Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MISSISSIPPI STATE MEDICAID FRAUD CONTROL UNIT: 2014 ONSITE REVIEW

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WHY WE DID THIS STUDY

The Office of Inspector General (OIG) oversees the activities of all State Medicaid Fraud Control Units (MFCUs or Units). As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. The 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 conducted an onsite review in January 2014. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation on the Unit's operations, staffing, and caseload for fiscal years (FYs) 2011 through 2013; (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 a sample of case files that were open in FYs 2011 through 2013; and (7) an onsite observation of Unit operations.

WHAT WE FOUND

From FYs 2011 through 2013, the Unit reported recoveries of $52 million, 174 convictions, and 37 civil judgments and settlements. A Unit supervisor approved the opening and closing of most case files; however, 44 percent of case files lacked documentation of periodic supervisory reviews. In addition, the Unit did not adequately safeguard some of its case files. The Unit did not investigate 5 percent of cases before the statute of limitations expired, and may not have enough investigators assigned to patient abuse and neglect cases. The Unit also did not refer 11 sentenced individuals to OIG for program exclusion within an appropriate timeframe. Finally, the Unit's policies and procedures manual did not reflect current Unit operations.

WHAT WE RECOMMEND

We recommend that the Mississippi Unit (1) ensure that supervisors approve the opening and closing of cases and that periodic supervisory reviews are conducted and documented in Unit case files; (2) ensure that case files are secure; (3) ensure that all cases are investigated or closed, as appropriate, before the statute of limitations expires; (4) assess the allocation of existing staff levels; (5) ensure that it refers all sentenced individuals for exclusion to OIG within an appropriate timeframe; and (6) revise its policies and procedures manual to reflect current operations. The Unit concurred with all six of our recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.[1] Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State; and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.[2] Currently, 49 States and the District of Columbia (States) have created such Units.[3] In fiscal year (FY) 2013, combined Federal and State grant expenditures for the Units totaled $230 million.[4, 5] That year, the 50 Units employed 1,912 individuals.[6]

To carry out its duties in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.[7] The staff reviews complaints referred by the State Medicaid agency and other sources and determines their potential for

[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. *Medicaid Fraud Control Units*, Office of Inspector General (OIG) web site. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on February 11, 2014 .

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

[5] OIG, *MFCU Statistical Data for Fiscal Year 2013*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/ on March 10, 2014.

[6] Ibid.

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

criminal prosecution and/or civil action. Collectively, in FY 2013, the 50 Units reported 1,341 convictions and 879 civil judgments and settlements. That year, the Units reported recoveries of approximately $2.5 billion.[8]

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.[9] In Mississippi and 43 other States, the Units are located within offices of State Attorneys General that have this authority. In the remaining six States, the Units are located within other State agencies; generally, such Units must refer cases to offices with prosecutorial authority.[10, 11] 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—i.e., a memorandum of understanding (MOU)—that describes the Unit's relationship with that agency.[12]

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to OIG the authority both to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating them.[13] All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.[14] To receive Federal reimbursement, each Unit must submit an initial application to OIG.[15] OIG reviews the application and notifies the Unit whether it is

[8] OIG, *MFCU Statistical Data for Fiscal Year 2013*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/ on March 10, 2014. Pursuant to 42 CFR § 1007.17, Units report the total amount of recovered funds in their annual reports to OIG. "Recoveries" are defined as the amount of money that defendants are required to pay as a result of a judgment or settlement in criminal and civil cases, and may not reflect actual collections. Recoveries may involve cases that include participation by other Federal and State agencies.

[9] SSA § 1903(q)(1).

[10] *Medicaid Fraud Control Units*, OIG web site. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on March 18, 2014.

[11] 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 activities against fraud, waste, and abuse for the State agency.

[12] SSA § 1903(q)(2) and 42 CFR §§ 1007.5 and 1007.9(d).

[13] 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.

[14] SSA § 1903(a)(6)(B).

