up with courts to obtain sentencing documents. This staff person stated that she requested preliminary sentencing documents from courts if the 30-day timeframe was approaching for a particular conviction. If the court provided a preliminary sentencing document, the conviction was reported to NPDB based on that preliminary document. However, some courts did not provide such documents.

The Unit maintained proper fiscal control of its resources

The Unit maintained proper fiscal control of its resources during the review period. According to Performance Standard 11, the Unit should exercise proper fiscal control over the Unit's resources. On the basis of the review OIG auditors conducted, the Unit's financial documentation indicated that the Unit's requests for reimbursement for FYs 2012 through 2014 represented allowable, allocable, and reasonable costs. In addition, the Unit maintained adequate internal controls relating to accounting, budgeting, personnel, procurement, property, and equipment.

Other observation: The Virginia Unit's partnerships with a variety of stakeholders led to successful Medicaid fraud prosecutions and increased recoveries

Having effective partnerships with a variety of stakeholders can enhance a Unit's ability to prosecute Medicaid fraud, recover inappropriate payments, and achieve increased savings to Federal programs. The Virginia Unit leveraged its partnerships with the Food and Drug Administration (FDA), the Internal Revenue Service (IRS), and the Social Security Administration to achieve significant results.

The Unit's partnership with FDA enhanced the Unit's ability to successfully prosecute Medicaid fraud

Unit staff reported that, in its joint investigations with FDA, shared technological and investigative resources led to the successful prosecution

of pharmaceutical manufacturers. Many of these prosecutions were for the sale of misbranded drugs to nursing homes, long-term-care facilities, and hospitals. The Unit Director stated that this partnership allowed the Unit to leverage resources effectively and provided unique insights into pharmaceutical investigations. Because the FDA has staff with specialized investigative experience throughout the country, it was able to conduct interviews with witnesses nationwide. FDA also can expedite access to information, such as new drug applications, that the Unit might not otherwise be able to access as easily. The Unit Director reported that the partnership also allowed the Unit to access the significant forensic capabilities of the FDA. This includes imaging electronic information onsite and providing significant staff support for execution of search warrants.

The Unit's partnership with IRS resulted in increased State recoveries of inappropriate payments

The Unit's largest-ever recoveries resulted from two investigations of large pharmaceutical manufacturers conducted jointly with IRS. One of these cases resulted in $1.5 billion in total recoveries—the highest total recoveries ever from a Medicaid fraud case investigated by a Unit.[22] In these joint investigations, IRS financial experts helped Unit investigators and attorneys by tracing fraud proceeds so that the Unit could freeze assets. Unit staff reported that IRS's expertise was particularly beneficial when the Unit's cases involved international corporations. The IRS has the ability to track money to accounts outside of the United States and identify related organizations that may hold assets on behalf of target corporations.

The Unit partnered with the Social Security Administration to achieve savings for State and Federal programs

The Unit participates in a joint taskforce with the Social Security Administration which resulted in combined savings of $40 million, including ($10 million in savings to the Medicaid program and $30 million in savings to the Social Security program). Some Unit investigators are detailed to the taskforce. These investigators conduct surveillance on individuals suspected of fraudulently receiving disability benefits,[23] and may observe these individuals participating in activities inconsistent with the disability on which those benefits are based. For

[22] The $1.5 billion included a criminal fine and forfeiture totaling $700 million, and civil settlements totaling $800 million. The Unit did not receive the entire $1.5 billion; rather, it was split among the Federal government and States participating in the case.

[23] The investigators detailed to the taskforce are funded by the Social Security Administration, not by the MFCU grant.

example, an investigator observed a disability recipient with a prosthetic leg coach a high school football team, demonstrating exercises to the players and mowing the football field after practice concluded. This individual also posted photos to a social networking site showing himself engaged in rappelling and hunting.

