

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEVADA 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 State Medicaid Fraud Control Units (MFCU or Unit) with respect to Federal grant compliance. As part of this oversight, OIG annually reviews and certifies all Units. In addition, OIG conducts onsite reviews of selected States. These reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor Unit compliance with Federal grant requirements, laws, and regulations.

HOW WE DID THIS STUDY

We analyzed 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 and selected staff; (6) an onsite review of case files; and (7) an onsite review of Unit operations.

WHAT WE FOUND

From fiscal years 2009 through 2011, the Unit reported recoveries of \$13.4 million, Unit convictions increased, and the Unit opened 262 cases. All reviewed case files contained documentation indicating supervisory approval to open and close cases, and we found that almost all case files contained documentation indicating periodic supervisory reviews. Unit professional staff occasionally performed non-Unit duties, however. In addition, the Unit's policies and procedures manual and its memorandum of understanding (MOU) with Nevada's State Medicaid agency—the Division of Health Care Financing and Policy (DHCFP)—were not updated, and the Unit did not always comply with the MOU provisions. The Unit maintained proper fiscal control of its resources, but incorrectly claimed indirect costs. Except for the use of Unit professional staff for non-Unit duties, an MOU stipulation that the Unit assist DHCFP in obtaining funding for data requests, and the overclaiming of indirect costs, we found no evidence of noncompliance with applicable laws, regulations, and policy transmittals.

WHAT WE RECOMMEND

We recommend that the Nevada Unit (1) ensure that Unit professional staff exclusively perform Unit duties, (2) revise its policies and procedures manual, (3) revise its MOU with DHCFP, (4) comply with the MOU provisions, and (5) ensure that it correctly claims indirect costs. In its written comments to our draft report, the Unit did not indicate whether it concurred with each of the recommendations. However, the Unit described actions that it has taken, or plans to take, to address each of the recommendations

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OBJECTIVE

To conduct an onsite review of the Nevada 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) 2012, combined Federal and State grant expenditures for the Units totaled \$217.3 million, of which Federal funds represented \$162.9 million.⁴ That year, the 50 Units employed 1,901 individuals.⁵

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.⁶ 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 2012, the 50 Units reported 1,337 convictions and 823 civil settlements or judgments. That year, the Units reported recoveries of approximately \$2.9 billion.⁷

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

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

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

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

⁵ Office of Inspector General (OIG), *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on March 19, 2013.

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

⁷ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Pursuant to 42 CFR § 1007.17, Units report the total amount of recovered funds in their annual reports to OIG.

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 Nevada and 43 other States, the Units are located with 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 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 of 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 it 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 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

⁸ SSA § 1903(q)(1).

⁹ In 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 anti-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 referred to as 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. Prior to the time of our onsite data collection (July–August 2012), OIG published a revision of the performance standards, 77 Fed. Reg. 32645 (June 1, 2012). The performance standards referred to in this report are from 1994 and were in effect during the time of our review period (FYs 2009 through 2011).

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.

Nevada Unit

The Unit is an autonomous entity within the Bureau of Criminal Justice of the Nevada 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's 18 employees were divided between 2 offices. The Unit Director and 11 additional employees were located at the Unit's "South" office in Las Vegas. The Chief Investigator and five additional employees were located at the Unit's "North" office in the State capital of Carson City. The Unit Director directly supervises all South office employees, supervises the Chief Investigator, and acts as the Chief Attorney. The Chief Investigator directly supervises all North office employees.

The Unit receives referrals of provider fraud from the State Medicaid agency—the Nevada Division of Health Care Financing and Policy (DHCFP)—and from Federal agencies, such as OIG. The Unit receives referrals of patient abuse and neglect from the Nevada Bureau of Health Care Quality and Compliance (BHQC) and the Nevada Aging and Disability Services Division. In addition, the Unit receives referrals from other State and local agencies, from the public through a Medicaid Fraud Report hotline, and from an electronic form available on the Nevada Attorney General's Web site.¹⁷ For additional information on Unit referrals, see Appendix B.

