Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

LOUISIANA STATE MEDICAID FRAUD CONTROL UNIT: 2012 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 reviewed data from seven sources: (1) a review of documents, 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

From fiscal year (FY) 2009 through FY 2011 (our period of review), the Unit reported recoveries of $95 million, obtained 192 convictions and 86 civil judgments or settlements, and received 1,043 referrals. Provider fraud referrals to the Unit increased and the Unit received patient abuse and neglect referrals from a variety of sources. All reviewed Unit case files contained documentation indicating supervisory approval to open cases, and 94 percent of closed case files contained documentation indicating supervisory approval to close cases. Twenty-two percent of the Unit case files lacked documentation indicating at least one supervisory review and 28 percent lacked documentation indicating additional, periodic supervisory review. The Unit did not refer 14 percent of sentenced providers to OIG for program exclusion within the appropriate timeframe. The Unit had not updated its memorandum of understanding (MOU) with the Louisiana Department of Health and Hospitals (DHH) to reflect current law and practice. The Unit maintained proper fiscal control of its resources; however, it did not report program income properly in FYs 2010 and 2011. Except for not reporting all of its program income, we found no evidence of Unit noncompliance with applicable laws, regulations, and policy transmittals.

WHAT WE RECOMMEND

We recommend that the Louisiana Unit: (1) revise its policies and procedures to ensure that periodic supervisory reviews are documented in Unit case files, (2) ensure that letters referring providers for exclusion are submitted to OIG within the appropriate timeframe, (3) revise its MOU with DHH to reflect current law and practice, and (4) ensure that all program income is reported properly on its Federal Financial Status Reports. The Unit concurred with all but the first of our four recommendations. However, the Unit is nevertheless implementing new procedures to ensure that case files include documentation of all future supervisory reviews.

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OBJECTIVE

To conduct an onsite review of the Louisiana 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 (HHS) determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State; and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.[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] That year, 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 Louisiana and 43 other States, the Units are located

[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] In this report, "fiscal year" refers to 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).

within offices of State Attorneys General that have this authority. In the remaining six 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 them.[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 are valid 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 (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] In 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) and 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.

[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 has published a revision of the performance standards, 77 Fed. Reg. 32645 (June 1, 2012).

Louisiana Unit

The Unit is an autonomous entity within the Louisiana Department of Justice's Criminal Division and has the authority to prosecute Medicaid fraud and patient abuse and neglect cases. At the time of our review (February 2012), the Unit had 53 employees—50 located in the State capital of Baton Rouge, and 1 investigator located in each of 3 satellite offices. Unit investigators generally are assigned to one of five teams; each team has a senior investigator as team leader. Noninvestigative personnel may be assigned to a team and/or work with multiple teams, according to need.

The Unit receives provider fraud referrals from the State Medicaid agency—Louisiana Department of Health and Hospitals (DHH)—and from Federal sources, such as OIG. The Unit receives patient abuse and neglect referrals from DHH and the State Long-Term Care Ombudsman. The Unit receives referrals of both types from various law enforcement agencies and other State and local sources, such as health care providers and the State survey and certification agency. From FY 2009 through FY 2011, the Unit received an average of 348 referrals (see Appendix B). The Unit reviews each referral and opens a case if management determines the referral appears to have the potential for criminal or civil prosecution and/or collection.

After Unit management assigns an investigator to an opened case, the investigator gathers background data and presents the case to the Unit Director and Chief Investigator, who collectively decide whether to proceed with the investigation or refer the case to another agency. From FY 2009 through FY 2011, the Unit opened an average of 348 cases annually—an average of 170 provider fraud and 178 patient abuse and neglect cases.[17] For additional information on the Unit's opened and closed investigations, including a breakdown by case type and provider category, see Appendix C.

The Unit may open a case and pursue it through a variety of actions, including criminal prosecution, civil action, or a combination of the two. The Unit may close a case for a variety of reasons, including, but not limited to, resolving it through criminal or civil action or referring it to another agency. From FY 2009 through FY 2011, the Unit closed an average of 357 cases annually—an average of 149 provider fraud and 208 patient abuse and neglect cases.[18] From FY 2009 through

[17] Averages are rounded to the nearest whole number. The Unit occasionally will 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.

[18] OIG analysis of Unit Quarterly Statistical Reports, FYs 2009 through 2011. The number of closed cases includes multiple cases that were opened before FY 2009.

FY 2011, the Unit obtained an annual average of 64 convictions and closed an annual average of 29 cases through civil action (Table 1).

