

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**SOUTH DAKOTA STATE
MEDICAID FRAUD CONTROL
UNIT: 2016 ONSITE REVIEW**



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**EXECUTIVE SUMMARY: SOUTH DAKOTA STATE MEDICAID FRAUD
CONTROL UNIT: 2016 ONSITE REVIEW
OEI-07-16-00170**

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 Unit's 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 South Dakota Unit in April 2016. We based our review on an analysis of data from six sources: (1) policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) financial documentation for fiscal years (FYs) 2013 through 2015; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's staff; (5) a review of files for cases that were open at some point during FYs 2013 through 2015; and (6) observation of Unit operations.

WHAT WE FOUND

For FYs 2013 through 2015, the South Dakota Unit reported 5 criminal convictions, 12 civil judgments and settlements, and combined criminal and civil recoveries of \$7 million. We found that the South Dakota Unit was generally in compliance with applicable laws, regulations, and policy transmittals, with some exceptions. Specifically, the Unit did not report program income properly in FY 2013; and a Unit investigator performed non-Unit duties, for which associated costs were not subtracted from claimed Unit expenditures. With respect to adherence to the Performance Standards, we found that the Unit did not always document periodic supervisory reviews in its case files. Further, the Unit did not report all convictions and adverse actions to Federal partners within required timeframes. In addition, we noted that only a small portion of Unit fraud referrals—8 percent—came from the State Medicaid agency's Program Integrity Unit. We also noted that the Unit uses peer education as a means of deterring fraudulent conduct.

WHAT WE RECOMMEND

We recommend that the South Dakota Unit (1) deduct the Federal share for the unallowable withdrawal from current expenditures and ensure that all program income is reported properly on its Federal financial reports, (2) reimburse the Federal share of unallowable personnel costs related to non-Unit duties and ensure that the Unit claims Federal reimbursement only for appropriate Unit-related duties, (3) implement processes to ensure that all case files include documentation of periodic supervisory reviews, and (4) implement processes to ensure that convictions and adverse actions are reported to

Federal partners within required timeframes. The Unit concurred with all four recommendations.

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OBJECTIVE

To conduct an onsite review of the South Dakota State 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 (1) operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in a particular 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 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 potential 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 or 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 February 16, 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 approximately \$251 million, \$188 million of which represented Federal funds.¹²

Administration and 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 South Dakota MFCU. During these onsite reviews, OIG evaluates Units' compliance with laws, regulations, and policies, as well as adherence to the 12 performance standards. OIG also makes observations about best practices, provides recommendations to the Units, and monitors the

⁹ SSA § 1903(q)(1).

¹⁰ SSA § 1903(a)(6)(B).

¹¹ Ibid.

¹² 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 16, 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 77 Fed. Reg. 32645 (June 1, 2012).

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.

South Dakota Medicaid Program

In 2013, South Dakota's Medicaid program provided health coverage to approximately 116,000 beneficiaries, which was approximately 14 percent of the State's population.^{16, 17} In FY 2015, combined Federal and State expenditures for South Dakota's Medicaid program were approximately \$860 million.¹⁸

South Dakota MFCU

The Unit, a division of the South Dakota Office of the Attorney General, investigates and prosecutes cases of Medicaid fraud and patient abuse. At the time of our review, the Unit employed five staff members including the director, the senior investigator, an investigator, an auditor, and an administrative analyst.

Referrals. The Unit receives referrals from a variety of sources, including the State Medicaid agency, health care providers, local law enforcement, and OIG. Appendix B depicts Unit referrals by referral source for FYs 2013 through 2015.

Generally, referrals provided to the Unit are received and reviewed by the administrative analyst. The administrative analyst also gathers any additional information needed before forwarding the referral to the director. The Unit director reviews all referrals and ultimately decides whether to open a case.

Investigations and prosecutions. The Unit uses a team approach to investigate and prosecute cases. Typically, the team is comprised of at least one investigator, an auditor, and the director (who serves as the attorney). For each case, either an investigator or auditor is assigned as the team leader. The team leader is responsible for coordinating case activities, including collecting, reviewing, and analyzing documents; interviewing witnesses;

¹⁶ CMS, *South Dakota Comprehensive Program Integrity Review: Final Report*, January 2015.

¹⁷ World Population Statistics, *South Dakota Population 2013*. Accessed at <http://www.worldpopulationstatistics.com/south-dakota-population-2013/> on June 10, 2016.