When individuals' disability claims are shown to be false, as in the example above, the Social Security Administration disenrolls them from the disability program. Since individuals receiving disability benefits are automatically eligible for Medicaid, disenrolling these individuals from the disability program eliminates their eligibility for Medicaid based on their disability status, resulting in savings to Medicaid.

Other observation: The Unit's use of specialty software improved its ability to process and share investigative information

Because of the Unit's large civil caseload, the Unit invested in specialty software (i.e., e-discovery software) to improve its ability to process, track, and analyze evidence collected during the Unit's investigations.[24] Civil cases often involve multiple parties and take years to complete. The Unit Director explained that it is not unusual for the Unit to process millions of documents during the course of some civil cases. As the Unit Director described, "[W]e couldn't [pursue these large cases] the old-fashioned way by going through boxes." The e-discovery software used by the Unit can read the text in a document, analyze it for key words, subject matter, or other characteristics, and systematically code it according to criteria established by an analyst.

Unit staff also reported that their e-discovery software allowed them to more easily share data with Federal and State partners. The software allowed staff from partner agencies secure, offsite access to evidence, thereby facilitating the investigation and prosecution of the Unit's joint cases. Unit staff and some stakeholder organizations also stated that the software increased the Unit's ability to work joint cases efficiently.

[24] E-discovery is short for electronic discovery. Discovery is a phase of litigation in which the parties in a dispute must provide each other relevant information and records. When discovery is conducted on electronic documents, such as emails, Web sites, and databases, or using specialized software, it is referred to as e-discovery.

CONCLUSION AND RECOMMENDATIONS

The Unit reported significant results during the review period, including 79 criminal convictions and 46 civil judgments and settlements. The Unit reported combined criminal and civil recoveries of $1.1 billion, and recovered more than $34 for every $1 spent in the review period. We identified two practices that assisted the Unit in obtaining these results. The Unit partnered with a variety of stakeholders and used specialty software to help it successfully prosecute Medicaid fraud, maximize recoveries, and process and share investigative information with those partners. In addition, our review of the Virginia Unit found that it was generally in compliance with applicable laws, regulations and policy transmittals and maintained proper fiscal control of its resources.

However, we identified several areas where the Unit should improve its operations. Although the Unit's active case files generally contained the required supervisory reviews, the Unit's policy did not require supervisory reviews of monitored cases. Furthermore, the Unit's policy did not define what constituted a monitored case. Also, the Unit did not report all convictions and adverse actions to Federal partners within required timeframes.

We recommend that the Virginia Unit:

Revise Unit policy to define what constitutes a monitored case and the level and frequency of supervisory review appropriate for such cases

The Unit should revise its policy to: (1) define what constitutes a monitored case, as opposed to an active case, and provide information in the case file related to status changes, should they occur; and (2) determine the level of supervisory review appropriate for monitored cases, including the frequency of such reviews. We recognize that the Unit has a large number of monitored cases that are not actively investigated. Therefore, the Unit should determine the level of review for monitored cases that best fits its need and available resources.

Formalize its processes to ensure that convictions and adverse actions are consistently reported to Federal partners within required timeframes

The Unit should formalize its processes to ensure that convictions are consistently reported to OIG within 30 days of sentencing and that adverse actions are reported to NPDB within 30 days of the action. The Unit could accomplish this by documenting its process to contact the various courts to request preliminary sentencing documents for all convictions and

adverse actions in its policies and procedures manual. The Unit may also want to consider maintaining dated copies of its requests for sentencing documents.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Virginia Unit concurred with both of our recommendations.

Regarding the first recommendation, the Unit stated that it has updated its Policy Manual to define a monitored case and establish a reasonable periodic supervisory review requirement for monitored cases.

Regarding the second recommendation, the Unit stated that it has included in its Weekly Report, all individuals convicted and sentenced. This will help Unit management monitor reporting to the appropriate agencies.

The Unit's comments are provided in Appendix F.

