Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SOUTH CAROLINA STATE MEDICAID FRAUD CONTROL UNIT: 2011 ONSITE REVIEW

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WHY WE DID THIS STUDY

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

HOW WE DID THIS STUDY

We based our review on an analysis of data from seven sources: (1) a review of documentation, policies, and procedures related to the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) an onsite review of case files; and (7) an onsite review of Unit operations.

WHAT WE FOUND

Our analysis of collected data from fiscal year (FY) 2008 through FY 2010 shows that the Unit's caseload increased by 65 percent and that the amount of funds the Unit recovered nearly doubled, from $15.3 million in FY 2008 to $30.3 million in FY 2010. Although almost all Unit case files documented supervisory approval to open and close cases, the Unit's case files lacked consistent documentation of periodic supervisory reviews. In addition, the Unit had not updated its policies and procedures manual to reflect the Unit's current operations or its memorandum of understanding with South Carolina's State Medicaid agency to reflect current law and practice. Finally, although the Unit maintained proper fiscal control of its resources, it did not report program income properly in FY 2010. We found no further evidence of noncompliance with applicable laws, regulations, and policy transmittals.

WHAT WE RECOMMEND

We recommend that the South Carolina Unit: (1) ensure that periodic supervisory reviews are documented in Unit case files; (2) complete revisions to its policies and procedures manual to reflect current Unit operations and revise its memorandum of understanding with South Carolina's single State Medicaid agency to reflect current law and practice; and (3) ensure that program income is reported properly. The South Carolina Unit concurred with all three of our recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.[1] Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State; and (2) the State has other adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.[2] Currently, 49 States and the District of Columbia (States) have created such Units.[3] In fiscal year (FY) 2011, combined Federal and State grant expenditures for the Units totaled $208.6 million, of which Federal funds represented $156.7 million.[4] The 50 MFCUs employed 1,833 individuals.

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

Units are required to have either Statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an office with such authority.[8] In South Carolina and 43 other States, the Units are

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

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

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

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

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

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

[7] Pursuant to 42 CFR § 1007.17, Units report the total amount of recovered funds in their annual reports to OIG.

[8] SSA § 1903(q)(1).

located within offices of State Attorneys General that have this authority. In the remaining 6 States, the Units are located in other State agencies;[9] generally, such Units must refer cases to other offices with prosecutorial authority. Additionally, each Unit must be a single identifiable entity of State government, distinct from the State Medicaid agency, and each Unit must develop a formal agreement—e.g., a memorandum of understanding (MOU)—that describes the Unit's relationship with that agency.[10]

Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority to both annually certify the Units and administer grant awards to reimburse States for a percentage of their costs in operating certified Units.[11] All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.[12] To receive Federal reimbursement, each Unit must submit an initial application to OIG.[13] OIG reviews the application and notifies the Unit if the application is approved and the Unit is certified. Approval and certification is for a 1-year period; the Unit must be recertified each year thereafter.[14]

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.[15] OIG developed and issued 12 performance standards to define further the criteria that OIG applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements.[16] Examples include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all three of the professional disciplines (i.e., for auditors, investigators, and attorneys), and establishing policy and procedures manuals to reflect the Unit's operations. See Appendix A for a complete list of the performance standards.

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[9] Among those States with a Unit, the Unit shares responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States also employ a Medicaid Inspector General who conducts and coordinates fraud, waste, and abuse activities for the State agency.

[10] SSA § 1903(q)(2); 42 CFR § 1007.9(d).

[11] The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called Federal Financial Participation (FFP).

[12] SSA § 1903(a)(6)(B).

[13] 42 CFR § 1007.15(a).

[14] 42 CFR § 1007.15(b) and (c).

[15] SSA § 1902(a)(61).

[16] 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at http://oig.hhs.gov on November 22, 2011. Since the time of our review, OIG published a revision of the performance standards, 77 Fed. Reg. 32645 (June 1, 2012).

South Carolina Unit

The Unit is an autonomous entity within the Criminal Prosecution Division of the South Carolina Office of the Attorney General and has the authority to prosecute Medicaid fraud and patient abuse and neglect cases. At the time of our review, the Unit had 16 employees, all of whom were located in the State capital of Columbia.[17] Unit investigators are generally assigned to cover one of two areas: provider fraud or patient abuse and neglect. However, because of the Unit's relatively small size, investigators and attorneys often work on both types of cases.

The Unit receives referrals of provider fraud from the single State Medicaid agency, the South Carolina Department of Health and Human Services (SCDHHS). Fraud referrals also come to the Unit from Federal sources, such as OIG. Patient abuse and neglect referrals come from the State Long Term Care Ombudsman. Referrals in both categories also come from various law enforcement agencies and other State and local sources. From FY 2008 through FY 2010, the Unit received an average of 100 referrals annually (see Appendix B). The Unit's Provider Fraud Intake Committee—composed of the Chief Attorney, a Chief Investigator, and an analyst—decides whether to accept a referral as a case or to refer it to another agency.

The Unit will not open a case unless it plans to investigate and prosecute it. Unit management assigns an attorney, investigator, supervisor, and analyst to each case the Unit decides to open. From FY 2008 through FY 2010, the Unit opened an average of 101 cases annually—an average of 62 cases of provider fraud and 39 cases of patient abuse and neglect.[18] For additional information on Unit investigations opened and closed, including a breakdown by case type and provider category, see Appendix C.