[15] 42 CFR § 1007.15(a).

approved and the Unit is certified. Approval and certification are valid for a 1-year period; the Unit must be recertified each year thereafter.[16]

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.[17] 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.[18] Examples of standards include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all three of the professional disciplines (i.e., for auditors, investigators, and attorneys), and establishing policy and procedures manuals to reflect the Unit's operations. See Appendix A for a complete list of the performance standards.[19]

Mississippi Unit

Located in Jackson, the Unit is an autonomous entity within the Mississippi Office of the Attorney General and has the authority to prosecute cases of Medicaid fraud and cases of patient abuse and neglect.[20] The Unit Director serves as the Chief Attorney and directly supervises all Unit attorneys, the Chief Investigator, Unit auditors, and Unit support staff. The Chief Investigator supervises all Unit investigators and the Fraud Supervisor. The Fraud Supervisor shares supervisory duties with the Chief Investigator by directly supervising the Unit investigators who specialize in provider fraud. At the time of our review, 30 of the Unit's employees were located in Jackson, and 1 attorney and 1 investigator were located in Biloxi.

Mississippi State law mandates that any person who "has knowledge of or reasonable cause to believe that any patient or resident of a care facility has been the victim of abuse, neglect or exploitation" must file a report with the Unit.[21] Unit management stated that this reporting requirement leads to an average of 1,900 referrals of patient abuse and neglect from

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[16] 42 CFR § 1007.15(b) and (c).

[17] SSA § 1902(a)(61).

[18] 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at http://oig.hhs.gov on February 11, 2014.

[19] The performance standards referred to in this report were published in 1994 and were in effect during FYs 2011 and 2012, which constitutes most of our review period. In June 2012, OIG published a revision of the performance standards (77 Fed. Reg. 32645, June 1, 2012). Our onsite data collection took place in January 2014. When referring to the performance standards, we refer to the 1994 standards, unless otherwise noted. See Appendix B for a complete list of the revised performance standards.

[20] For the purposes of this report, misappropriation of patients' private funds in residential health care facilities is included in the category of patient abuse and neglect.

[21] MS Code § 43-47-37.

providers to the Unit each year. The Unit also receives referrals of provider fraud from the Mississippi Division of Medicaid, private citizens, and from Federal agencies such as OIG. For additional information on Unit referrals, see Appendix C.

According to the Unit, upon receiving a referral of patient abuse and neglect, the Chief Investigator should review the information and determine whether to refer it to another agency or open it as a case and assign it to an investigator. Fraud referrals should be reviewed by the Unit Director and Fraud Supervisor before being assigned to a team consisting of an investigator, auditor, and attorney. After a referral is accepted for investigation, one of the legal secretaries should open it as a case in the Unit's electronic case tracking system. 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. For additional information on the Unit's opened and closed investigations, including a breakdown by case type and provider category, see Appendix D.

Previous Review

In 2008, while the Mississippi Unit was under the supervision of a previous director, OIG conducted an onsite review of the Unit and identified two concerns related to the MFCU performance standards. The review found that the Unit did "not have standardized MFCU-specific policies and procedures in place governing MFCU activities." The review also noted that supervisory case file reviews were not conducted on a periodic basis. In its response to the review, the Unit stated that it would incorporate MFCU-specific policies and procedures into a written manual. The Unit also noted that it had begun documenting supervisory reviews in the case files since the 2008 onsite review. According to current Unit staff, the staff at that time developed draft policies and procedures that were formally implemented in July 2010 after the current director was hired.

METHODOLOGY

We conducted the onsite review in January 2014. We based our review on an analysis of data from seven sources: (1) a review of Unit documentation, including policies and procedures related to the Unit's operations, staffing, and caseload for FYs 2011 through 2013; (2) a review of financial documentation for FYs 2011 through 2013; (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 a sample of case files that were open at any point during FYs 2011 through 2013; and (7) an onsite review of Unit operations. Appendix E contains a detailed methodology. Appendix F contains the point estimates and 95-percent confidence intervals for the statistics in this report.