Table 1: Louisiana Unit Convictions and Civil Judgments or Settlements, FY 2009 Through FY 2011

	FY 2009	FY 2010	FY 2011	Total	Annual Average
Convictions*	56	70	66	192	64
Civil Judgments or Settlements	31	25	30	86	29

Source: OIG analysis of Unit data and Quarterly Statistical Reports, FYs 2009 through 2011.
*Convictions are reported to OIG at the time of sentencing. The total number of convictions does not include 15 convictions because those defendants were not sentenced until after our period of review (i.e., after FY 2011).

One of the Unit's attorneys serves as an intake attorney on *qui tam* (whistleblower) cases for the National Association of Medicaid Fraud Control Units (NAMFCU).[19] The Unit Director and Chief Investigator have both participated as speakers and organizers of NAMFCU training sessions, and the Chief Investigator served on NAMFCU's Training Committee for several years. Unit investigators and attorneys directly participated in several "global"—i.e., multi-State—cases for NAMFCU during the review period.

Previous Review

In 2007, OIG conducted an onsite review of the Louisiana Unit and found that (1) Unit employees worked in a non-MFCU capacity without OIG approval and (2) MFCU grant funds were used to purchase vehicles that were improperly placed under the control of another division of the Louisiana Department of Justice and were used for non-MFCU activities. Unit management responded that Unit employees had only worked "de minimus" in a non-MFCU capacity and stated that it would remind Unit employees of the pertinent regulations. The vehicles in question were transferred to Unit control and the Federal Government was reimbursed for related unallowable expenses. Our 2012 onsite review of the Unit found no indication that either issue persisted.

[19] The intake attorney monitors *qui tam* cases and reports on their status to NAMFCU. NAMFCU is a voluntary association of all 50 Units. Among other services it provides training opportunities and facilitates the settlement of "global" civil false claims cases involving the U.S. Department of Justice and other State MFCUs. More information on NAMFCU and its involvement in global cases is available online at http://www.namfcu.net.

METHODOLOGY

We analyzed data from seven sources: (1) a review of documentation, policies, and procedures related to the Unit's operations, staffing, and caseload for FYs 2009 through 2011; (2) a review of financial documentation for FYs 2009 through 2011; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) an onsite review of case files that were open in FYs 2009 through 2011; and (7) an onsite review of Unit operations.

We analyzed data from all seven sources to describe the caseload and assess the performance of the Unit. We also analyzed the data to identify any opportunities for improvement and any instances in which the Unit did not meet the performance standards or was not operating in accordance with laws, regulations, and policy transmittals.[20] In addition, we noted any practices that appeared to benefit 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. To evaluate internal controls, we reviewed policies and procedures related to budgeting, accounting systems, cash management, procurement, property, and personnel. We obtained from the Unit its claimed grant expenditures for FYs 2009 through 2011 to: (1) review final Federal Status Reports[21] 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 HHS Payment Management

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

[21] 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.

System (PMS)[22] and revenue accounts to identify any unreported program income.[23]

Interviews With Key Stakeholders. We conducted structured interviews with eight individual stakeholders among five agencies who were familiar with Unit operations. Specifically, we interviewed DHH's Director of Program Integrity; the former State Long-Term Care Ombudsman; two Assistant U.S. Attorneys based in Baton Rouge; the Louisiana Department of Justice's Criminal Division Supervisor; two OIG Special Agents based in Louisiana; and an Assistant Special Agent in Charge for OIG's Region VI, which includes Louisiana.[24] These interviews focused on the Unit's interaction with external agencies, Unit operations, opportunities for improvement, and any practices that appeared to benefit 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 50 nonmanagerial staff members, for a 100-percent response rate.[25] Our questions focused on operations of the Unit, opportunities for improvement, and practices that appeared to benefit 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 (chief attorney), deputy director (chief investigator), and auditor. 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 benefit 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 1,472 cases[26] that were open at any point from FY 2009 through FY 2011. The design of this sample allowed us to

[22] The PMS is a grant payment system operated and maintained by the HHS Program Support Center, Division of Payment Management. The PMS provides disbursement, grant monitoring, reporting, and cash management services to awarding agencies and grant recipients, such as Units.

[23] Program income is defined as "gross income received by the grantee or subgrantee directly generated by a grant supported activity, or earned only as a result of the grant agreement during the grant period." 45 CFR § 92.25(b).

[24] The Criminal Division Supervisor supervises the Unit Director.