The Unit may pursue a case through a variety of actions, including criminal prosecution, civil action, or a combination of the two. From FY 2008 through FY 2010, the Unit closed an average of 113 cases annually—an average of 55 provider fraud and 58 patient abuse and neglect cases.[19] From FY 2008 through FY 2010, the Unit obtained an

[17] We conducted our onsite review of the South Carolina Unit in December 2011.

[18] The Unit will occasionally open cases that were not formally referred by another agency. For example, a case may be brought to the Unit's attention by the media.

[19] Averages are rounded to the nearest whole number. The number of closed cases includes multiple cases opened before FY 2008.

annual average of 32 convictions (89 total) and closed an annual average of 16 cases (49 total) through civil action.[20]

From FY 2008 through FY 2010, the Unit directly participated in 18 "global"—i.e., multi-State—cases through the National Association of Medicaid Fraud Control Units.[21] The Unit Director, Chief Auditor, and Administrative Assistant to the Director all participated in global cases, and the Unit Director and Chief Auditor trained State and Federal prosecutors in the global process.[22] The Unit Director is a member of the National Association of Medicaid Fraud Control Unit's Global Case Committee, which coordinates training in the global case process for State attorneys and data analysts.

Previous Review

In 2005, OIG conducted an onsite review of the South Carolina Unit. In the resulting memorandum, OIG noted no instances of noncompliance with applicable Federal laws, regulations, or policy transmittals. The memorandum contained no recommendations for Unit improvement. In addition, the Unit received the 2010 State Fraud Award from OIG "in recognition of efficient and effective management practices in combating fraud and abuse in the Medicaid program."

METHODOLOGY

We based our review on an analysis of data from seven sources: (1) a review of documentation, policies, and procedures related to the Unit's operations, staffing, and caseload for FYs 2008 through 2010; (2) a review of financial documentation for FYs 2008 through 2010; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) an onsite review of case files that were open in FYs 2008 through 2010; and (7) an onsite review of Unit operations.

We analyzed data from all seven sources to describe the caseload and assess the performance of the Unit. We also analyzed the data to identify

[20] The Unit provided these figures on January 27, 2012. Figures are based on cases closed as a result of criminal prosecution and/or civil action. These figures do not include cases closed because the Unit determined the cases were no longer viable.

[21] "Global" cases are civil false-claims cases involving the U.S. Department of Justice and other State MFCUs. The National Association of Medicaid Fraud Control Units is a voluntary association of all 50 Units. Among other services, the Association provides training opportunities and facilitates the settlement of global cases. More information on the Association and its involvement in global cases is available online at http://www.namfcu.net.

[22] During the review period, the Unit Director participated as a trainer/speaker in five training sessions, and the Chief Auditor participated as a trainer once.

any opportunities for improvement and any instances in which the Unit did not meet the performance standards or was not operating in accordance with laws, regulations, and policy transmittals.[23] In addition, we noted any practices that appeared to be beneficial to the Unit. We based these observations on statements from Unit staff, data analysis, and our own judgment. We did not independently verify the effectiveness of these practices, but included the information because it may be useful to other Units in their operations.

Data Collection and Analysis

Review of unit documentation. We requested and reviewed documentation, policies, and procedures related to the Unit's operations, staffing, and cases, including its annual reports, quarterly statistical reports, and responses to recertification questionnaires. We also requested and reviewed the Unit's data describing how it investigates and prosecutes Medicaid cases. Data collected included information such as the number of referrals received by the Unit and the number of investigations opened and closed.

Review of financial documentation. We reviewed policies and procedures related to budgeting, accounting systems, cash management, procurement, property, and personnel to evaluate internal controls and to design our test of financial documentation. We obtained from the Unit its claimed grant expenditures for FY 2008 through FY 2010 to: (1) review final Federal Status Reports[24] and supporting documentation; (2) select and review transactions within direct cost categories to determine if costs were allowable; and (3) verify that indirect costs were accurately computed using the approved indirect cost rate. Finally, we reviewed records in the Department of Health & Human Services' (HHS) Payment Management System[25] and revenue accounts to identify any unreported program income.[26]

Interviews with key stakeholders. We conducted structured interviews with eight individual stakeholders among four agencies who were familiar

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

[24] The Unit transmits financial status reports to OIG's Office of Management and Policy on a quarterly and annual basis. These reports detail Unit income and expenditures.

[25] HHS uses its electronic Payment Management System to distribute funds to program grantees.

[26] Program income refers to any funds typically received by the Unit as part of a legal judgment or settlement, including restitution of Unit investigative and legal costs. However, State settlement proceeds provided to the MFCU after refunding the Federal share of the entire recovery to the Centers for Medicare & Medicaid Services do not constitute program income under Federal grant regulations. *OIG State Fraud Policy Transmittal 10-01, Program Income* (March 22, 2010).

with Unit operations. Specifically, we interviewed SCDHHS's Director of Program Integrity; two Assistant U.S. Attorneys based in Columbia; South Carolina's Chief Deputy Attorney General; three OIG Special Agents based in Columbia; and an Assistant Special Agent in Charge for OIG's Region IV, which includes the State of South Carolina.[27] These interviews focused on the Unit's interaction with external agencies, Unit operations, opportunities for improvement, and any practices that appeared to be beneficial to the Unit and that may be useful to other Units in their operations.