¹⁸ 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 16, 2016.

serving subpoenas; assisting in search warrants; and preparing factual findings. The director provides legal expertise and guidance to the investigative team and, as appropriate, prepares the case for prosecution.

Previous OIG Onsite Review

In 2009, OIG conducted an onsite review of the South Dakota Unit. The review found that although the Unit investigator worked under the direction of the Unit director; the Unit director did not personally approve or sign the investigator's performance evaluation. OIG policy requires that all MFCU staff work "under the supervision and direction of the Unit."¹⁹ As a result, OIG recommended that the Unit director or the senior investigator should approve and sign the investigator's performance evaluation. The Unit concurred with the recommendation. For the current review, we confirmed with the Unit director that all Unit staff work under his supervision.²⁰

METHODOLOGY

We conducted an onsite review in April 2016. We based our review on an analysis of data from six sources: (1) policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) financial documentation for FYs 2013 through 2015; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's staff; (5) a review of files for cases that were open at some point during FYs 2013 through 2015; and (6) observation of Unit operations. Appendix C provides details of our methodology.

Standards

These reviews are conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

¹⁹ OIG, State Fraud Policy Transmittal No. 2014-1, *Employment and Reimbursement of Full- and Part-Time Staff and Performance of Non-MFCU Duties*, June 3, 2014.

²⁰ During our onsite review in April 2016, the Unit director stated that prior to 2016, the South Dakota Attorney General's Office did not conduct formal performance evaluations of its staff. The MFCU is located within the South Dakota Attorney General's Office and as a result, formal performance evaluations were not conducted for any MFCU staff. The Attorney General's Office began conducting formal performance evaluations in 2016.

FINDINGS

For FYs 2013 through 2015, the South Dakota Unit reported 5 criminal convictions, 12 civil judgments and settlements, and combined criminal and civil recoveries of \$7 million

For FYs 2013 through 2015, the Unit reported 5 criminal convictions and 12 civil judgments and settlements. See Table 1 for yearly convictions and civil judgments and settlements. Of the Unit’s five convictions over the 3-year period, four involved provider fraud, and one involved patient abuse or neglect.

Table 1: South Dakota MFCU Criminal Convictions and Civil Judgments and Settlements, FYs 2013–2015

Outcomes	FY 2013	FY 2014	FY 2015	3-Year Total
Criminal Convictions	2	1	2	5
Civil Judgments and Settlements	0	6	6	12

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

For the same period, the Unit reported combined criminal and civil recoveries of approximately \$7 million. See Table 2 for the Unit’s yearly recoveries and expenditures. The majority of the recoveries were obtained from “global” cases, which accounted for 86 percent of all recoveries during the 3-year review period.²¹

Table 2: South Dakota MFCU Recoveries and Expenditures, FYs 2013–2015*

Type of Recovery	FY 2013	FY 2014	FY 2015	3-Year Total
Global Civil	\$2,673,918	\$3,386,939	\$75,100	\$6,135,958
Nonglobal Civil	\$14,790	\$466,251	\$87,047	\$568,088
Criminal	\$365,165	\$566	\$27,680	\$393,411
Total Recoveries	\$3,053,873	\$3,853,756	\$189,827	\$7,097,457
Total Expenditures	\$396,605	\$409,564	\$423,691	\$1,229,861

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

* Due to rounding, dollar amounts for each category of recoveries do not always sum to the total recovery amount.

South Dakota’s global recoveries declined from more than \$3 million in FY 2014 to approximately \$75,000 in FY 2015. This is consistent with a

²¹ 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.

national trend of declining civil health care fraud complaints and settlements, especially those involving pharmaceutical companies.²²

In FY 2013, the Unit did not report program income properly

The Unit did not report as program income \$1,000 it received for investigative costs incurred while investigating a patient abuse case in FY 2013. Consistent with Federal regulation, OIG policy states that any funds received by the Unit—including reimbursements for expenses incurred during patient abuse investigations—that meet the definition of program income must be reported on the Unit's Federal financial expenditure reports.²³ The terms and conditions of the grant award and OIG policy require that these funds be deducted from total costs under the grant.^{24, 25} Because the Unit did not follow OIG policy of reporting and deducting this program income, the Unit withdrew \$750 more from the HHS Payment Management System than it was entitled to receive.²⁶ Since our review, the Unit has worked with OIG to reimburse the overdrawn funds.