Upon receipt of a referral, Unit administrative assistants enter the referral and related information into the Unit's case file tracking system. On a biweekly basis, the Unit's Director, Chief Investigator, and a Unit attorney screen these referrals and decide whether to proceed with the investigations or refer the cases to another agency. 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 Director assigns an investigator and attorney to cases that are accepted for investigation; the assigned investigator and attorney then meet to plan the case strategy. 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 and/or civil action or referring it to another agency.

¹⁷ The Unit will occasionally open cases that were not formally referred by an outside source. For example, a case may be brought to the Unit's attention by the media.

Previous Review

In 2007, OIG conducted an onsite review of the Nevada Unit and found it to be “in general compliance with all applicable Federal rules and regulations.” However, the review identified a concern related to the use of MFCU grant funds to pay the salaries of two non-MFCU personnel. The Unit subsequently reimbursed the Federal government for the related unallowable costs.¹⁸

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 and selected staff; (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.¹⁹ 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.

We conducted the onsite review in July–August 2012.

Data Collection and Analysis

Review of Unit Documentation. We 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 reviewed this documentation to determine how the Unit 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.

¹⁸ This 2012 onsite review of the Unit found no indication that this issue persisted.

¹⁹ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov>.

Review of Financial Documentation. To evaluate internal controls of fiscal resources, OIG auditors reviewed policies and procedures related to the Unit’s 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 Reports²⁰ 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 System (PMS)²¹ and revenue accounts to identify any unreported program income.²²

Interviews With Key Stakeholders. We conducted structured interviews with nine individual stakeholders among five agencies who were familiar with Unit operations. Specifically, we interviewed DHCFP’s Surveillance Utilization Review System (SURS) Manager; the BHQC’s Facilities Inspection Manager; the BHQC’s Long-Term Care Ombudsman; two Assistant U.S. Attorneys based in Las Vegas; the Nevada Attorney General’s Chief of Staff; the Nevada Attorney General’s First Assistant;²³ an OIG Special Agent based in Las Vegas; and an OIG Assistant Special Agent in Charge for the State of Nevada. 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 Unit staff.²⁴ We requested and received responses from 15 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

²⁰ The Unit transmits financial status reports to OIG’s Office of Management and Policy (OMP) on a quarterly and annual basis. These reports detail Unit income and expenditures.

²¹ 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.

²² 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).

²³ The Attorney General’s Chief of Staff and First Assistant supervise the Unit Director.

²⁴ We did not survey one of the Unit’s nonmanagerial auditors because we interviewed that auditor onsite.

²⁵ This report uses the terms “management” and “supervisors” interchangeably. “Non-management” employees are Unit staff members who have no supervisory authority.

operations. The survey also sought information about the Unit's compliance with applicable laws, regulations, and policy transmittals.

Interviews With Unit Management and Selected Staff. We conducted structured interviews with the Unit's Director (Chief Attorney), Chief Investigator, and an auditor. We asked them 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 80 case files from the 262 cases²⁶ that were open at any point from FY 2009 through FY 2011. The design of this sample allowed us to estimate the percentage of all 262 cases with various characteristics at the 95-percent confidence level. We reviewed these 80 sampled case files and the Unit's processes for monitoring the status and outcomes of cases. From these 80 case files, we selected another simple random sample of 45 for a more in-depth review of potential issues. This second-phase sample allowed us to conduct a more comprehensive review of case files 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

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

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 \$13.4 million, Unit convictions increased, and the Unit opened 262 cases

From FY 2009 through FY 2011, the Unit reported total criminal and civil recoveries of \$13.4 million—an annual average of \$4.5 million (see Table 1). Of the \$13.4 million in recoveries, the Unit attributed \$12.6 million to civil recoveries and \$766,000 to criminal recoveries. Global²⁸ case judgments and settlements accounted for \$10.7 million of the total civil recoveries and global cases accounted for 190 of the Unit’s 262 cases over the 3-year period. The Unit’s annual average expenditures for FYs 2009 through 2011 were \$1.6 million.²⁹