Survey of Unit staff. We conducted an electronic survey of all nonmanagerial Unit staff. We requested and received responses from each of the 11 nonmanagerial staff members, a 100-percent response rate.[28] Our questions focused on operations of the Unit, opportunities for improvement, and practices that appeared to be beneficial to the Unit and that may be useful to other Units in their operations. The survey also sought information about the Unit's compliance with applicable laws, regulations, and policy transmittals.

Interviews with Unit management. We conducted structured interviews with the Unit's director, deputy director (chief attorney), two chief investigators, and chief auditor/analyst. We asked these managers to provide us with additional information necessary to better understand the Unit's operations, identify opportunities for improvement, identify practices that appeared to be beneficial to the Unit and that may be useful to other Units in their operations, and clarify information obtained from other data sources.

Onsite review of case files. We selected a simple random sample of 100 case files from the 456 cases[29] that were open at any point from FY 2008 through FY 2010. The design of this sample allowed us to estimate the percentage of all 456 cases with various characteristics (+/-10 percent) at the 95-percent confidence level. We reviewed the 100 sampled case files and the Unit's processes for monitoring the status and outcomes of cases.[30] Of these 100 case files, we selected a further

[27] The Chief Deputy Attorney General supervises the Unit Director.

[28] This report uses the terms "management" and "supervisors" interchangeably. "Nonmanagement" employees are Unit staff members who have no supervisory authority.

[29] This figure includes cases opened before FY 2008 that remained open at some point during FYs 2008–2010.

[30] The Unit provided us with an orientation of the case files and case tracking system to confirm and supplement our understanding of how the Unit maintains and tracks case progress and documentation. The Unit also gave us access to staff to answer any questions and locate any available documentation missing from the case files.

random sample of 50 files for a more in-depth review of selected issues, such as the timeliness of investigations and prosecutions.[31] For population and sample size counts, as well as confidence interval estimates, see Appendix D.

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

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.[32]

[31] We initially selected 50 case files for more in-depth review; however, because time allowed, we viewed an additional 3 case files.

[32] Full text of these standards is available online at http://www.ignet.gov/pande/standards/oeistds11.pdf.

FINDINGS

From FY 2008 through FY 2010, the Unit's caseload increased by 65 percent and the amount of funds the Unit recovered nearly doubled

The Unit's caseload (measured by the number of opened cases) increased each year of the review period and the Unit's reported recovered funds nearly doubled, from approximately $15.3 million in FY 2008 to approximately $30.3 million in FY 2010.

The Unit's caseload increased by 65 percent

The Unit's caseload increased each year from FY 2008 through FY 2010. The Unit opened 71 cases in FY 2008, 116 in FY 2009, and 117 in FY 2010—a 65-percent increase over the review period. Unit management and staff attributed the increased number of opened cases partly to the establishment of the Unit's Provider Fraud Intake Committee in 2009. This committee meets biweekly to review recent referrals and determine which to open as cases and which to refer to another agency. According to Unit management and staff, the committee greatly streamlined the process of accepting and directing appropriate cases, serving as a "terrific screening process … a kind of triage." One staff member stated that the committee helped the Unit "become more efficient in handling our cases."

Unit management and staff also attributed the increased number of opened cases partly to an increase in referrals. According to Performance Standard 4, the Unit should take steps to ensure that it maintains an adequate workload through referrals from the single State Medicaid agency—SCDHHS—and other sources. The Unit received 71 referrals in FY 2008, 114 in FY 2009, and 114 in FY 2010—a 61-percent increase over the review period. According to management, staff, and individual stakeholders, the increase in Unit referrals is partly due to the Unit's productive relationships with other agencies. For example, the Unit established MOUs with the South Carolina Law Enforcement Division and the State Long Term Care Ombudsman, and the Unit has made numerous outreach efforts to local law enforcement. From FY 2008 through FY 2010, the Unit received 100 combined referrals from law enforcement and the State Long Term Care Ombudsman. Both the Unit Director and the SCDHHS Program Integrity director indicated that the relationship between the Unit and SCDHHS was excellent. From FY 2008 through FY 2010, the Unit received 39 referrals from SCDHHS. According to individual stakeholders, the Unit also established a productive working relationship with OIG, which resulted in the Unit

receiving 17 referrals from OIG in FY 2010, compared to 3 in the previous 2 years combined.

The Unit's recovered funds nearly doubled

The total reported amount of funds the Unit recovered nearly doubled from FY 2008 to FY 2010 (see Table 1). The Unit's total operating costs for FY 2010 were approximately $1.35 million.[33] That year, the Unit received over $30 million in reported recovered funds—a return on investment of roughly 22.5 to 1.[34]

Table 1: South Carolina MFCU recovered funds, FY 2008 through FY 2010

	FY 2008	FY 2009	FY 2010	3-Year Total
Reported Criminal Recoveries	$2,496,686	$375,011	$3,779,253	**$6,650,950**
Reported Civil Recoveries	$12,791,408	$16,652,635	$26,521,904	**$55,965,947**
Total Reported Recoveries	$15,288,094	$17,027,646	$30,301,157	**$62,616,897**

Source: OIG analysis of Unit Quarterly Statistical Reports, FY 2008 through FY 2010.