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

[26] This figure includes cases opened before FY 2009 that remained open at some point during FYs 2009–2011.

estimate the proportion of all 1,472 case files with certain characteristics +/- 10 percent at the 95-percent confidence level. We reviewed these 100 sampled case files and the Unit's processes for monitoring the status and outcomes of cases. From these 100 case files, we selected another simple random sample of 50 for a more in-depth review of potential issues. This second-phase sample of 50 cases allowed us to conduct a more comprehensive review to identify other potential issues from a qualitative perspective. 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.[27]

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

FINDINGS

From FY 2009 through FY 2011, the Unit reported recoveries of $95 million and obtained 192 convictions and 86 civil judgments or settlements

The Unit reported recoveries of $95 million from FY 2009 through FY 2011—an average of $31.7 million annually (see Table 2). Of the $95 million in recoveries, the Unit attributed $82 million to civil recoveries and $13 million to criminal recoveries. The Unit's annual average expenditures for FYs 2009 through 2011 were $4.6 million.[28]

Table 2: Louisiana MFCU Recovered Funds, FYs 2009 through 2011

	FY 2009	FY 2010	FY 2011	Total Recoveries	Annual Average
Reported Criminal Recoveries	$2,192,365	$4,959,531	$5,748,227	$12,900,123	$4,300,041
Reported Civil Recoveries	$8,948,818	$52,645,597	$20,576,309	$82,170,724	$27,390,241
Total Reported Recoveries	$11,141,183	$57,605,128	$26,324,536	$95,070,847	$31,690,282
Total Expenditures	$4,399,538	$4,616,945	$4,752,048	$13,768,531	$4,589,510

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

From FY 2009 through FY 2011, the Unit obtained 192 convictions and 86 civil judgments or settlements—an average of 64 convictions and 29 civil judgments or settlements annually. The Unit's total reported recoveries increased by 417 percent from FY 2009 through FY 2010 and by 136 percent over the review period as a whole.[29] The Unit's reported criminal recoveries increased by 162 percent over the review period.

From FY 2009 through FY 2011, provider fraud referrals to the Unit increased by 21.4 percent and the Unit received patient abuse and neglect referrals from a variety of sources

According to Performance Standard 4, a Unit should ensure that it "maintains an adequate workload through referrals" from the State Medicaid agency and other sources. Total provider fraud referrals to the Unit increased from 145 in FY 2009 to 176 in FY 2011—an increase of 21.4 percent over the review period. From FY 2009 through FY 2011, the Unit received 1,043 total referrals—an average of 348 annually. Of these, 504 (48 percent) were related to provider fraud—an average of

[28] The figures presented in this paragraph are rounded.

[29] A significant portion of the increase in FY 2010 was due to a large global settlement.

168 annually. Of the 1,043 total referrals, 539 (52 percent) were related to patient abuse and neglect—an average of 180 annually.

Six of eight interviewed individual stakeholders reported that the Unit's collaborative working relationships with outside agencies benefitted the Unit's overall production and increased the number of referrals it received during the review period. In addition, both the Unit Director and the DHH Program Integrity Director reported that the "great" working relationship between the Unit and DHH benefitted the Unit by ensuring a consistent number of referrals. According to Unit management and OIG staff who work with the Unit, the Unit's relationship with OIG also benefitted Unit performance, as demonstrated by the 42 provider fraud referrals the Unit received from OIG during the review period.

The Unit received patient abuse and neglect referrals from a variety of sources

According to Performance Standard 4(d), a Unit should ensure that it receives adequate patient abuse and neglect referrals from a variety of sources.[30] During the review period, 8 sources each referred 10 or more patient abuse and neglect complaints to the Unit. Of the 539 patient abuse and neglect referrals received by the Unit, 156 (29 percent) were referred by DHH, 141 (26 percent) by health care providers, and 135 (25 percent) by the State survey and certification agency—the Health Standards Section of DHH.

Provider Outreach Program. Unit management and a few staff indicated that the Unit's outreach program to providers and provider trainees benefitted the Unit's performance by generating a high number of provider referrals and promoting fraud and abuse/neglect deterrence. The outreach program consists of statewide visits by Unit presenters to inform providers and provider trainees of the State's mandatory abuse/neglect reporting rule, describe the various types of fraud and abuse/neglect, discuss Federal and State laws regarding fraud and abuse/neglect, and provide Unit contact information for the reporting of Medicaid-related crime. According to Unit staff, the outreach program is very successful and providers frequently ask the Unit to present its program annually. One Unit staff member noted that the outreach program "gets our names and faces out [across the State] and it has proven to be fruitful. I, personally, have had calls from [provider] employees who sat through [an outreach presentation] and wanted to report something to me later."

[30] For a breakdown of referral sources, see Appendix B, Table B-2.

All reviewed case files contained documentation indicating supervisory approval to open cases and 94 percent of closed case files contained documentation indicating supervisory approval to close cases

According to Performance Standard 6(b), Unit supervisors should approve the opening and closing of cases to help ensure a continuous case flow and the timely completion of cases. Supervisory approval to open and close cases demonstrates that Unit supervisors are monitoring the intake of cases and the timeliness of case resolutions, thereby promoting the efficiency and effectiveness of Unit staff. The Unit documented supervisory approval to open cases in all 100 reviewed case files[31] and to close cases in 94 percent of closed case files.