APPENDIX A

2012 Performance Standards[25]

1. A UNIT CONFORMS WITH ALL APPLICABLE STATUTES, REGULATIONS, AND POLICY DIRECTIVES, INCLUDING:
A. Section 1903(q) of the Social Security Act, containing the basic requirements for operation of a MFCU;
B. Regulations for operation of a MFCU contained in 42 CFR part 1007;
C. Grant administration requirements at 45 CFR part 92 and Federal cost principles at 2 CFR part 225;
D. OIG policy transmittals as maintained on the OIG Web site; and
E. Terms and conditions of the notice of the grant award.
2. A UNIT MAINTAINS REASONABLE STAFF LEVELS AND OFFICE LOCATIONS IN RELATION TO THE STATE'S MEDICAID PROGRAM EXPENDITURES AND IN ACCORDANCE WITH STAFFING ALLOCATIONS APPROVED IN ITS BUDGET.
A. The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
B. The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
C. The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
D. The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
E. To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.
3. A UNIT ESTABLISHES WRITTEN POLICIES AND PROCEDURES FOR ITS OPERATIONS AND ENSURES THAT STAFF ARE FAMILIAR WITH, AND ADHERE TO, POLICIES AND PROCEDURES.
A. The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.
B. The Unit adheres to current policies and procedures in its operations.
C. Procedures include a process for referring cases, when appropriate, to Federal and State agencies. Referrals to State agencies, including the State Medicaid agency, should identify whether further investigation or other administrative action is warranted, such as the collection of overpayments or suspension of payments.
D. Written guidelines and manuals are readily available to all Unit staff, either online or in hard copy.
E. Policies and procedures address training standards for Unit employees.
4. A UNIT TAKES STEPS TO MAINTAIN AN ADEQUATE VOLUME AND QUALITY OF REFERRALS FROM THE STATE MEDICAID AGENCY AND OTHER SOURCES.
A. The Unit takes steps, such as the development of operational protocols, to ensure that the State Medicaid agency, managed care organizations, and other agencies refer to the Unit all suspected provider fraud cases. Consistent with 42 CFR 1007.9(g), the Unit provides timely written notice to the State Medicaid agency when referred cases are accepted or declined for investigation.
B. The Unit provides periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.

[25] 77 Fed. Reg. 32645, June 1, 2012.

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.
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.
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.
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 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.
6. The number of criminal convictions and the number of civil judgments.
7. The dollar amount of overpayments identified.
8. The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of recoveries and the types of relief obtained through civil judgments or prefiling settlements.
8. A UNIT COOPERATES WITH OIG AND OTHER FEDERAL AGENCIES IN THE INVESTIGATION AND PROSECUTION OF MEDICAID AND OTHER HEALTH CARE FRAUD.
A. The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.
B. The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, cases involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.
C. The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.
D. For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.
E. For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.
F. The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.
G. The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.
9. A UNIT MAKES STATUTORY OR PROGRAMMATIC RECOMMENDATIONS, WHEN WARRANTED, TO THE STATE GOVERNMENT.
A. The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.
B. The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.
10. A UNIT PERIODICALLY REVIEWS ITS MEMORANDUM OF UNDERSTANDING (MOU) WITH THE STATE MEDICAID AGENCY TO ENSURE THAT IT REFLECTS CURRENT PRACTICE, POLICY, AND LEGAL REQUIREMENTS.
A. The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.
B. The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR § 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR § 455.23, "Suspension of payments in cases of fraud."
C. The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).
D. Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.
E. The MOU incorporates by reference the *CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit*.