Although almost all case files contained documentation of supervisory approval to open and close cases, 61 percent contained no documentation of periodic supervisory reviews

According to Performance Standard 6, a Unit should have a continuous case flow and cases should be completed in a reasonable time. To help ensure this, according to Performance Standard 6(b), Unit supervisors should approve the opening and closing of cases. The Unit documented supervisory approval to open cases 97 percent of the time. Among closed cases, the Unit documented supervisory approval to close them 98 percent of the time.

According to five of eight individual Unit stakeholders, the Unit's program knowledge benefitted the Unit's case flow. In addition, Unit staff and three of eight individual Unit stakeholders identified personnel retention as beneficial to the Unit's case flow. For example, the current Unit Director has served as Director since immediately after the Unit's establishment in 1995. Unit supervisors have an average of 15 years'

[33] The South Carolina Attorney General's Office Finance staff provided the total operating costs.

[34] Reported recoveries include funds recovered from global cases, both those worked directly by the Unit and those worked by staff from Federal agencies and other Units.

experience with the Unit and investigators have an average of 8 years of experience.

According to Performance Standard 6(c), supervisory reviews also should be "conducted periodically and noted in the case file" to ensure timely case completion.[35] Ninety-three percent of Unit case files contained documentation of at least one supervisory review. However, 61 percent of case files contained no documentation of additional, periodic supervisory review. Although 70 percent of closed case files contained no documentation of periodic supervisory review, 22 percent of open case files in our sample (4 of 18) contained no such documentation.[36] Fifty-seven percent of all cases without documentation of additional periodic supervisory review were open for more than a year.[37]

Unit supervisors explained that they conducted reviews frequently through informal conversations and that they did not record these conversations in the case files. Management further explained that the Unit had recently taken steps to ensure periodic supervisory review of documentation by using case status forms, which track supervisory approval and review (including informal conversations) as well as pertinent actions on a case. The Unit began using the case status forms in FY 2011.

The Unit had not updated its policies and procedures manual or its MOU with SCDHHS

Although the Unit was in the process of updating its policies and procedures, these updates had not yet been completed and had not been incorporated into the Unit's written manual. Moreover, the Unit's MOU with SCDHHS had not been updated to reflect recent legal changes that allow the Unit to refer any provider under investigation for a credible fraud allegation to SCDHHS for payment suspension.

The Unit had not updated its policies and procedures manual to reflect current Unit operations

According to Performance Standard 3, a Unit should establish policies and procedures for its operations, which should be included in a policies and procedures manual. The current edition of the Unit's policies and

[35] For the purposes of this report, supervisory approval to open and close a case does not constitute a case file "review." Periodic supervisory review indicates that a supervisor reviewed a case more than once between its opening and closing.

[36] We were unable to confidently project this percentage to all 392 closed case files due to the small sample size.

[37] Because there were only 61 cases without documentation of additional periodic supervisory review in our sample, the 95-percent confidence interval for this estimate is 44–69 percent.

procedures manual was created in 2005. Unit supervisors stated that they "constantly review policies and procedures for potential revisions," and that the manual is "overdue for a formal, written overhaul." According to Unit management, the manual needs to be further revised to address the Unit's new electronic case management system and electronic health records seizure policy. Unit management stated that the manual was currently being revised and would be completed in 2012.

The Unit had not updated its MOU with SCDHHS to reflect current law and practice

According to Performance Standard 10, Units should periodically review their MOU with the single State Medicaid agency—SCDHHS—to ensure that the MOU reflects current law and practice. As required by Federal regulation, the Unit had an MOU with SCDHHS.[38] However, the MOU was not revised to reflect recent legal changes that allow the Unit to refer any provider under investigation for a credible fraud allegation to SCDHHS for payment suspension.[39] Both Unit management and SCDHHS officials stated that they are aware of this omission and are currently working to update the MOU, with the applicable changes to "be incorporated in the next revision."

The Unit maintained proper fiscal control of its resources, but it did not report program income properly in FY 2010

According to Performance Standard 11, the Unit Director should exercise proper fiscal control over the Unit's resources. "Control" includes maintaining an equipment inventory, using generally accepted accounting principles, properly reporting program income, and conducting proper reporting between the Unit and its State parent agency.

From FY 2008 through FY 2010, the Unit claimed expenditures that represented allowable, allocable, and reasonable costs in accordance with applicable Federal regulations. In addition, the Unit maintained adequate internal controls relating to accounting, budgeting, staff, procurement, property, and equipment. However, the Unit improperly reported $8,275 of its portion of settlement proceeds as program income on its Federal Financial Status Reports for FY 2010.[40] According to OIG policy,

[38] 42 CFR § 1007.9(d).

[39] 42 CFR § 455.23; 42 CFR §1007.9(e). These MOU revisions also should specify the procedures for referring such providers and the subsequent actions to be taken by the single State Medicaid agency, such as SCDHHS.

[40] The Unit reports annual expenses and program income to account for how much money the Unit "draws down," or withdraws, from the HHS Payment Management System as Federal reimbursement for its annual operating costs.

State settlement proceeds provided to the MFCU after refunding the Federal share of the entire recovery to the Centers for Medicare & Medicaid Services do not constitute program income under Federal grant regulations.[41, 42] Because the Unit did not follow OIG policy, the Unit subsequently withdrew fewer funds from the HHS Payment Management System than it was entitled to receive.

[41] *OIG State Fraud Policy Transmittal 10-01, Program Income* (March 22, 2010).