Table 1: Nevada Unit Reported Recovered Funds, FYs 2009 Through 2011

	FY 2009	FY 2010	FY 2011	3-Year Total	Annual Average
Reported Criminal Recoveries	\$4,675	\$119,814	\$641,552	\$766,041	\$255,347
Global Recoveries	\$5,557,737	\$2,494,568	\$2,619,011	\$10,671,316	\$3,557,105
Non-Global Civil Recoveries	\$50,000	\$1,226,788	\$688,138	\$1,964,926	\$654,975
Total Reported Recoveries	\$5,612,412	\$3,841,170	\$3,948,701	\$13,402,283	\$4,467,427
Total Expenditures	\$1,549,762	\$1,603,654	\$1,721,663	\$4,875,079	\$1,625,026

Source: Data provided by the Unit to OIG.

From FY 2009 through FY 2011, Unit convictions increased

From FY 2009 through FY 2011, the Unit obtained 27 convictions and reported 37 civil judgments and settlements—an annual average of 9 convictions and 12.3 civil judgments and settlements (see Table 2).

²⁸ Unit-reported recoveries include funds recovered from multi-State, or “global,” civil false claims cases, both those worked directly by the Unit and those worked by staff from other Units.

²⁹ The figures presented in this paragraph are rounded.

Table 2: Unit Convictions and Civil Judgments and/or Settlements, FYs 2009 Through 2011³⁰

	FY 2009	FY 2010	FY 2011	3-Year Total	Annual Average
Convictions	1	7	19	27	9
Civil Judgments and/or Settlements	12	17	8	37	12.3

Source: Data provided by the Unit to OIG.

The Unit’s convictions increased during the review period—from 1 in FY 2009 to 19 in FY 2011.

From FY 2009 through FY 2011, the Unit opened 262 cases

From FYs 2009 through 2011, the Unit opened an average of 87 cases annually, with an average of 83 cases of provider fraud and 4 cases of patient abuse and neglect. From FYs 2009 through 2011, the Unit closed an average of 55 cases annually, averaging 52 cases of provider fraud and 3 cases of patient abuse and neglect.³¹ From FYs 2009 through 2011, the Unit received an average of 98 referrals annually, with an average of 72 referrals of provider fraud and 26 referrals of patient abuse and neglect.

All reviewed case files contained documentation indicating supervisory approval to open and close cases and almost all case files contained documentation indicating periodic supervisory reviews

According to Performance Standard 6(b), Unit supervisors should approve the opening and closing of cases to 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. Based on our review of 80 case files, the Unit documented supervisory approval to both open and close cases in all of the case files.

According to Performance Standard 6(c), supervisory reviews should be “conducted periodically and noted in the case file” to ensure timely case completion.³² Based on our review of 80 case files, 98 percent of Unit case files contained documentation indicating periodic supervisory reviews.

³⁰ Civil Judgments and/or Settlements include those received from global cases.

³¹ Closures include multiple cases opened before FY 2009.

³² For the purposes of this report, supervisory approval to open and close a case does not constitute a supervisory “review.” Periodic supervisory review indicates that a supervisor reviewed a case more than once between the case’s opening and closing.

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

According to Performance Standard 1(a), “Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.”³³ In addition, pursuant to Federal regulations, a Unit may claim Federal reimbursement only for costs attributable to the establishment and operation of the Unit.³⁴ During the review period, Unit professional staff occasionally served warrants for other Nevada Attorney General components. In addition, Unit professional staff performed peace officer duties outside of the Unit for approximately one day per month. These activities were not attributable to the investigation and prosecution of Medicaid fraud or of patient abuse and neglect. Costs not associated with the establishment or operation of the Unit are not subject to Federal reimbursement.

The Unit’s policies and procedures manual was not updated, and the Unit’s MOU with DHCFP did not reflect current law and practice

The Unit’s policies and procedures manual was last updated in 2006. This manual did not contain policies and procedures to address certain Unit operations or financial oversight. In addition, the Unit’s June 2009 MOU with DHCFP includes a provision that may allow the Unit to be charged for data requests made to SURS.³⁵ That MOU also was not updated to include a provision describing the referral process between the Unit and DHCFP for providers who are subject to a payment suspension on the basis of a credible allegation of fraud.³⁶

The Unit’s policies and procedures manual was not updated to reflect current Unit operations

³³ “Professional staff” includes attorneys, investigators, auditors, and managers. *OIG Policy Transmittal 89-1*.