Unit professional staff performed non-Unit duties, and the associated costs were not subtracted from claimed Unit expenditures

For FYs 2013 through 2015, a Unit investigator performed non-Unit duties, and the associated costs were not subtracted from claimed Unit expenditures. Federal regulations state that a Unit may only claim Federal reimbursement for costs attributable to the establishment and operation of

²² From the 1990s through the early 2000s, a significant number of pharmaceutical companies were the subject of large monetary settlements in civil fraud actions. As a condition of those settlements, pharmaceutical companies were required to adopt corporate integrity agreements designed to prevent future abusive practices. Other corporations have adopted voluntary compliance programs, promoted by OIG, which may have further reduced the incidence of fraud allegations. See OIG Compliance Program Guidance for Pharmaceutical Manufacturers, 68 Fed. Reg. 23731 (May 5, 2003), available at <http://www.oig.hhs.gov/authorities/docs/03/050503FRCPGPharmac.pdf>.

²³ 45 CFR § 92.25 (2013); OIG State Fraud Policy Transmittal 10-01, Program Income (March 22, 2010).

²⁴ OIG, *General Terms and Conditions*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/terms-conditions.asp> on June 2, 2016.

²⁵ OIG, State Fraud Policy Transmittal 10-01, Program Income (March 22, 2010).

²⁶ This amount represents the Federal share (75 percent) of the Unit's budget; in this case, \$750 of the \$1,000 total expenses. The State is responsible for the remaining 25 percent of the \$1,000 total (\$250). OIG policy requires Units to deduct program income from their total costs under the grant, pursuant to 45 CFR § 95.25(g)(1), thus making the 75-percent share unallowable.

the Unit.²⁷ During the review period, the investigator occasionally conducted background investigations for other divisions of the Office of Attorney General, amounting to 40 hours. These activities were not attributable to the investigation and prosecution of Medicaid fraud or patient abuse or neglect. Since our review, the Unit has worked with OIG to reimburse these funds.

Half of the Unit's case files lacked documentation of periodic supervisory reviews; however, the supervisor documented the opening and closing of all cases

Fifty-one percent of the Unit's case files lacked documentation of consistent periodic supervisory review required by Unit policy. Of the 19 cases that did not include all required periodic reviews, 15 had at least one supervisory review documented in the case file. Performance Standard 7(a) states that supervisory reviews should be conducted periodically, consistent with the Unit's policies and procedures, and noted in the case file.²⁸ Further, the Unit's policy requires that supervisory reviews occur quarterly and be documented in the case file.²⁹ Periodic supervisory reviews can help ensure timely completion of cases and may identify potential issues during the investigation.

All of the Unit's 65 case files included documentation of supervisory approval to open the case; all of the case files for the Unit's 59 closed cases included documentation of supervisory approval to close the case.³⁰ Performance Standard 5(b) states that Unit supervisors should approve the opening and closing of all cases.³¹ Supervisory approval to open cases indicates that Unit supervisors are monitoring the intake of cases, thereby facilitating progress in the investigation. Further, supervisory approval of case closing helps ensure the timely completion and resolution of cases.

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. Performance Standard 8(f) states

²⁷ 42 CFR § 1007.19(d).

²⁸ 77 Fed. Reg. 32647 (June 1, 2012).

²⁹ The Unit began using a form to document supervisory reviews in November 2013.

³⁰ For FYs 2013 through 2015, the Unit had a total of 65 cases. We reviewed case files for all 65 cases. Fifty-nine of the Unit's 65 cases were closed at the start of the onsite review.

³¹ 77 Fed. Reg. 32647 (June 1, 2012).

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.³² Additionally, Federal regulations require that the Unit report any adverse actions resulting from investigations or prosecutions of healthcare providers to the NPDB within 30 days.³³

The Unit did not always report its convictions to OIG within required timeframes

Of the Unit's five convictions that should have been reported to OIG, three were not reported within 30 days of sentencing, as required. Specifically, the Unit reported one conviction 255 days late, one conviction 230 days late, and one conviction 25 days late. 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.

According to the Unit, the convictions were not reported in a timely manner due to what the Unit termed administrative error. The Unit director stated that the Unit thought that another entity would report the convictions to OIG. Once the Unit realized that the convictions were not reported, the Unit reported them to OIG. Upon case closing, the Unit's policy requires that staff report the conviction information to OIG. The director affirmed that the Unit values the OIG exclusion process and educates State prosecutors about the importance of reporting convictions to OIG for the purpose of exclusion.