[42] Pursuant to 45 CFR § 92.25(g), program income is deducted from total net outlays to defray a portion of Federal reimbursement to a grantee (in this case, the Unit). The Unit should not have reported settlement proceeds on its Federal Financial Status Reports because the Federal Medical Assistance Percentage share of the total recovery proceeds already had been reimbursed to CMS. The Federal Medical Assistance Percentage is the State-specific rate of Federal matching funds allocated annually to assist State programs such as Medicaid.

CONCLUSION AND RECOMMENDATIONS

From FY 2008 through FY 2010, the Unit opened 304 cases, obtained 89 convictions, and reported over $62 million in recoveries and restitution. During this period, the Unit's caseload increased by 65 percent and the total reported amount of funds the Unit recovered nearly doubled. A practice that appeared to be beneficial and that may have contributed to this increase was the establishment of the Unit's Provider Fraud Intake Committee. Unit supervisors consistently approved the opening and closing of cases, and 93 percent of cases documented at least one supervisory review.

Despite this progress, opportunities for improvement exist. Specifically, Unit case files did not consistently document periodic supervisory reviews. Additionally, the Unit did not complete ongoing revisions to the Unit's policies and procedures manual and the Unit's MOU with SCDHHS was not updated to reflect current law and practice. Finally, the Unit did not report program income properly in FY 2010.

We found no further evidence of noncompliance with applicable laws, regulations, and policy transmittals.

We recommend that the South Carolina Unit:

Ensure That Periodic Supervisory Reviews Are Documented in Unit Case Files

To ensure timely completion of its cases, the Unit should include documentation in its case files to demonstrate that supervisors conducted periodic reviews.

Complete Revisions to Its Policies and Procedures Manual To Reflect Current Unit Operations and Revise Its MOU With SCDHHS To Reflect Current Law and Practice

The Unit should incorporate its pending policies and procedures revisions into an updated edition of the policies and procedures manual. The Unit should also add sections that address aspects of its operations not covered previously, such as the Unit's new electronic case management system and electronic health records seizure policy.

The Unit should also revise its MOU with SCDHHS to specify that the Unit may refer any provider suspected of fraud for payment suspension to SCDHHS and to describe the procedure for this type of referral.

Ensure That Program Income Is Reported Properly

The Unit should report its program income according to guidelines in OIG State Fraud Policy Transmittal 10-01.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with the three report recommendations.

Regarding our first recommendation, the Unit implemented a "case status form" that documents supervisory approval at the appropriate case stages. The Unit also restructured its procedure for assigning investigative teams to ensure periodic supervisory review.

Regarding our second recommendation, the Unit Director created a Policies and Procedures Manual Committee to complete the final draft of a revised policies and procedures manual by the end of 2012; after vetting, the revised manual should be completed in early 2013. The Unit and SCDHHS are working to complete a revised MOU by the end of 2012.

Regarding our third recommendation, the Unit implemented a process to ensure that program income is reported appropriately according to Federal guidelines.

The full text of the Unit's comments is provided in Appendix E. We did not make any changes to the report based on the Unit's comments.

APPENDIX A

Performance Standards for Medicaid Fraud Control Units (Unit)[43]

1. **A Unit will be in conformance with all applicable statutes, regulations and policy transmittals.** In meeting this standard, the Unit must meet, but is not limited to, the following requirements:

   a. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.
   b. The Unit must be separate and distinct from the single State Medicaid agency.
   c. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.
   d. The Unit must submit annual reports, with appropriate certifications, on a timely basis.
   e. The Unit must submit quarterly reports on a timely basis.
   f. The Unit must comply with the Americans with Disabilities Act, the Equal Employment opportunity requirements, the Drug Free workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.

2. **A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit employ the number of staff that was included in the Unit's budget as approved by [the Office of Inspector General (OIG)]?
   b. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?
   c. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?
   d. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?

3. **A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit have policy and procedure manuals?

[43] 59 Federal Register 49080 (Sept. 26, 1994). These performance standards were in effect at the time of our review and precede the performance standards published in June 2012.

b. Is an adequate, computerized case management and tracking system in place?

4. **A Unit should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit work with the single State Medicaid agency to ensure adequate fraud referrals?
   b. Does the Unit work with other agencies to encourage fraud referrals?
   c. Does the Unit generate any of its own fraud cases?
   d. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?

5. **A Unit's case mix, when possible, should cover all significant provider types.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit seek to have a mix of cases among all types of providers in the State?
   b. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?
   c. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?
   d. Are there any special Unit initiatives targeting specific provider types that affect case mix?
   e. Does the Unit consider civil and administrative remedies when appropriate?

6. **A Unit should have a continuous case flow, and cases should be completed in a reasonable time.** In meeting this standard, the following performance indicators will be considered:

   a. Is each stage of an investigation and prosecution completed in an appropriate time frame?
   b. Are supervisors approving the opening and closing of investigations?
   c. Are supervisory reviews conducted periodically and noted in the case file?

7. **A Unit should have a process for monitoring the outcome of cases.** In meeting this standard, the following performance indicators will be considered:

   a. The number, age, and type of cases in inventory.

b. The number of referrals to other agencies for prosecution.

c. The number of arrests and indictments.

d. The number of convictions.

e. The amount of overpayments identified.

f. The amount of fines and restitution ordered.

g. The amount of civil recoveries.

h. The numbers of administrative sanctions imposed.