³⁴ 42 CFR § 1007.19(d).

³⁵ *Memorandum of Understanding between the Nevada Office of Attorney General and the Division of Health Care Financing and Policy of the Nevada Department of Health and Human Services*, § 1.

³⁶ The Affordable Care Act, § 6402(h)(2), requires State Medicaid programs, as a condition of receiving FFP, to suspend payments to providers for whom there is a credible allegation of fraud, unless good cause exists to not suspend payments. One way to establish good cause is for the MFCU to inform the Medicaid agency that the suspension would compromise or jeopardize its investigation of the provider. CMS and OIG implemented this provision in revisions to 42 CFR §§ 455.23 and 1007.9(e) effective March 25, 2011 (76 Fed. Reg. 5862).

According to Performance Standard 3, a Unit should establish policies and procedures for its operations, which should be included in a manual. However, the Unit's manual was not updated to include policies and procedures for various current Unit operations, such as provider training and "field projects."³⁷ In addition, the Unit did not have policies and procedures for ensuring that indirect costs are claimed accurately.

Since our onsite review, the Unit provided OIG with a draft of a revised policies and procedure manual that comprehensively addresses Unit operations, including provider training and field projects.

The Unit's MOU with DHCFP did not reflect current law and practice

According to Performance Standard 10, Units should periodically review their MOUs with the State Medicaid agency to ensure that the MOUs reflect current law and practice. As required by Federal regulations,³⁸ the Unit had an MOU with DHCFP. In the MOU, DHCFP must agree to comply with 42 CFR § 455.21, which includes a requirement to provide the Unit with "access to, and free copies of, any records or information kept by the agency or its contractors."³⁹ However, the MOU includes a provision that the "MFCU agrees to assist SURS in obtaining any additional funding that may be necessary to comply with requests from [the] MFCU."⁴⁰ This provision could allow the Unit to be charged for data requests made to SURS, which would be inconsistent with Federal regulations. However, the Unit Director reported that the Unit has never been asked by SURS to assist in obtaining additional funding for data requests.

In addition, the MOU that was in effect during the review period was not updated to include a provision describing the referral process between the Unit and DHCFP for providers who are subject to a payment suspension on the basis of a credible allegation of fraud. During our onsite review, we received an updated MOU from the Unit Director that includes provisions for suspending provider payments based on a credible allegation of fraud. The updated MOU was dated March 2012.

³⁷ The term "field projects" refers to a variety of informal actions taken by Unit investigators to gather information on providers that may be useful at a later date.

³⁸ 42 CFR § 1007.9(d).

³⁹ 42 CFR §§ 455.21(a)(2)(i) and 1007.9(d).

⁴⁰ *Memorandum of Understanding between the Nevada Office of Attorney General and the Division of Health Care Financing and Policy of the Nevada Department of Health and Human Services*, § 1.

The Unit did not always comply with the MOU provisions

Pursuant to the Unit's MOU with DHCFP, the Unit "will, on a monthly basis, inform SURS of all providers it has under investigation, all cases it has settled or closed, and [provide] copies of all supporting documentation of any settlement agreements reached and/or money collected."⁴¹ Pursuant to Federal regulations, State Medicaid agencies must report this information to HHS at prescribed intervals.⁴² The DHCFP's MOU with the Unit was structured to ensure that SURS received the pertinent Unit case information monthly for this reporting purpose. However, DHCFP staff indicated that the Unit did not always comply with the provisions during the review period. Consequently, DHCFP was unable to provide the required Unit case information to HHS in a timely manner.

The Unit maintained proper fiscal control of its resources, but incorrectly claimed indirect costs

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 reported program income in accordance with applicable Federal requirements and maintained adequate internal controls related to accounting, budgeting, personnel, procurement, property, and equipment. In addition, most of the expenditures that the Unit claimed represented allowable costs in accordance with applicable Federal requirements.