The Unit did not always report its adverse actions to the NPDB within required timeframes

Of the five adverse actions that should have been reported to the NPDB, three were not reported within 30 days of the final action as required. Specifically, the Unit reported one adverse action 255 days late, one adverse action 230 days late, and one adverse action 25 days late. 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 report adverse actions to the NPDB, individuals may be able to find new

³² Ibid. at 32648.

³³ 45 CFR § 60.5. Both Federal regulations and the Performance Standards require Units to report to NPDB. 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." 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.

healthcare employment with an organization that is not aware of their adverse actions.

The Unit director also attributed the Unit's not reporting adverse actions in a timely manner to administrative error. The Unit director stated that the Unit thought that another entity would report the adverse actions to the NPDB. Once the Unit realized that the actions were not reported, the Unit reported them to the NPDB. Upon case closing, the Unit's policy also requires that staff report adverse actions to the NPDB.

Other observation: Only a small portion of Unit fraud referrals—8 percent—came from the State Medicaid agency's Program Integrity Unit

Over the course of 3 years, the State Medicaid agency's Program Integrity (PI) Unit provided only 8 percent of the Unit's fraud referrals; half as many as from private citizens.³⁴ The PI referrals included six fraud referrals in FY 2013, but only one fraud referral each in FY 2014 and FY 2015. Typically, referrals from the PI Unit are an essential component of a Unit's ability to effectively investigate and prosecute Medicaid provider fraud. The Unit director stated that the PI Unit may be understaffed. The PI Unit director stated that the PI Unit has a staffing issue (i.e., the PI Unit has only three staff). As of March 2016, the PI Unit had only two investigators responsible for detecting Medicaid provider fraud. The limited number of staff within the PI Unit may have affected the PI Unit's ability to provide referrals to the MFCU.³⁵

Other observation: The Unit uses peer education as a fraud deterrent

In a few cases, the Unit has recommended that providers investigated for Medicaid fraud educate peers as a means of deterring fraud. The Unit director stated that on occasion, he has recommended that the judge include as part of sentencing, or has included in a settlement agreement, that the provider educate his/her peers about Medicaid fraud. For instance, as a condition of a civil settlement agreement, a provider was required to give such a presentation with the Unit at an optometry

³⁴ Private citizens provided the Unit six fraud referrals in FY 2013, seven fraud referrals in FY 2014, and three fraud referrals in FY 2015.

³⁵ The Centers for Medicare & Medicaid Services (CMS) conducts reviews of each State's Medicaid program integrity activities to assess the State's effectiveness in combating Medicaid fraud, waste, and abuse. In a 2015 report, CMS recommended that the South Dakota PI Unit determine an appropriate staffing level to ensure necessary oversight of program integrity operations. CMS, *South Dakota Comprehensive Program Integrity Review: Final Report*, January 2015.

conference. As a condition of another provider's suspended jail sentence, the provider presented alongside the Unit at the same conference. A third provider also gave a presentation alongside the Unit at a social work association meeting as a result of a criminal sentencing recommendation. The Unit director stated that the Unit has received feedback from both providers making the presentations and audience members that such presentations are helpful in highlighting Medicaid billing issues and deterring fraud.

CONCLUSION AND RECOMMENDATIONS

For FYs 2013 through 2015, the South Dakota Unit reported 5 criminal convictions, 12 civil judgments and settlements, and combined criminal and civil recoveries of \$7 million.

The South Dakota Unit was found to be in general compliance with applicable laws, regulations, and policy transmittals, with some exceptions. Specifically, the Unit did not report program income properly in FY 2013; and a Unit investigator performed non-Unit duties, for which associated costs were not subtracted from claimed Unit expenditures. With respect to adherence to the Performance Standards, the Unit did not always document periodic supervisory reviews in its case files, nor did it report all convictions and adverse actions to Federal partners in a timely manner. In addition, we noted that only a small portion of Unit fraud referrals—8 percent—came from the State Medicaid agency's PI Unit. We also noted that the Unit uses peer education as a means of deterring fraudulent conduct.

We recommend that the South Dakota Unit:

Deduct the Federal share for the unallowable withdrawal from current expenditures and ensure that all future program income is reported properly on Federal financial reports

The Unit should continue to work with OIG to deduct \$750 from current Federal expenditures to account for the unallowable withdrawal in FY 2013. In addition, in the future the Unit should report its program income according to the guidelines in OIG State Fraud Policy Transmittal 10-01.