8. A Unit will cooperate with the OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud. In meeting this standard, the following performance indicators will be considered:

a. Does the Unit communicate effectively with the OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?
b. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?
c. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?
d. Does the Unit transmit to the OIG, for purposes of program exclusions under section 1128 of the [Social Security Act], reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

9. A Unit should make statutory or programmatic recommendations, when necessary, to the State government. In meeting this standard, the following performance indicators will be considered:

a. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?
b. Does the Unit provide program recommendations to single State agency when appropriate?
c. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?

10. **A Unit should periodically review its memorandum of understanding (MOU) with the single State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice.** In meeting this standard, the following performance indicators will be considered:

    a. Is the MOU more than 5 years old?
    b. Does the MOU meet Federal legal requirements?
    c. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?
    d. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?

11. **The Unit director should exercise proper fiscal control over the Unit resources.** In meeting this standard, the following performance indicators will be considered:

    a. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?
    b. Does the Unit maintain an equipment inventory?
    c. Does the Unit apply generally accepted accounting principles in its control of Unit funding?

12. **A Unit should maintain an annual training plan for all professional disciplines.** In meeting this standard, the following performance indicators will be considered:

    a. Does the Unit have a training plan in place and funds available to fully implement the plan?
    b. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?
    c. Are continuing education standards met for professional staff?
    d. Does the training undertaken by staff aid to the mission of the Unit?

APPENDIX B

Referrals of Provider Fraud and Patient Abuse and Neglect to the Medicaid Fraud Control Unit by Source, Fiscal Years 2008 Through 2010

Table B1: Medicaid Fraud Control Unit Referrals

	FY 2008		FY 2009		FY 2010		
Referral Source	**Fraud**	**Abuse and Neglect**	**Fraud**	**Abuse and Neglect**	**Fraud**	**Abuse and Neglect**	**Total**
South Carolina Department of Health and Human Services	14	0	12	1	12	0	**39**
Other State Agencies	9	13	9	0	16	0	**47**
Licensing Board	0	1	1	0	1	0	**3**
Law Enforcement	0	19	3	18	1	23	**64**
Office of Inspector General (OIG)	1	0	2	0	17	0	**20**
Outside Prosecutors	2	1	0	0	2	0	**5**
Providers	0	2	0	0	0	0	**2**
Provider Associations	0	0	10	0	0	0	**10**
Long Term Care Ombudsman	2	3	0	22	0	9	**36**
Private Citizens	2	0	1	0	6	0	**9**
Unit Hotline	0	0	9	0	11	0	**20**
Other	2	0	26	0	10	6	**44**
Total	32	39	73	41	76	38	**299**
Annual Total		**71**		**114**		**114**	
Annual Average						**100**	

Source: OIG analysis of South Carolina Medicaid Fraud Control Unit (Unit) Quarterly Statistical Reports, fiscal year (FY) 2008 through FY 2010.

APPENDIX C

Investigations Opened and Closed by Provider Category and Case Type, Fiscal Years 2008 through 2010

Table C1: Total Annual Opened and Closed Investigations

Case Type	FY 2008	FY 2009	FY 2010	3-Year Total	Annual Average
Opened	71	116	117	304	101*
Patient Abuse and Neglect	40	42	34	116	39
Provider Fraud	31	74	83	188	63
Closed	72	109	157	338	113
Patient Abuse and Neglect	48	52	73	173	58
Provider Fraud	24	57	84	165	55

Source: Office of Inspector General (OIG) analysis of South Carolina Medicaid Fraud Control Unit (Unit) Annual Reports, fiscal year (FY) 2008 through FY 2010.

*Due to rounding, the total average of opened cases does not match the combined averages of patient abuse and neglect and provider fraud opened cases.

Table C2: Total Investigations, by Case Type

Case Type	FY 2008		FY 2009		FY 2010		
	Opened	Closed	Opened	Closed	Opened	Closed	Total
Patient Abuse and Neglect	40	48	42	52	34	73	**289**
Provider Fraud	31	24	74	57	83	84	**353**
Total	**71**	**72**	**116**	**109**	**117**	**157**	**642**

Source: OIG analysis of Unit Annual Reports, FY 2008 through FY 2010.

Table C3: Patient Abuse and Neglect Investigations

Provider Category	FY 2008		FY 2009		FY 2010		
	Opened	Closed	Opened	Closed	Opened	Closed	Total
Nursing Facility	2	2	0	2	0	3	**9**
Nondirect Care	15	13	8	13	7	10	**66**
Other Long Term Care	1	1	1	0	0	1	**4**
Certified Nurse Aides	1	4	19	7	1	18	**50**
Other	21	28	14	30	26	41	**160**
Total	**40**	**48**	**42**	**52**	**34**	**73**	**289**

Source: OIG analysis of Unit Annual Reports, FY 2008 through FY 2010.