Twenty-two percent of the total Unit case files lacked documentation indicating at least one supervisory review and 28 percent lacked documentation indicating additional, periodic supervisory reviews

According to Performance Standard 6(c), supervisory reviews should be "conducted periodically and noted in the case file" to ensure timely case completion.[32] Twenty-two percent of Unit case files lacked documentation indicating at least one supervisory review and 28 percent of the total case files lacked documentation of additional, periodic supervisory reviews.[33] Of the 28 case files in our sample lacking documentation indicating periodic supervisory reviews, 11 (39 percent) indicated that the cases were open for more than a year.[34] Four of these 28 case files (14 percent) indicated that the cases were open for 3 or more years. Of these 28 cases, 25 were criminal (16 involved provider fraud and 9 involved patient abuse or neglect) and 3 were civil.

Unit management explained that they frequently review cases through informal conversations that are not always documented in the case files. In addition, the Unit Director and Chief Investigator conduct formal case status reviews of every open case with senior investigators on a quarterly

[31] Although we cannot conclude that all 1,472 case files contained documentation indicating supervisory approval to open cases, we are 95-percent confident that between 1,420 and 1,472 case files contain such documentation because the 95-percent confidence interval for this projection is 96.5–100%.

[32] 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.

[33] Ten additional case files lacked documentation indicating periodic supervisory review. However, these case files were open for 3 months or less and may not have warranted periodic supervisory review.

[34] We were unable to confidently project these percentages to all 1,472 case files due to the small sample size.

basis. Since our onsite review, Unit management has mandated that Unit investigators complete a "case file review checklist." According to management, the checklist is used as a guide throughout the investigation and prosecution stages of cases to ensure that all pertinent documentation is included in Unit case files. The Unit has documented these processes in its policies and procedures manual and provided us with a copy of both the checklist and the revised policies and procedures.

The Unit did not refer 14 percent of sentenced providers to OIG for program exclusion within the appropriate timeframe

According to Performance Standard 8(d), when a convicted provider is sentenced, the Unit should send a referral letter to OIG "within 30 days or other reasonable time period" for the purpose of program exclusion.[35] The Unit referred 165 of 192 (86 percent) sentenced providers to OIG within the appropriate timeframe, and 27 (14 percent) of the sentenced providers outside the appropriate timeframe. However, after our onsite review, the Unit referred these 27 sentenced providers to OIG for program exclusion. In addition, since our onsite review, the Unit has implemented new procedures to ensure that notification letters are sent to OIG for program exclusion within the appropriate timeframe.

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

According to Performance Standard 10, Units should periodically review their MOUs with the State Medicaid agency—DHH—to ensure that they reflect current law and practice. As required by Federal regulation, the Unit had an MOU with DHH.[36] However, the MOU was not revised to reflect recent legal changes that allow the Unit to refer any provider under investigation of a credible fraud allegation to DHH for payment suspension.[37] Although the Unit reported making referrals on the basis of credible fraud allegations, both Unit management and DHH officials stated that they are aware of the issue and will update the MOU to reflect the legal change.[38]

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[35] Pursuant to 42 U.S.C. § 1320a-7(a), OIG excludes from participation in Federal health care programs any person or entity convicted of a criminal offense related to the delivery of an item or service under the Medicaid program or to the neglect or abuse of patients in residential health care facilities. No payment may be made by Medicaid, Medicare, or other Federal health care programs for an item or service provided, ordered, or prescribed by an excluded individual or entity. 42 CFR § 1001.1901.

[36] 42 CFR § 1007.9(d).

[37] 42 CFR § 455.23 and 42 CFR § 1007.9(e).

[38] Although we reviewed the MOU, we did not independently verify whether the Unit actually referred providers on the basis of a credible fraud allegation.

The Unit maintained proper fiscal control of its resources, but did not report program income properly in FYs 2010 and 2011

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 2009 through FY 2011, the Unit claimed expenditures that represented allowable costs in accordance with applicable Federal regulations. In addition, the Unit maintained adequate internal controls relating to accounting, budgeting, personnel, procurement, property, and equipment. However, the Unit did not report as program income $10,773 it received for investigative and legal costs incurred while investigating patient abuse and neglect cases in FYs 2010 and 2011.[39] According to OIG policy, any funds received by the Unit—including reimbursements for expenses incurred during patient abuse and neglect investigations—that meet the definition of program income[40] must be reported on the Unit's Federal Financial Status Reports and deducted from total costs under the grant in accordance with Federal regulations.[41] Because the Unit did not follow OIG policy by reporting and deducting this program income, the Unit withdrew $8,080 more from the HHS Payment Management System than it was entitled to receive.[42]

Since our review, the Unit has agreed to reimburse the overdrawn funds and has implemented procedures to ensure that future investigative and legal costs that meet the definition of program income will be properly reported on Federal Financial Status Reports and deducted from total costs under the grant.