11. A UNIT EXERCISES PROPER FISCAL CONTROL OVER UNIT RESOURCES.
A. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.
B. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.
C. The Unit maintains an effective time and attendance system and personnel activity records.
D. The Unit applies generally accepted accounting principles in its control of Unit funding.
E. The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.
12. A UNIT CONDUCTS TRAINING THAT AIDS IN THE MISSION OF THE UNIT.
A. The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.
B. The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.
C. Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.
D. The Unit participates in MFCU-related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.
E. The Unit participates in cross-training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

APPENDIX B

Virginia State Medicaid Fraud Control Unit Referrals by Referral Source for FYs 2012 Through 2014

	FY 2012			FY 2013			FY 2014		
Referral Source	**Fraud**	**Abuse & Neglect**	**Patient Funds**	**Fraud**	**Abuse & Neglect**	**Patient Funds**	**Fraud**	**Abuse & Neglect**	**Patient Funds**
Medicaid agency – PI/SURS[26]	115	0	1	100	0	0	80	0	0
Medicaid agency – other	0	0	0	0	0	0	0	0	0
Managed care organizations	0	0	0	0	0	0	0	0	0
State survey and certification agency	0	0	0	0	0	0	0	0	0
Other State agencies	1	13	0	8	1	0	7	0	0
Licensing board	0	0	0	0	0	0	0	0	0
Law enforcement	0	6	0	1	2	0	5	1	0
Office of Inspector General	2	2	0	0	1	0	5	3	0
Prosecutors	0	2	0	0	0	0	1	1	0
Providers	0	2	0	8	0	0	11	0	0
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	1	0	0	0	0	0	0	0
Adult protective services	0	24	0	1	15	0	5	19	1
Private citizens	20	9	0	37	11	0	67	4	1
MFCU hotline	0	0	0	0	0	0	0	0	0
Self-generated	0	3	0	0	1	0	0	0	0
Other	16	0	0	28	2	0	29	5	0
Total	**154**	**62**	**1**	**183**	**33**	**0**	**210**	**33**	**2**
Annual Total			**217**			**216**			**245**

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

APPENDIX C

Investigations Opened and Closed By Provider Category for FYs 2012 Through 2014

Table C-1: Fraud Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
Facilities	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Hospitals	2	0	1	1	2	2
Nursing facilities	1	0	2	0	1	1
Other long-term-care facilities	0	0	0	1	0	0
Substance abuse treatment centers	0	0	0	0	0	0
Other	1	0	3	2	4	4
Subtotal	**4**	**0**	**6**	**4**	**7**	**7**
Practitioners	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Doctors of medicine or osteopathy	0	0	5	0	4	4
Dentists	4	2	2	1	1	0
Podiatrists	0	0	0	0	1	1
Optometrists/opticians	0	0	0	0	0	0
Counselors/psychologists	3	2	1	7	4	1
Chiropractors	0	0	0	0	0	0
Other	0	3	2	2	3	1
Subtotal	**7**	**7**	**10**	**10**	**13**	**7**
Medical Support	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Pharmacies	8	0	16	3	12	11
Pharmaceutical manufacturers	44	40	63	70	38	65
Suppliers of durable medical equipment and/or supplies	12	7	21	13	24	25
Laboratories	1	3	10	7	12	3
Transportation services	0	4	1	0	0	1
Home health care agencies	2	3	4	6	5	1
Home health care aides	10	8	38	16	42	25
Nurses, physician assistants, nurse practitioners, certified nurse aides	0	0	0	0	0	0
Radiologists	0	0	1	1	1	0
Medical support—other	2	0	2	2	7	2
Subtotal	**79**	**65**	**156**	**118**	**141**	**133**

Table C-1 (Continued): Fraud Investigations

Program Related	Opened	Closed	Opened	Closed	Opened	Closed
Managed care	1	1	0	0	2	0
Medicaid program administration	0	0	0	1	0	0
Billing company	0	0	0	1	0	0
Other	3	1	6	0	0	4
Subtotal	**4**	**2**	**6**	**2**	**2**	**4**
Total Provider Categories	**94**	**74**	**178**	**134**	**163**	**151**

Source: OIG analysis of Unit-submitted documentation, 2016.