Reimburse the Federal share of unallowable personnel costs related to non-Unit duties and ensure that the Unit only claims Federal reimbursement for Unit-related duties

The Unit should continue to work with OIG to reimburse the Federal share of the unallowable costs related to non-Unit duties. The Unit should ensure that it only claims Federal reimbursement for appropriate Unit-related duties.

Implement processes to ensure that all case files include documentation of periodic supervisory reviews

The Unit should implement processes to ensure that periodic supervisory reviews are documented consistent with the Unit's policy. Such processes could include automated reminders to alert Unit staff when cases are due for periodic reviews and to ensure that documentation is maintained.

Implement processes to ensure that convictions and adverse actions are reported to Federal partners within required timeframes

The Unit should implement processes to ensure that convictions are reported to OIG within 30 days and that adverse actions are reported to NPDB within 30 days. Such processes could include automated reminders to alert Unit staff when to report convictions and adverse actions to Federal partners.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The South Dakota Unit concurred with all four of our recommendations.

Regarding the first recommendation, the Unit stated that it has deducted the \$750 from current Federal expenditures. Additionally, the Unit stated it will use memo and checklist reminders to ensure that program income is properly handled in the future.

Regarding the second recommendation, the Unit stated that it has deducted from current Federal expenditures the \$1,157.94 Federal share of unallowable personnel costs related to non-Unit duties. Additionally, the Unit stated that it has provided written instructions to Unit staff and to the South Dakota Attorney General's fiscal staff regarding accounting for non-Unit duties.

Regarding the third recommendation, the Unit stated that it has transitioned to the use of new forms to document quarterly supervisory reviews. The Unit also stated that it also has placed reminders in their calendar system to help ensure the quarterly reviews take place.

Regarding the fourth recommendation, the Unit stated that it has set automated reminders to alert Unit staff to report convictions and adverse actions to Federal partners.

The Unit's comments are provided in Appendix D.

APPENDIX A

2012 Performance Standards³⁶

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.

³⁶ 77 Fed. Reg. 32646, 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 pre-filing 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 <i>CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit</i> .
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

Unit Referrals by Referral Source for FYs 2013 Through 2015

Referral Source	FY 2013		FY 2014		FY 2015		Total
	Fraud	Abuse & Neglect ¹	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	
State Medicaid agency – Program Integrity Unit	6	1	1	0	1	0	9
State Medicaid agency – other	0	0	0	0	1	0	1
Managed care organizations	0	0	0	0	0	0	0
State survey and certification agency	0	6	1	6	0	0	13
Other State agencies	0	2	0	0	0	0	2
Licensing board	0	1	0	0	0	1	2
Law enforcement	1	2	1	1	0	0	5
Office of Inspector General	1	1	2	0	4	0	8
Prosecutors	0	0	0	0	0	0	0
Providers	0	0	0	0	0	0	0
Provider associations	0	0	0	0	0	0	0
Private health insurer	3	0	0	0	0	0	3
Ombudsman	0	0	0	0	0	0	0
Adult protective services	0	3	1	4	0	1	9
Private citizens	6	1	7	0	3	0	17
MFCU hotline ²	0	0	0	0	N/A	N/A	0
Anonymous ³	N/A	N/A	N/A	N/A	0	0	0
Other	31	0	25	0	0	0	56
Total	48	17	38	11	9	2	125
Annual Total	65		49		11		

Source: OIG analysis of Unit Quarterly and Annual Statistical Reports, FYs 2013–2015, 2016.

¹ The category of abuse & neglect referrals includes patient funds referrals.

² The referral source “MFCU hotline” was not a category reported on the FY 2015 Annual Statistical Report.

³ The referral source “Anonymous” was not a category reported on the FY 2013 and FY 2014 Quarterly Statistical Reports.

APPENDIX C

Detailed Methodology

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

Data Collection

Review of Unit Documentation. We collected information for FYs 2013 through 2015 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 information from several sources, including the Unit’s quarterly statistical reports; its annual reports; its recertification questionnaire; its policies and procedures manual; 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. 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.