[39] The Unit reports annual expenses and program income on its Federal Financial Status Reports to account for how much money the Unit "draws down," or withdraws, as reimbursement from the PMS as Federal reimbursement for its annual operating costs.

[40] 45 CFR § 92.25(b); *OIG State Fraud Policy Transmittal 10-01, Program Income* (March 22, 2010).

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

[42] This amount represents the Federal share (75 percent) of the Unit's budget; in this case, $8,080 of the $10,773 total expenses. The State is responsible for the remaining 25 percent of the $10,773 total ($2,693). OIG policy requires Units to deduct program income from their total costs under the grant, pursuant to 45 CFR § 92.25(g)(1), thus making the 75-percent share unallowable.

CONCLUSION AND RECOMMENDATIONS

From FY 2009 through FY 2011, the Unit obtained 192 convictions and 86 civil judgments or settlements, received 1,043 referrals from DHH and a variety of other sources, and reported recoveries of $95 million. Provider fraud referrals received by the Unit increased by 21.4 percent during the review period, and the Unit received patient abuse and neglect referrals from a variety of sources. Unit management, stakeholders, and staff indicated that the Unit's collaborative working relationships with outside agencies and its statewide provider outreach program were beneficial to increasing the number of provider fraud referrals the Unit received. Unit case files consistently contained documentation indicating supervisory approval to open and close cases. Finally, the Unit maintained proper control of its fiscal resources.

Additional opportunities for improvement exist. Specifically, 22 percent of the total Unit cases files lacked documentation indicating at least one supervisory review and 28 percent of case files lacked documentation indicating additional, periodic supervisory reviews. Out of 192 sentenced providers in FYs 2009–2011, the Unit did not refer 27 (14 percent) to OIG for program exclusion within the appropriate timeframe. In addition, the Unit's MOU with DHH was not updated to reflect recent legal changes. Finally, the Unit did not report program income properly or deduct this from the total costs under its Federal grant in FYs 2010 and 2011. With the exception of not reporting and deducting all of its program income, we found no evidence of Unit noncompliance with applicable laws, regulations, and policy transmittals.

Since the onsite review, the Unit has reported that it has implemented practices to improve its operations and performance, including mandating that Unit investigators complete a "case file review checklist" and ensuring that notification letters are sent to OIG for program exclusion within the appropriate timeframe. The Unit has documented these processes in its policies and procedures manual and provided us with a copy of both the checklist and the revised policies and procedures.

On the basis of these findings, we recommend that the Louisiana Unit:

Revise Its Policies and Procedures To Ensure That Periodic Supervisory Reviews Are Documented in Unit Case Files

Ensure That Letters Referring Providers for Exclusion Are Submitted to OIG Within the Appropriate Timeframe

The Unit should ensure that letters referring providers for exclusion are sent within 30 days of defendant sentencing or another reasonable time period, as required by the performance standards.

Revise Its MOU With DHH To Reflect Current Law and Practice

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

Ensure That All Program Income Is Reported Properly on Its Federal Financial Status Reports

The Unit should report its program income according to guidelines set out in OIG State Fraud Policy Transmittal 10-01. In addition, the Unit should reimburse OIG $8,080 for the unallowable HHS Payment Management System withdrawals in FYs 2010 and 2011.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with all but the first of our four recommendations.

Regarding our second recommendation, the Unit implemented new procedures to ensure that letters referring providers for exclusion are sent to OIG within the appropriate timeframe. These new procedures include sending an automated case tracking system email to investigators and supervisors reminding them to send the appropriate referral letter to OIG upon the sentencing of a provider.

Regarding our third recommendation, the Unit is reviewing the entire MOU with DHH and will revise it as needed. The Unit and DHH will work to complete a revised MOU in 2013.

Regarding our fourth recommendation, the Unit agreed to reimburse OIG for the overdrawn funds and has implemented new procedures to ensure that program income is properly reported on Federal Financial Status Reports and that the proper amount is withdrawn annually from the HHS Payment Management System.

The Unit did not concur with our first recommendation, to revise its policies and procedures to ensure periodic supervisory reviews are documented in Unit case files. Despite its nonconcurrence, the Unit is implementing new procedures to ensure that case files include documentation of all future supervisory reviews. This new procedure directly addresses our recommendation.

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 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:

[43] 59 Fed. Reg. 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.

a. Does the Unit have policy and procedure manuals?