Table C4: Provider Fraud Investigations

Provider Category	FY 2008		FY 2009		FY 2010		
Facilities	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**	**Total**
Nursing Facilities	0	0	0	0	3	2	**5**
Other Long Term Care Facilities	1	0	0	1	0	0	**2**
Other	1	1	1	2	5	5	**15**
Practitioners	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**	**Total**
Doctors of Medicine or Osteopathy	3	0	5	4	11	11	**34**
Dentists	6	0	7	8	3	5	**29**
Podiatrists	0	0	0	1	0	0	**1**
Optometrists/ Opticians	0	0	0	0	2	2	**4**
Counselors/ Psychologists	1	1	2	1	1	3	**9**
Chiropractors	0	1	0	0	3	3	**7**
Other	0	1	2	2	1	1	**7**
Medical Support	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**	**Total**
Pharmacies	1	3	4	6	3	5	**22**
Pharmaceutical Manufacturers	2	0	26	3	9	5	**45**
Suppliers of Durable Medical Equipment and/or Supplies	1	0	3	6	7	3	**20**
Laboratories	0	4	2	2	0	3	**11**
Transportation Services	4	2	0	8	3	5	**22**
Home Health Care Agencies	7	3	4	5	6	6	**31**
Home Health Care Aides	3	6	5	4	1	3	**22**
Nurses, Physician Assistants, Nurse Practitioners, Certified Nurse Aides	0	0	2	1	2	1	**6**
Radiologists	0	0	0	0	2	0	**2**
Medical Support—Other	1	2	10	3	21	21	**58**
Program Related	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**	**Total**
Managed Care	0	0	1	0	0	0	**1**
Total	**31**	**24**	**74**	**57**	**83**	**84**	**353**

Source: OIG analysis of Unit Annual Reports, FY 2008 through FY 2010.

APPENDIX D

Case File Review Population, Sample Size Counts, and Confidence Interval Estimates

Table D-1 shows population and sample counts and percentages by case type. Note that both samples have percentages of case types similar to the general population, though sample counts for some case types are very small. Due to these small sample sizes, we cannot generalize what we found in our sample review to case types in the population, and only our overall point estimates project to the population of all case files. We estimated the 6 population values for all 456 case files from the results of our review of the case files selected in our simple random sample. Table D-2 includes the estimate descriptions, sample sizes, point estimates, and 95-percent confidence intervals for these six estimates.

Table D-1: Population and Sample Size Counts for Case Types

Case Type	Population Count and (%) n=456	Sample Count* and (%) n=100	Sample Count* and (%) n=50
Closed	392 (86%)	82 (82%)	43 (86%)
Open	64 (14%)	18 (18%)	7 (14%)
Civil	73 (16%)	17 (17%)	9 (18%)
Criminal	367 (80%)	79 (79%)	39 (78%)
Civil and Criminal	16 (4%)	4 (4%)	2 (4%)
Patient Abuse/Neglect	199 (44%)	39 (39%)	22 (44%)
Provider Fraud	257 (56%)	61 (61%)	28 (56%)

Source: The Medicaid Fraud Control Unit provided a list of all case files open during fiscal year (FY) 2008 through FY 2010.
*The Office of Inspector General generated this random sample.

Table D-2: Confidence Intervals for Key Case File Review Data

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Case files with documented supervisory approval for opening	100	97.0%	91.5%–99.4%
Case files with documented supervisory approval for closing	82	97.6%	91.5%–99.7%
Case files with documentation indicating at least one supervisory review	100	93.0%	86.1%–97.1%
Case files with no documentation indicating periodic supervisory review	100	61.0%	52.5%–69.5%
Closed case files with no documentation indicating periodic supervisory review	82	69.5%	60.7%–78.3%
Case files with no documentation indicating periodic supervisory review open for more than a year	61	57.4%	44.0%–69.0%

APPENDIX E

Unit Comments

ALAN WILSON
ATTORNEY GENERAL

September 14, 2012

Stuart Wright
Deputy Inspector General for Evaluation and Inspections
Department of Health and Human Services
Office of Inspector General
Room 5660, Cohen Building
330 Independence Avenue, S.W.
Washington, DC 20201

Re: South Carolina State Medicaid Fraud Control Unit (OEI-09-11-00610)

Dear Mr. Wright:

We are in receipt of your letter dated August 21, 2012, enclosing the *South Carolina State Medicaid Fraud Control Unit: 2011 Onsite Review,* OEI-09-11-00610. We appreciate the opportunity to respond to the Onsite Review and we particularly appreciate the courtesies and professionalism of the Audit Team during and after the audit. Your staff's recognition of the challenges facing MFCUs in best implementing the Performance Standards - in the context of our respective authorities, resources and the nuances in the operation of each state's Medicaid Program - renders the review process constructive and effective. We particularly appreciate the recognition in the Review of the achievements of the South Carolina MFCU. The increases in recoveries and our growing number of investigations represents hard work by SC MFCU staff and our colleagues at SC DHHS, the single state agency. What follows below are the comments requested by the OIG-HHS from the SC MFCU.

Ensure that periodic supervisory reviews are documented in unit case files
To ensure timely completion of its cases, the Unit should include documentation in its case files to demonstrate that supervisors conducted periodic reviews.

Response
We concur with OIG-HHS finding that periodic supervisory reviews were not documented in unit case files 61% of the time during the review period. An updated procedure is currently in place to ensure periodic supervisory reviews are documented in case files.

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Analysis

Unit supervisors explained that, during the review period, supervisory reviews were conducted via ad hoc, called Team meetings. These meetings were often not documented in the case files. The OIG Audit Team was advised that (1) the size of the unit and the close quarters allow for frequent opportunities for case discussions among team members and supervisors; (2) supervisory interactions may be discoverable; and, (3) the electronic mechanism and format of the "Case Status Form" was not finalized during the audit time period.