We reviewed three purposive samples to assess the Unit’s internal control of fiscal resources. All three samples were limited to the review period of FYs 2013 through FY 2015. The three samples included the following:

1. To assess the Unit’s expenditures, we selected a purposive sample of 24 items from the Unit’s 236 expenditure transactions. We selected routine and nonroutine transactions representing a variety of budget categories and payment amounts.
2. To assess the Unit’s travel expenditures, we selected a purposive sample of 25 items from the Unit’s 155 travel transactions. We selected a variety of travel expenditure categories related to both in-State and out-of-State travel, such as hotel stays, airfare, and conference expenses.
3. To assess employees’ “time and effort”—i.e., their work hours spent on various MFCU tasks—we selected a sample of three pay periods, one from each fiscal year. We then requested and reviewed documentation (e.g., time card records) to support the time and effort of the MFCU staff during the selected pay periods.

We also reviewed a purposive sample of the Unit's supply inventory. Specifically, we selected and verified a purposive sample of 26 items from the current inventory list of 29 items maintained in the Unit's office.

Interviews with Key Stakeholders. In March 2016, 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 (e.g., the Medicaid Program Integrity Unit, Department of Human Services, and Department of Health). We also interviewed supervisors from OIG's Region VII Office of Investigations 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 opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Onsite Interviews with Unit Staff. We conducted structured interviews with the Unit's staff in April 2016. We interviewed the Unit director, Senior Investigator, investigator, auditor, and administrative analyst. 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. We requested that the Unit provide us with a list of cases that were open at any point during FYs 2013 through 2015. The Unit provided a list of 171 cases that were open during this period. For each of these 171 cases, the Unit provided data including the current status of the case; whether the case was criminal or civil; and the date on which the case was opened. From this list of cases, we excluded 105 cases that were categorized as "global"³⁷ and 1 case that had been opened subsequent to the period of our review and thus should not have been included. The remaining number of cases was 65.

We selected all 65 cases for review. From the population of 65 cases, we purposively assigned 33 for a more indepth review of selected issues, such as the timeliness of investigations and case development. Of the 65 cases reviewed, 37 were open longer than 90 days and 59 were closed as of the start of the onsite review.

³⁷ 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 those cases from our review of a Unit's case files. Therefore, we excluded 105 cases that were categorized as "global" from the list of cases.

Based on the results of our review of the 65 case files, we reported: (1) the percentage of all case files that were open longer than 90 days that lacked documentation of periodic supervisory review, (2) the percentage of all case files that included documentation of supervisory approval for opening the case, and (3) the percentage of all closed case files that included documentation of supervisory approval for closing.

Onsite Review of Unit Operations. During our April 2016 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 any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.³⁸

³⁸ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu>.

APPENDIX D

Unit Comments

Medicaid Fraud Control Unit

G.S. Mickelson Criminal Justice Ctr
1302 East Highway 14 Suite 4
Pierre, South Dakota 57501-8504

STATE OF SOUTH DAKOTA



Phone (605) 773-4102
FAX (605) 773-6279
ATGMedicaidFraudHelp@state.sd.us

OFFICE OF ATTORNEY GENERAL

August 31, 2016

Via Email

Ms. Suzanne Murrin
Deputy Inspector General for Evaluations and Inspections
Office of Inspector General
Department of Health and Human Services
330 Independence Ave., SW Room 5660
Washington, DC 20201

Re: SD MFCU 2016 Onsite Review

Dear Ms. Murrin:

Thank you for your letter dated August 3, 2016, which includes the draft report entitled *South Dakota State Medicaid Fraud Control Unit: 2016 Onsite Review*, OEI-07-16-00170. We appreciate the opportunity to respond to the findings of the Onsite Review. We are grateful for the assistance provided to us by our partners at OIG over the years, and specifically, we are grateful for the work of the audit team who conducted the review. The OIG review team was very professional and provided excellent guidance to us. We appreciate their time and expertise, and we look forward to continuing our partnership with OIG.

Please find our responses to the OIG recommendations below:

Recommendation 1:

Deduct the Federal share for the unallowable withdrawal from current expenditures and ensure that all future program income is reported properly on Federal financial reports

The Unit should continue to work with OIG to deduct \$750 from current Federal expenditures to account for the unallowable withdrawal in FY 2013. In addition, in the future the Unit should report its program income according to the guidelines in OIG State Fraud Policy Transmittal 10-01.

Response:

We concur. We have already deducted the \$750 from current federal expenditures to account for the unallowable withdrawal in FY 2013. SD MFCU identified this issue to OIG prior to the on-site visit. Going forward, SD MFCU will use memo and checklist reminders to ensure that program income is properly handled. Like other MFCU's, SD MFCU receives program income very infrequently.