Although the Unit maintained proper fiscal control of its resources, it incorrectly claimed its indirect costs. The Unit claimed indirect costs that differed from the amounts approved in the State's cost allocation plans. Specifically, the Unit either omitted or added a fiscal quarter of approved costs during each year of the review period. As a result, the Unit underclaimed indirect costs in FY 2009 and FY 2010, but overclaimed indirect costs in FY 2011.

Units claim indirect costs to fund general operations, such as administration; these costs are not attributable to specific purchases or to other "direct" costs. Pursuant to Federal regulations,⁴³ a "cost allocation

⁴¹ *Memorandum of Understanding between the Nevada Office of Attorney General and the Division of Health Care Financing and Policy of the Nevada Department of Health and Human Services*, § 11.

⁴² 42 CFR § 455.17.

⁴³ 2 CFR pt. 225, Appendixes A and C.

plan” identifies and allocates billing rates based on allowable costs of services provided by, or for, State agencies, such as Units. Each State must submit an approved cost allocation plan to HHS for each year in which it claims such costs under Federal awards. These costs are reimbursed by the Federal government to its benefitting State agencies. Costs omitted from these plans are not reimbursable.⁴⁴

Other Observation: Provider Outreach and “Train the Trainer” Programs

According to Performance Standard 4, a Unit “should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources.” The Unit’s outreach program consists of educational classes taught by Unit presenters to 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.

Unit management and staff highlighted the Unit’s “Train the Trainer” program as being instrumental to the success of the provider outreach program. “Train the Trainer” is a PowerPoint presentation given to Unit investigators who are scheduled to teach the provider education classes. This presentation helps to ensure that the classes are uniformly taught, that all pertinent information is imparted to providers, and that Unit investigators become skilled presenters.

⁴⁴ Pursuant to Federal regulations, a grantee (such as a Unit) should charge only those costs incurred during the specific funding period. 45 CFR § 92.23(a).

CONCLUSION AND RECOMMENDATIONS

From FY 2009 through FY 2011, the Unit reported recoveries of \$13.4 million, and opened 262 cases. Unit convictions increased during the review period. All reviewed case files contained documentation indicating supervisory approval to open and close cases and almost all case files contained documentation indicating periodic supervisory reviews. The Unit also exercised proper fiscal control over its resources. Finally, the Unit took steps to educate providers about fraud through a provider outreach programs.

Additional opportunities for improvement exist. Specifically, Unit professional staff performed non-Unit duties, contrary to Federal regulations. The Unit's policies and procedures manual had not been updated to reflect current Unit operations. The Unit's MOU with DHCFP allowed for the Unit to be charged by DHCFP for data requests, contrary to Federal regulations. The Unit also did not always comply with the MOU terms. Finally, the Unit incorrectly claimed indirect costs. With the exceptions of the use of Unit professional staff for non-Unit duties and an MOU stipulation that the Unit agreed to help DHCFP obtain funding for data requests, we found no evidence of noncompliance with applicable laws, regulations, and policy transmittals.

We recommend that the Nevada Unit:

Ensure That Unit Professional Staff Perform Duties Exclusively Related to Unit Operations

The Unit should ensure that professional staff are full-time employees who work on duties exclusively related to the operation of the Unit. In addition, the Unit should work with OIG's Office of Management and Policy (OMP) to determine the extent to which the Unit should reimburse OIG the Federal share of unallowable personnel costs related to non-Unit duties.

Revise Its Policies and Procedures Manual To Reflect Current Unit Operations

The Unit should regularly update its policies and procedures manual to reflect current Unit operations. The Unit should develop and incorporate a procedure for ensuring that indirect costs are claimed correctly.

Revise Its MOU With DHCFP To Reflect Current Law and Practice

The Unit should revise its MOU with DHCFP to remove the stipulation that the Unit agrees to assist DHCFP in obtaining funding for data requests.

Ensure That DHCFP Consistently Receives Unit Case Information in a Timely Manner

The Unit should provide case information to DHCFP on a monthly basis so that DHCFP can fulfill its reporting requirements to HHS.