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

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

a. Does the Unit work with the 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 SSA, 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 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 2009 through 2011

Table B-1: Total Medicaid Fraud Control Unit Fraud and Abuse Referrals and Annual Average

Case Type	FY 2009	FY 2010	FY 2011	3-Year Total	Annual Average
Patient Abuse and Neglect	166	220	153	539	180
Provider Fraud	145	183	176	504	168
Total	**311**	**403**	**329**	**1,043**	**348**

Source: Office of Inspector General (OIG) analysis of Louisiana Medicaid Fraud Control Unit (Unit) Quarterly Statistical Reports, fiscal years (FY) 2009 through 2011.

Table B-2: Unit Referrals, by Referral Source

	FY 2009		FY 2010		FY 2011			
Referral Source	**Fraud**	**Abuse and Neglect**	**Fraud**	**Abuse and Neglect**	**Fraud**	**Abuse and Neglect**	**Total**	**Percentage of All Referrals**
State Medicaid Agency	89	41	85	88	93	27	**423**	40.6
Providers	4	51	6	61	7	29	**158**	15.2
State Survey and Certification	2	46	3	32	8	57	**148**	14.2
Other	33	13	35	11	37	4	**133**	12.8
Private Citizens	8	4	10	10	8	9	**49**	4.7
OIG	0	1	34	0	8	0	**43**	4.1
Law Enforcement	2	2	3	3	3	13	**26**	2.5
Other State Agencies	2	6	2	8	3	0	**21**	2.0
Licensing Board	2	2	2	2	1	12	**21**	2.0
Unit Hotline	0	0	3	5	4	0	**12**	1.2
Outside Prosecutors	2	0	0	0	3	1	**6**	0.6
Long-Term Care Ombudsman	0	0	0	0	1	1	**2**	0.2
Private Health Insurers	1	0	0	0	0	0	**1**	0.1
Total	145	166	183	220	176	153	**1,043**	100

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

APPENDIX C

Investigations Opened and Closed by Provider Category and Case Type, Fiscal Years 2009 through 2011

Table C-1: Total Annual Opened and Closed Investigations

Case Type	FY 2009	FY 2010	FY 2011	3-Year Total	Annual Average
Opened	312	404	327	1,043	348
Patient Abuse and Neglect	164	219	150	533	178
Provider Fraud	148	185	177	510	170
Closed	347	394	330	1,071	357
Patient Abuse and Neglect	236	220	167	623	208
Provider Fraud	111	174	163	448	149

Source: Office of Inspector General (OIG) analysis of Louisiana Medicaid Fraud Control Unit (Unit) Quarterly Statistical Reports, fiscal years (FY) 2009 through 2011.

Table C-2: Total Investigations, by Case Type

Case Type	FY 2009		FY 2010		FY 2011		
	Opened	Closed	Opened	Closed	Opened	Closed	Total
Patient Abuse and Neglect	164	236	219	220	150	166	**1,155**
Provider Fraud	148	111	185	174	177	163	**958**
Total	**312**	**347**	**404**	**394**	**327**	**329**	**2,113**

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

Table C-3: Patient Abuse and Neglect Investigations

Provider Category	FY 2009		FY 2010		FY 2011		
	Opened	Closed	Opened	Closed	Opened	Closed	Total
Certified Nurse Aides	121	131	153	148	93	113	**759**
Other Providers	21	63	20	37	20	15	**176**
Nurses/Doctors' Assistants	8	9	19	13	22	20	**91**
Home Health Aides	9	20	8	6	2	3	**48**
Nursing Facilities	1	10	9	5	4	7	**36**
Nondirect Care Providers	3	3	6	7	6	4	**29**
Other Long-Term Care Facilities	1	0	4	4	3	4	**16**
Total	**164**	**236**	**219**	**220**	**150**	**166**	**1,155**

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

Table C-4: Provider Fraud Investigations

Provider Category	FY 2009		FY 2010		FY 2011		
Facilities	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**	**Total**
Hospitals	7	4	3	6	3	2	**25**
Nursing Facilities	3	1	1	1	2	4	**12**
Other Long-Term Care Facilities	0	1	0	0	0	0	**1**
Practitioners	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**	**Total**
Doctors of Medicine or Osteopathy	23	26	16	19	19	19	**122**
Dentists	3	2	10	4	4	1	**24**
Optometrists/ Opticians	1	0	0	0	3	2	**6**
Other Practitioners	0	1	1	1	0	1	**4**
Counselors/ Psychologists	0	0	1	0	1	0	**2**
Podiatrists	0	1	0	0	0	0	**1**
Medical Support	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**	**Total**
Home Health Care Aides	71	42	105	85	100	93	**496**
Other Medical Support	12	16	9	16	13	12	**78**
Pharmaceutical Manufacturers	6	1	3	11	13	13	**47**
Durable Medical Equipment Suppliers	0	1	21	5	4	5	**36**
Transportation Services	10	1	5	11	4	4	**35**
Pharmacies	3	7	3	5	3	3	**24**
Laboratories	3	4	2	2	1	3	**15**
Home Health Care Agencies	2	0	2	3	5	0	**12**
Nurses/Doctors' Assistants	1	3	0	2	1	0	**7**
Program Related	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**	**Total**
Medicaid Program Administration	2	0	3	3	0	1	**9**
Billing Companies	0	0	0	0	1	0	**1**
Other Program Related	1	0	0	0	0	0	**1**
Total	**148**	**111**	**185**	**174**	**177**	**163**	**958**