Table C-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing facilities	5	7	3	3	1	2
Other long-term-care facilities	2	0	0	2	1	1
Nurses, physician's assistants, nurse practitioners, certified nurse aides	1	0	1	1	4	0
Home health aides	3	2	0	2	2	1
Other	0	0	0	0	3	1
Total	**11**	**9**	**4**	**8**	**11**	**5**

Source: OIG analysis of Unit-submitted documentation, 2016.

Table C-3: Patient Funds Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nondirect care	0	2	1	2	0	0
Nurses, physician's assistants, nurse practitioners, certified nurse aides	0	0	0	0	0	0
Home health aides	0	0	0	0	0	0
Other	0	0	0	0	0	0
Total	**0**	**2**	**1**	**2**	**0**	**0**

Source: OIG analysis of Unit-submitted documentation, 2016.

APPENDIX D

Detailed Methodology

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

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information regarding the Unit's investigation of Medicaid cases, including 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, its annual reports, its recertification questionnaire, its policy and procedures manuals, and its MOU with the State Medicaid agency. We requested any additional data or clarification from the Unit as necessary.

Review of Unit Financial Documentation. To evaluate internal control of fiscal resources, we reviewed policies and procedures related to the Unit's budgeting, accounting systems, cash management, procurement, property, and staffing. We reviewed records in the Payment Management System (PMS)[27] and revenue accounts to determine the accuracy of the Federal Financial Reports (FFRs) for FYs 2012 through 2014. We also obtained the Unit's claimed grant expenditures from its FFRs and the supporting schedules. From the supporting schedules, we requested and reviewed supporting documentation for the selected items. We noted any instances of noncompliance with applicable regulations.

We selected three purposive samples to assess the Unit's internal control of fiscal resources. The three samples included the following:

1. To assess the Unit's expenditures, we selected a purposive sample of 89 accounting records. We selected routine and nonroutine transactions representing a variety of budget categories and payment amounts.
2. To assess inventory, we selected and verified a purposive sample of 45 items from the current inventory list of 1,035 items. To ensure

[27] The PMS is a grant payment system operated and maintained by the Department of Health and Human Services, Program Support Center, Division of Payment Management. The PMS provides disbursement, grant monitoring, reporting, and case management services to awarding agencies and grant recipients, such as MFCUs.

a variety in our inventory sample, we included items that were portable, high value, or unusual in nature (e.g., vehicles, communication equipment).

3. To assess employee time and effort, we selected two purposive samples of Unit employees who were paid during the review period: for FY 2013, we sampled 29 of 103 employees, and for FY 2014, we sampled 35 of 114 employees. We then requested and reviewed documentation (e.g., time card records) to support the time and effort of that employee in the selected pay period.

Interviews with Key Stakeholders. In July and August 2015, we interviewed key stakeholders, including officials in the United States Attorneys' Offices, the State Attorney General's Office, and other State agencies that interacted with the Unit (i.e., the Medicaid Program Integrity Unit, the Office of the State Long-Term Care Ombudsman, and the Office of Licensure and Certification). We also interviewed supervisors from OIG's Region IV offices who work regularly with the Unit. 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 August 2015, we conducted an online survey of all 77 nonmanagerial Unit staff within each professional discipline (i.e., investigators, auditors, attorneys, analysts, and nurse investigators) as well as support staff. The response rate was 99 percent.[28] Our questions focused on Unit operations, 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 during the onsite review in September 2015. We interviewed the Unit's Director, Deputy Director, Chief of Fraud and Corporate Neglect Investigations, Chief of Investigations and Elder Abuse, Chief Section Counsel, Chief of Civil Litigation, Chief Prosecutor, and Administrative Manager. We asked these individuals to provide information related to (1) Unit operations, (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance, (3) opportunities for the Unit to improve

[28] One nonmanagerial staff person was on maternity leave during the period of the staff survey and therefore did not respond.

its operations and/or performance, and (4) clarification regarding information obtained from other data sources.