Ensure That Indirect Costs Are Claimed Correctly

The Unit should work with OMP to ensure that it correctly claims indirect costs on its cost allocation plan assessments. The Unit should also work with OMP to determine whether it should reimburse indirect costs that were incorrectly claimed during the review period.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments to our draft report, the Unit did not indicate whether it concurred with each of the recommendations. However, the Unit's comments described the following actions that it has taken, or plans to take, to address each of the recommendations. In its final management letter, the Unit should clarify whether it concurs with the recommendations.

Regarding our first recommendation, the Unit has ceased the once-a-month rotational desk duty that is unrelated to MFCU operations and is working with the OIG OMP to determine the extent to which the Unit should reimburse OIG for unallowable personnel costs. The Unit did not comment specifically on the other activity identified in our finding, relating to the execution of search warrants.

Regarding our second recommendation, the Unit will periodically review its policies and procedures manual to ensure that it reflects current Unit operations.

Regarding our third recommendation, the Unit is working with DHCFP to revise its MOU to reflect current law and practice.

Regarding our fourth recommendation, the Unit has "incorporated measures" to ensure that DHCFP receives Unit case information in a timely manner.

Regarding our fifth recommendation, the Unit is working with OMP to ensure that indirect costs are claimed accurately and to determine whether the Unit should reimburse indirect costs that were incorrectly claimed during the review period.

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

APPENDIX A

Performance Standards for Medicaid Fraud Control Units (Unit)⁴⁵

- 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?

⁴⁵ 59 Fed. Reg. 49080 (Sept. 26, 1994). These performance standards were in effect during the time of our review period and precede the performance standards published in June 2012.

- 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?
 - 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 Nevada 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	37	16	24	77	26
Provider Fraud	51	92	74	217	72
Total	88	108	98	294	98

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

Table B-2: Unit Referrals, by Referral Source

Referral Source	FY 2009		FY 2010		FY 2011		Total	Percentage of All Referrals
	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect		
Private Citizens*	20	2	30	3	31	2	88	29.9
Providers	11	1	13	0	8	2	35	11.9
Other	6	2	17	1	7	2	35	11.9
Long-Term Care Ombudsman	2	28	1	3	0	0	34	11.6
Single State Medicaid Agency	5	0	16	0	12	0	33	11.2
Law Enforcement	1	2	2	6	1	10	22	7.5
OIG	1	0	12	0	5	0	18	6.1
Other State Agencies	5	0	1	0	5	0	11	3.7
State Survey and Certification Agency	0	2	0	2	2	1	7	2.4
Adult Protective Services	0	0	0	0	2	4	6	2.1
Licensing Board	0	0	0	1	1	3	5	1.7
Total	51	37	92	16	74	24	294	100
Annual Total	88		108		98			
Annual Average							98	

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

*Includes phone calls to the Unit's main number, emails to the Unit, electronic fraud report submissions, and walk-in referrals.

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	49	99	114	262	87
Patient Abuse and Neglect	3	5	5	13	4
Provider Fraud	46	94	109	249	83
Closed	37	63	66	166	55
Patient Abuse and Neglect	3	3	4	10	3
Provider Fraud	34	60	62	156	52

Source: Unit response to OIG data request.

*Averages in this table are rounded.

Table C-2: Total Investigations, by Case Type

Case Type	FY 2009		FY 2010		FY 2011	
	Opened	Closed	Opened	Closed	Opened	Closed
Patient Abuse and Neglect	3	3	5	3	5	4
Provider Fraud	46	34	94	60	109	62
Total	49	37	99	63	114	66

Source: Unit response to OIG data request.

Table C-3: Patient Abuse and Neglect Investigations

Provider Category	FY 2009		FY 2010		FY 2011	
	Opened	Closed	Opened	Closed	Opened	Closed
Home Health Aides	0	0	1	0	1	0
Nursing Facilities	0	0	0	0	1	0
Other Long-Term Care Facilities	2	3	3	2	1	4
Other	1	0	1	1	2	0
Total	3	3	5	3	5	4

Source: Unit response to OIG data request.