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

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. Because of these small sample sizes, we cannot reliably generalize what we found in our sample review to each case type in the population, and only our overall estimates project to the population of all case files. We estimated the 4 population values for all 1,472 case files from the results of our review of the case files selected in our simple random samples. Table D-2 includes the estimate descriptions, sample sizes, point estimates, and 95-percent confidence intervals for these four estimates.

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

Case Type	Population Count and (%) n=1,472	Sample Count* and (%) n=100	Sample Count* and (%) n=50
Closed	1,127 (77%)	70 (70%)	37 (74%)
Open	345 (23%)	30 (30%)	13 (26%)
Civil	59 (4%)	4 (4%)	2 (4%)
Criminal	1,413 (96%)	96 (96%)	48 (96%)
Global	46 (3%)	3 (3%)	2 (4%)
Patient Abuse/Neglect	736 (50%)	50 (50%)	25 (50%)
Provider Fraud	690 (47%)	47 (47%)	23 (46%)

Source: The Medicaid Fraud Control Unit provided a list of all case files open during fiscal years 2009 through 2011.
*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	100.0%	96.5–100.0%
Case Files With Documented Supervisory Approval for Closing	70	94.3%	86.3–98.4%
Case Files With Documentation Indicating at Least One Supervisory Review	100	78.0%	68.9–85.5%
Case Files With No Documentation Indicating Periodic Supervisory Review	100	38.0%	28.7–48.0%

APPENDIX E
Unit Comments

JAMES D. "BUDDY" CALDWELL
ATTORNEY GENERAL

State of Louisiana
DEPARTMENT OF JUSTICE
P.O. BOX 94005
BATON ROUGE
70804-9005

November 30, 2012

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

Re: Louisiana State Medicaid Fraud Control Unit (OEI-09-12-00010)

Dear Mr. Wright:

We appreciate the opportunity to review and respond to the HHS-OIG 2012 Onsite Review of the Louisiana State Medicaid Fraud Control Unit. We have taken this review as an opportunity to improve our operations and appreciate your identification of areas which need our attention. We would also like to take this opportunity to express our appreciation of the professionalism and courtesy extended by your staff during this review.

As requested, we are including our response to each of the recommendations resulting from the Onsite Review. We have already implemented many of the recommendations, and are in the process of implementing the remaining recommendations.

Finding:

Ninety-four percent of closed case files contained documentation indicating supervisory approval to close cases

Recommendation:

None

Response:

Although this finding had no official recommendation, we feel compelled to respond since we did not achieve one hundred percent compliance with this performance standard.

Analysis:

During the review period, it was the policy of the MFCU that upon closure of any case not resulting in prosecution, the case investigator prepared a closing memo explaining the reasons for closure. This memo was initialed by the case investigator, supervisory investigator, prosecutor and chief investigator and then placed in the case file. However, in a few instances the case file did not include a closing memo signed by the approving supervisor.

Plan:

As noted in the report, the MFCU has implemented procedures (SOP # 37) which require a "closed case file review" by the assigned investigator and their supervisor to ensure that all relevant documents are present in the case file. The case closing memo approved by the investigator's supervisor, assigned attorney, and Chief Investigator is a required document included on the checklist used to conduct this review. This new procedure also includes an automated computer generated monthly monitoring report which is sent to all Unit managers and will list any closed case where the Supervisory Investigator has not entered a review completion date into our case tracking system. These cases will remain on the report until the review is completed. With these new procedures in place, we are confident that in the future 100% of closed case files will include documentation indicating supervisory approval for closure.

Finding:

Twenty-two percent of the total Unit case files lacked documentation indicating at least one supervisory review and 28 percent lacked documentation indicating additional, periodic supervisory reviews.

Recommendation:

The Louisiana Unit should revise its policies and procedures to ensure that periodic supervisory reviews are documented in unit case files.

Response:

We do not concur with this finding/recommendation. However, in response to your concerns, we are implementing new procedures to ensure that case files include documentation of all supervisory reviews in the future.