Onsite Review of Case Files and Other Documentation. We requested that the Unit provide us with a list of cases that were open at any point during FYs 2012 through 2014. We requested data on the 777 open cases that included, but was not limited to, the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened. Because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs, we exclude all of the cases categorized as "global" from our review of a Unit's case files. Therefore, we excluded 82 cases that were categorized as "global" from the list of cases. The remaining number of case files was 695.

From the 695 cases, we selected a simple random sample of 100 cases for review. From this initial sample of 100 case files, we selected a simple random sample of 50 files for a more indepth review of selected issues, such as the timeliness of investigations and case development.

Through our case review, we determined that 58 of the 100 sampled cases were monitored cases. Appendix E contains the point estimates and their 95-percent confidence intervals.

Onsite Review of Unit Operations. During our September 2015 onsite visit, we reviewed the Unit's workspace and operations. Specifically, we visited the Unit headquarters in the State capital. While onsite, we observed the Unit's offices and meeting spaces, security of data and case files, location of select equipment, and the general functioning of the Unit.

Data Analysis

We analyzed data to identify any opportunities for improvement and instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.[29]

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

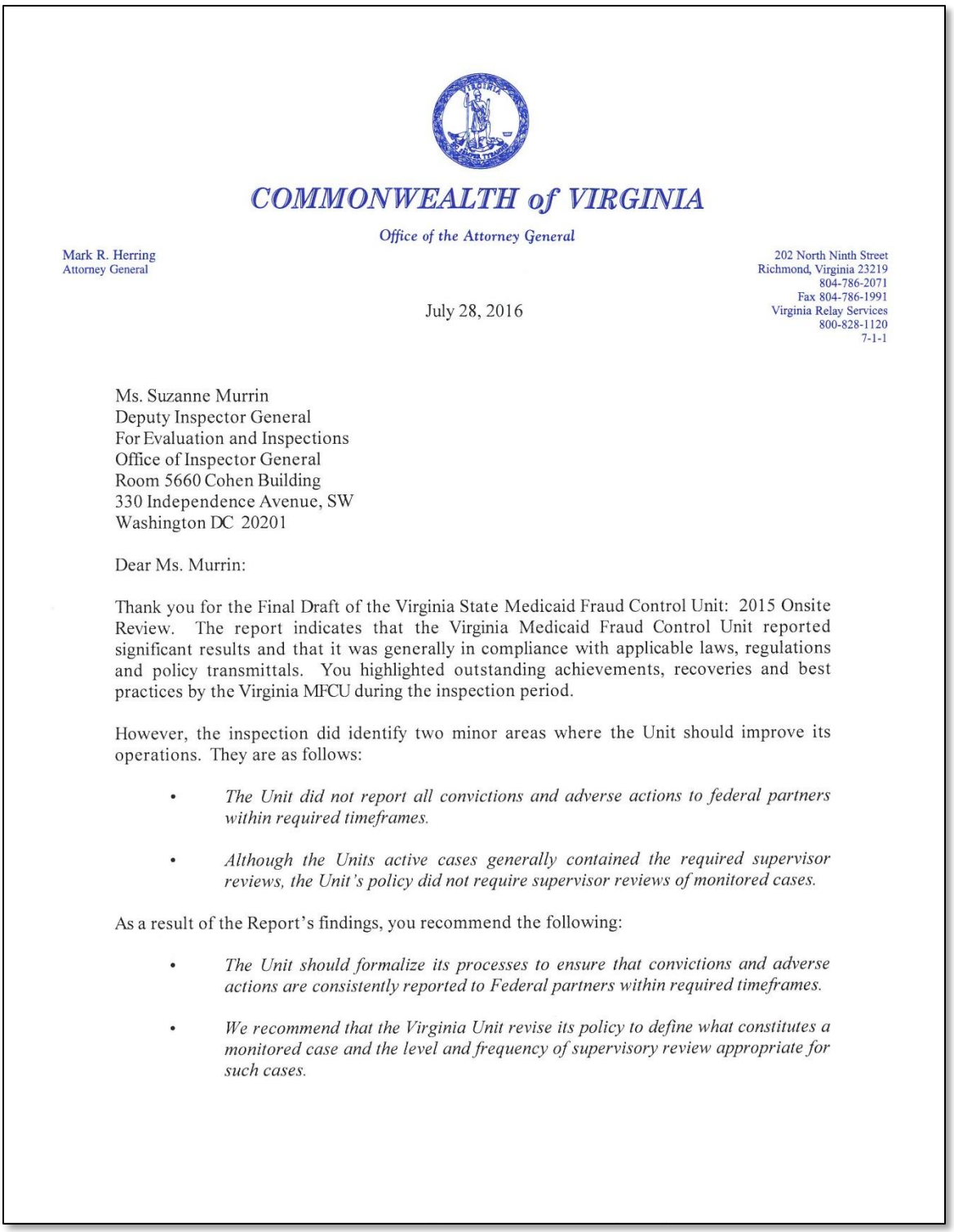
APPENDIX E

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

Estimate	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of monitored cases that had documented supervisory reviews in their respective case files	58	6.9%	2.0%	16.1%

Source: OIG analysis of Virginia MFCU case files, 2016.

APPENDIX F
Unit Comments



COMMONWEALTH of VIRGINIA

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July 28, 2016

Ms. Suzanne Murrin
Deputy Inspector General
For Evaluation and Inspections
Office of Inspector General
Room 5660 Cohen Building
330 Independence Avenue, SW
Washington DC 20201

Dear Ms. Murrin:

Thank you for the Final Draft of the Virginia State Medicaid Fraud Control Unit: 2015 Onsite Review. The report indicates that the Virginia Medicaid Fraud Control Unit reported significant results and that it was generally in compliance with applicable laws, regulations and policy transmittals. You highlighted outstanding achievements, recoveries and best practices by the Virginia MFCU during the inspection period.