Table C-4: Provider Fraud Investigations

Provider Category	FY 2009		FY 2010		FY 2011	
	Opened	Closed	Opened	Closed	Opened	Closed
Facilities						
Hospitals	1	0	3	2	3	0
Other	0	1	1	0	0	1
Practitioners						
Counselors/Psychologists	0	0	10	0	9	5
Dentists	2	1	1	3	0	2
Doctors of Medicine or Osteopathy	1	2	0	2	2	1
Other	0	2	1	0	0	1
Medical Support						
Durable Medical Equipment Suppliers	3	6	7	3	6	4
Home Health Care Agencies	1	3	2	2	0	2
Home Health Care Aides	7	6	8	14	7	12
Laboratories	0	0	3	1	1	2
Pharmaceutical Manufacturers	23	11	53	33	78	27
Pharmacies	6	0	2	0	0	1
Transportation Services	0	1	0	0	0	0
Other	0	1	1	0	1	1
Program Related						
Billing Companies	1	0	0	0	0	1
Managed Care	0	0	0	0	0	1
Other	1	0	2	0	2	1
Total	46	34	94	60	109	62

Source: Unit response to OIG data request.

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 262 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=262	Sample Count* and (%) n=80	Sample Count* and (%) n=45
Closed	88 (34%)	30 (38%)	14 (31%)
Open	174 (66%)	50 (62%)	31 (69%)
Civil	199 (76%)	55 (69%)	32 (71%)
Criminal	63 (24%)	25 (31%)	13 (29%)
Global	190 (72%)	54 (67%)	32 (71%)
Patient Abuse/Neglect	13 (5%)	6 (8%)	2 (5%)
Provider Fraud	59 (23%)	20 (25%)	11 (24%)

Source: The Nevada Unit provided a list of all case files open during FYs 2009 through 2011.

*OIG 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	80	100.0%	96.2–100.0%
Case Files With Documented Supervisory Approval for Closing	30	100.0%	89.8–100.0%
Case Files With Documentation Indicating at Least One Supervisory Review	80	97.5%	92.0–99.2%
Case Files With Documentation Indicating Periodic Supervisory Review	80	97.5%	92.0–99.2%

APPENDIX E

Unit Comments

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August 15, 2013

Re: OEI-09-12-00450

Dear Mr. Wright,

A review of the 2012 Nevada Medicaid Fraud Control Unit (MFCU) Onsite Review has been conducted, including the five recommends. Before commenting I wish to thank your staff for the professional and proficient manner in which they initiated the review. Your notation of the Unit's \$13.4 million dollars in recoveries, an increase in criminal convictions and case openings, plus the Unit's efforts of maintaining contacts for the reporting of fraud, abuse and neglect, is appreciated.

Comments to the recommends are as follows:

Ensure That Unit Professional Staff Perform Duties Exclusively Related to Unit Operations

The Unit has ceased once a month rotational desk duty and is in contact with the Office of Inspector General, Office of Management and Policy (OIG/OMP) regarding the potential for reimbursement of staff costs that may have been incorrectly claimed.

Revise Its Policies and Procedures Manual to Reflect Current Unit Operations

The Unit has complied with the recommend and will conduct periodic reviews of the manual for currentness.

Revise Its MOU With DHCFP To Reflect Current Law and Practice

Though the Unit respectfully disagrees with the review's interpretation of a sentence in the MOU, an updated MOU has been drafted and is being processed with DHCFP.

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Ensure That DHCFP Consistently Receives Unit Case Information in a Timely Manner

The Unit has incorporated measures in its meetings and correspondence with DHCFP to address the recommend.

Ensure That Indirect Costs are Claimed Correctly

The Unit has enacted contact with OIG/OMP to ensure the correct and timely reporting of indirect costs on its cost allocation plan assessment and to determine if there should be reimbursement of any untimely or incorrectly claimed indirect costs.

Throughout our future endeavors the Unit will continue its efforts to maintain a satisfactory relationship with your agency and staff.

Sincerely,

/S/
Mark Kemberling
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.

Matthew DeFraga served as the lead analyst for this study. Central office staff who provided support include Thomas Brannon, Kevin Farber, and Sherri Weinstein. Office of Audit Services staff who provided support include Gupa Goha, Ryan Moul, and Clarissa Yu. Office of Investigations staff who provided support include Ken Benson.

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