Given the size of the unit and the constant interaction among team members, the absence of documentary evidence of supervisory reviews has not affected the performance of the unit or the timely progress of investigations.

Plan

In FY 2011, the SC MFCU implemented a "Case Status form" that documents case opening, case progression, supervisory reviews, and case conclusion/closing. Recently, the unit director assigned staff to discrete investigative teams composed of an attorney, two investigators, an analyst, and support staff. This structure allows for the director, the senior attorney, the chief investigator, and the chief auditor to ensure that period supervisory reviews are documented in the case files. The case status form is created electronically at the opening of an investigation and includes a summary of the preliminary information. As the investigation progresses all team members document strategy, communications, progress, substantial events, tasks yet to perform, and plans for conclusion. Both the opening and closing of the case is noted in the form by the signature of the Director.

Complete revisions to its policies and procedures manual to reflect current unit operations and revise its MOU with SCDHHS to reflect current law and practice

The Unit should incorporate its pending policies and procedures revisions into an updated edition of the policies and procedures manual. The Unit should also add sections that address aspects of its operations not covered previously, such as the Unit's new electronic case management system and electronic health records seizure policy.

The Unit should also revise its MOU with SCDHHS to specify that the Unit may refer any provider suspected of fraud for payment suspension to SCDHHS and to describe the procedure for this type of referral.

Response

We agree that pending policies and procedures should be incorporated in the SC MFCU Policies and Procedures manual and that revision should include operations not covered in the previous version.

Analysis

During the review period there was an existing policy and procedures manual available to staff. Updates to this manual were currently ongoing in electronic form as the unit was designing and incorporating new operational procedures. While mostly ready and complete, an updated version reflecting the current operations had not been moved from draft form to final print at the time of the on-site review.

Plan

The current edition of the SC MFCU Policies and Procedures manual is currently being revised to address the unit's new electronic case management system and the electronic health records seizure policy. The director appointed a Policies and Procedures Manual committee consisting of chief auditor, senior attorney, investigator, and administrative assistant to complete the final draft of the updated edition by year end 2012. Thereafter, the Manual will be vetted to ensure that there is no conflict with the SC Attorney General Policies and Procedures Manual. This vetting process should be completed in early 2013.

Complete revisions to its policies and procedures manual to reflect current unit operations and revise its MOU with SCDHHS to reflect current law and practice

The Unit should incorporate its pending policies and procedures revisions into an updated edition of the policies and procedures manual. The Unit should also add sections that address aspects of its operations not covered previously, such as the Unit's new electronic case management system and electronic health records seizure policy.

The Unit should also revise its MOU with SCDHHS to specify that the Unit may refer any provider suspected of fraud for payment suspension to SCDHHS and to describe the procedure for this type of referral.

Response

We agree the existing Memorandum of Understanding, "MOU", between SC MFCU and SC DHHS should be updated to reflect current law and practice relative to the payment suspension provisions of the Performance Standards for State Medicaid Fraud Control Units, specifically 77FR 32645, Standard 10 B.

Analysis

The current MOU with SC DHHS was not amended to reflect the recent changes in law that allow the unit to refer any provider, under investigation of a credible fraud allegation, to SC DHHS for payment suspension. The Unit and SC DHHS have discussed a protocol and have developed a process to implement the payment suspension provisions; however, this protocol/process has not been formalized within the MOU.

Plan

The unit and SC DHHS officials are aware of this omission and will amend the MOU to reflect the current law and practices in the next revision. It is anticipated that this revision will be accomplished by the end of this calendar year.

Ensure that program income is reported properly

The Unit should report its program income according to guidelines in OIG State Fraud Policy Transmittal 10-01.

Response
We agree the unit should report its program income according to guidelines in OIG State Fraud Policy Transmittal 10-01.

Analysis
From FY 2008 to FY 2010 the unit drew down fewer funds from the HHS Payment Management System than it was entitled to receive. The unit improperly reported $8,275 of its portion of settlement proceeds as program income on its Federal Financial Status Reports for FY 2010, causing the deficiency in funding to the unit.

Plan
The unit will ensure that program income is reported appropriately and performed according to Federal Medical Assistance Percentage guidelines. This process has already been implemented.

CONCLUSION

The SC MFCU appreciates the efforts of HHS-OIG and found the audit process to be educational. We appreciate and concur with the recommendations. We commend OIG-HHS for going beyond the typical constraints of the audit process to include the many positives of the SC MFCU - increased caseload, increased recoveries, the productive, collegial relationship with external agencies, and modified processes which increase the efficiency of the Unit. The SC MFCU remains committed to the joint federal-state mission of fighting fraud in the Medicaid Program.

Sincerely yours,

/S/

C. William Gambrell, Jr.
Senior Assistant Attorney General
Director, Medicaid Fraud Control Unit

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ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy S. Brady, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Michael Henry, Deputy Regional Inspector General.

Matthew DeFraga served as the lead analyst for this study. Other Office of Evaluation and Inspections staff from the San Francisco regional office who conducted the study include Marcia Wong. Central office staff who provided support include Thomas Brannon, Kevin Farber, Debra Roush, Christine Moritz, and Maureen Pucciano. Office of Audit Services staff who provided support include Gupa Goha, Ryan Moul, and Clarissa Yu. Office of Investigations staff who provided support include Rene Olivas. Office of Management and Policy staff who provided support include Alexis Lynady.

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