Analysis:

It is the policy of the MFCU that supervisory Investigators continually review and monitor each of their investigators' cases as evidenced by their initials on every interview report and investigative memo contained in the case file. Furthermore, although not documented in the paper file, investigators and their supervisors make case activity entries into our case tracking system documenting their discussions about assigned cases. These entries again support regular and routine supervisory involvement in Unit cases. Lastly, in addition to informal discussions, the Unit Director and Chief Investigator conduct formal case status reviews on a periodic basis of **every** open case. These reviews include the preparation of a case status entry into our case tracking system by the assigned investigator, the review and discussion about the case status with their Supervisory Investigator, and finally a detailed discussion of each case's status between the Unit Director, Chief Investigator, and each Supervisory Investigator.

Plan:

The MFCU has adopted a new policy (SOP #38) addressing Supervisory Case Reviews. In accordance with this new policy, Supervisory Investigators will make an entry in our case tracking system under the task code "Case Review with Investigator" and the investigators will make an entry under the task code "Case Review with Supervisor" each time a case review is conducted. Additionally, when periodic case reviews are conducted by the Unit Director and Chief Investigator, the reviews will be documented with an entry in case tracking under the task code "Case Review with Director/Chief Investigator. We are forwarding a copy of this new SOP to OIG. Furthermore, a bi-monthly report of case review activity will be generated for each Supervisory Investigator and the Chief Investigator so that those cases which have not had a Supervisory Review conducted in the normal course of the investigation will be identified for Supervisory Review. It is expected that this quarterly report will be finalized and in place by the end of the calendar year.

Finding:

The Unit did not refer 14 percent of sentenced providers to OIG for program exclusion within the appropriate timeframe.

Recommendation:

The Louisiana unit should ensure that letters referring providers for exclusion are submitted to OIG within the appropriate timeframe.

Response:

We concur with this recommendation.

Analysis:

As noted in the report, since the onsite review, the Unit has implemented new procedures to ensure that notification letters are sent to OIG for program exclusion within the appropriate timeframe. Due to the fact that these letters require that we attach a copy of the court record regarding the subject's sentence, we are often unable to send these letters in the appropriate timeframe. It is often difficult for the MFCU to get the court record because it has not been prepared by the court in a timely manner.

Plan:

The MFCU has implemented new procedures (SOP # 36) which will ensure, where possible, that notification letters are sent to OIG for program exclusion within the appropriate timeframe. These new procedures include an automated case tracking system generated email to the assigned investigator and their supervisor advising them that a subject has been sentenced and that a notice letter to OIG is required. In addition, the case tracking system also prepares a monthly monitoring report which is sent to all Supervisory Investigators and the Chief Investigator which identifies any case where the OIG letter has not been sent within the appropriate timeframe.

Finding:

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

Recommendation:

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

Response:

We concur with this recommendation.

Analysis:

It is important to note that the MFCU has, for many years, referred some providers who are under investigation to the state agency for program payment suspension. The MFCU agrees with the need to modify its MOU to reflect recent legal changes that allow the Unit to refer any provider under investigation for a credible fraud allegation to DHH for payment suspension.

Plan:

The MFCU is reviewing the entire MOU for any additional revisions that may be needed and plans to create revisions or addenda to the MOU which will address the above issue as well as any other issues identified. Upon completion, the revised MOU will be forwarded to DHH for signature. We expect to make progress towards creating a revised MOU by the end of this year and to have the MOU completed in 2013.

Finding:

The Unit maintained proper fiscal control of its resources, but did not report program income properly in FYs 2010 and 2011.

Recommendation:

Ensure that all program income is reported properly on its Federal financial status reports.

Response:

We concur with this recommendation.

Analysis:

As noted in the report, since the on-site review we have agreed to reimburse the overdrawn funds and have implemented procedures to ensure that future investigative and legal costs that meet the definition of program income will be properly reported on Federal Financial Status Reports and deducted from total costs under the grant.

Plan:

Procedures have been implemented which include a notice to our accounting staff identifying those receipts which are to be included in program income so that that any investigation/legal costs which are recovered in the future that meet the definition of program income will be properly reported on the Federal Financial Status Report and deducted from total costs under the grant. The $8,080 (.09% of the Unit's FY 10 & 11 approved budget) identified as being an unallowable HHS Payment System withdrawal during the two year period FY 2010 and FY 2011 will be reimbursed to OIG. This will be accomplished by offsetting our FY13 award through a reduction in our award by $8,080 for our second quarter advance.

Conclusion

The Louisiana MFCU would again like to express our appreciation of the efforts of HHS-OIG in conducting this review in such a courteous and professional manner. We would also like to note that your staff members were understanding of the difficulties and challenges facing MFCUs in implementing the performance standards. We also appreciate the open lines of communication with your staff throughout the review process and the constructive criticism offered by your staff. We appreciate this opportunity to improve our operations so that we may complete our mission more efficiently and effectively.

Respectfully submitted,

/S/

Frederick A. Duhy, Jr.
Assistant Attorney General
Director, Medicaid Fraud Control Unit

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.

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Office of Inspector General

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