Recommendation 2:

Reimburse the Federal share of unallowable personnel costs related to non-Unit duties and ensure that the Unit only claims Federal reimbursement for Unit-related duties

The Unit should continue to work with OIG to reimburse the Federal share of the unallowable costs related to non-Unit duties. The Unit should ensure that it only claims Federal reimbursement for appropriate Unit related duties.

Response:

We concur. We have already deducted the federal share (\$1,157.94) of unallowable personnel costs related to non-Unit duties from current Federal expenditures. The SD Office of Attorney General respects federal grant restrictions and rules and we will continue to comply with federal grant restrictions and rules. Our colleagues in the Office of Attorney General and the Division of Criminal Investigation understand that SD MFCU staff perform MFCU duties. Our colleagues have been gracious in providing staff and resources to SD MFCU for several operations and cases and they understand that grant restrictions prevent SD MFCU from providing reciprocal assistance. SD MFCU staff has engaged in non-Unit duties on exceedingly rare occasions. We will continue to ensure that SD MFCU staff strictly limit or entirely avoid involvement in non-Unit duties.

We have taken steps to ensure that SD MFCU staff and Attorney General fiscal staff properly track and handle non-Unit duty matters in the rare event that SD MFCU staff engage in non-Unit duties. Specifically, we provided written instructions via email to SD MFCU staff and to Attorney General fiscal staff regarding accounting for non-Unit duties.

Recommendation 3:

Implement processes to ensure that all case files include documentation of periodic supervisory review

The Unit should implement processes to ensure that periodic supervisory reviews are documented consistent with the Unit's policy. Such processes could include automated reminders to alert Unit staff when cases are due for periodic reviews and to ensure that documentation is maintained.

Response:

We concur. As we have previously discussed, prior to November 2013, SD MFCU used quarterly case updates in an effort to comply with MFCU Performance Standards. SD MFCU transitioned to quarterly Supervisory Reviews in November 2013. We believe the quarterly Supervisory Review forms and processes implemented in November 2013 resolve this issue. The quarterly Supervisory Review forms and processes are superior to the quarterly case update forms and processes. We believe that the quarterly Supervisory Reviews forms and processes have improved our documentation of periodic supervisory review. We appreciate the positive feedback from the review team regarding the Supervisory Review form and process. We have placed reminders on our calendar system as an additional step to ensure that the quarterly Supervisory Reviews take place in a timely fashion.

Recommendation 4:

Implement processes to ensure that convictions and adverse actions are reported to Federal partners within required timeframes

The Unit should implement processes to ensure that convictions are reported to OIG within 30 days and that adverse actions are reported to NPDB within 30 days. Such processes could include automated reminders to alert Unit staff when to report convictions and adverse actions to Federal partners.

Response:

We concur. As we previously discussed, SD MFCU has consistently demonstrated our commitment over the years to protect health care programs and the public from excluded individuals and entities. For example, SD MFCU has conducted outreach regarding exclusion matters by speaking to various provider groups about topics including exclusion matters. Moreover, SD MFCU provided training and brochures to prosecutors and law enforcement throughout South Dakota. We appreciate the assistance and positive feedback from OIG over the years as we worked to increase awareness regarding exclusion matters. SD MFCU failed to ensure that some convictions were properly reported, but the OIG review confirmed that SD MFCU properly reported its most recent convictions. Thus, we believe that the issues we had previously were resolved prior to the OIG review. SD MFCU has taken affirmative steps to ensure that exclusion matters are handled properly, including the placement of automated reminders to alert SD MFCU staff to report convictions and adverse actions to Federal partners.

We appreciate the positive observations and comments made by OIG regarding our Unit. Please contact me if you need any further information or have any questions. Thank you.

Sincerely,



Paul Cremer
AAG/MFCU Director

PC/lw

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, and Jennifer King, Deputy Regional Inspector General; and in consultation with Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Rae Hutchison, of the Kansas City regional office, served as the project leader for the study. Other Office of Evaluation and Inspections staff who conducted the review include Abbi Warmker. Other Medicaid Fraud Policy and Oversight Division staff who participated in the review include Susan Burbach. Office of Investigations staff also participated in the review. Other central office staff who contributed to this review include Kevin Farber, Lonie Kim, and Joanne Legomsky.

Office of Inspector General

<http://oig.hhs.gov>

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