However, the inspection did identify two minor areas where the Unit should improve its operations. They are as follows:

- *The Unit did not report all convictions and adverse actions to federal partners within required timeframes.*
- *Although the Units active cases generally contained the required supervisor reviews, the Unit's policy did not require supervisor reviews of monitored cases.*

As a result of the Report's findings, you recommend the following:

- *The Unit should formalize its processes to ensure that convictions and adverse actions are consistently reported to Federal partners within required timeframes.*
- *We recommend that the Virginia Unit revise its policy to define what constitutes a monitored case and the level and frequency of supervisory review appropriate for such cases.*

Since your Office no longer requires certified copies of sentencing reports, we believe we can now meet the 30 day notification requirement to HHS-OIG Exclusion, HIPDB and National Practitioner's Data Base. We have also included into our Weekly Report all excluded individuals convicted and sentenced. This allows the MFCU Management to monitor reporting of the exclusion to the appropriate agencies. The Virginia MFCU has also updated our Policy Manual and specifically defined a "monitored" case with a reasonable periodic supervisor review requirement.

Therefore, the Virginia MFCU agrees with your findings and recommendations and has made the appropriate changes to comply. If you have any questions, please feel free to contact me at any time.

With kindest kegards, I remain,

Very Truly Yours,

Randall L. Clouse
Director and Chief
Medicaid Fraud Control Unit
Office of the Virginia Attorney General

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Jennifer King, Deputy Regional Inspector General; and in consultation with Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Michala Walker, of the Kansas City regional office, served as the project leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Michael Barrett and Conswelia McCourt. Other Medicaid Fraud Policy and Oversight Division staff who participated in the review include Jordan Clementi. Office of Investigations staff also participated in the review. Office of Audit Services staff who conducted a financial review include Marilyn Carrion, Valerie Johnson, and Michael Jones. Other central office staff who contributed to this review include Kevin Farber, Lonie Kim, Joanne Legomsky, and Jacquelyn Towns.

Office of Inspector General

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