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.[22]

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

FINDINGS

From FY 2011 through FY 2013, the Unit reported recoveries of $52 million, 174 convictions, and 37 civil judgments and settlements

From FY 2011 through FY 2013, the Unit reported total criminal and civil recoveries of $52 million—an annual average of $17 million (see Table 1). Of the $52 million in total recoveries, the Unit attributed $16 million to criminal recoveries. The Unit's criminal recoveries were significantly higher in FYs 2012 and 2013 than in FY 2011. The Unit reported that this increase resulted from one case in FY 2012 and one case in FY 2013 that each had significant recoveries. Over the 3-year period, "global" case judgments and settlements accounted for $33 million of the total civil recoveries and global cases accounted for 35 of the Unit's 2,121 cases.[23] The Unit's annual average expenditures for FYs 2011 through 2013 were $2.8 million.[24]

Table 1: Funds Reported Recovered by the Mississippi Unit, FYs 2011 Through 2013

	FY 2011	FY 2012	FY 2013	3-Year Total	Annual Average
Criminal Recoveries	$139,989	$7,241,534	$8,784,328	$16,165,851	$5,388,617
Global Civil Recoveries	$15,044,539	$1,459,454	$16,789,721	$33,293,714	$11,097,905
Nonglobal Civil Recoveries	$6,500	$154,000	$2,234,068	$2,394,568	$798,189
Total Civil Recoveries	$15,051,039	$1,613,454	$19,023,789	$35,688,282	$11,896,094
Total Civil and Criminal Recoveries	**$15,191,028**	**$8,854,988**	**$27,808,117**	**$51,854,133**	**$17,284,711**
Total Expenditures	$2,386,432	$2,802,537	$3,068,990	$8,257959	$2,752,653

Source: OIG review of Unit self-reported quarterly statistical reports and other data, FYs 2011–2013.

[23] Unit-reported recoveries include funds recovered from multi-State, or "global" civil false claims cases, which consist of both those worked directly by the Unit and those worked by staff from other Units.

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

From FY 2011 through FY 2013, the Unit Reported 174 Convictions and 37 Civil Judgments and Settlements. From FY 2011 through FY 2013, the Unit's convictions and civil judgments and settlements remained relatively consistent. During this period, the Unit reported 174 convictions and 37 civil judgments and settlements—an annual average of 58 convictions and 12 civil judgments and settlements (see Table 2). Of the Unit's 174 convictions over the 3-year period, 166 were for patient abuse and neglect cases and 8 were for provider fraud cases.

Table 2: Unit Convictions and Civil Judgments and Settlements, FYs 2011 Through 2013[25]

	FY 2011	FY 2012	FY 2013	3-Year Total	Annual Average
Convictions	52	69	53	174	58
Civil Judgments and Settlements	13	10	14	37	12.3

Source: OIG review of Unit self-reported quarterly statistical reports and other data, FYs 2011-2013.

From FYs 2011 through 2013, the Unit opened an average of 247 cases annually, with an average of 207 cases of patient abuse and neglect and 41 cases of provider fraud. During this time, the Unit closed an average of 463 cases annually, averaging 442 cases of patient abuse and neglect and 21 cases of provider fraud.[26] From FYs 2011 through 2013, the Unit received an average of 1,926 referrals annually, with an average of 1,885 referrals of patient abuse and neglect and 41 referrals of provider fraud.[27]

A Unit supervisor approved the opening and closing of most case files; however, 44 percent of case files lacked documentation of 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 suggests that Unit supervisors are monitoring the intake and resolutions of cases, thereby facilitating progress in the cases. According to Unit management, the Chief Investigator should approve the opening of all cases of patient abuse and neglect, and the Fraud Supervisor should approve the opening of all fraud cases. Unit management also reported

[25] Civil judgments and settlements include those received from global cases.

[26] Closures include multiple cases opened before FY 2011.

[27] The averages in this paragraph are rounded.

that during the review period, supervisory approval to close a case should have been documented in all case files except for cases of patient abuse and neglect that were closed due to court dispositions (for example, convictions). The Unit documented supervisory approval to open cases in 93 percent of the case files; the remaining 7 percent contained no indication of supervisory approval to open the cases. The Unit documented supervisory approval to close cases in 88 percent of the closed case files; the remaining 12 percent contained no indication of supervisory approval to close the cases.

According to Performance Standard 6(c), supervisory reviews should be "conducted periodically and noted in the case file" to ensure timely case completion.[28] According to Unit management, the Chief Investigator meets with each investigator at least three times a year to review all of the investigator's open cases. According to Unit management, each investigator should document these conversations (and any other conversations with Unit management) as supervisory reviews in the case files or electronic case file tracking system. However, 44 percent of Unit case files lacked documentation of periodic supervisory reviews.[29]

The Unit did not adequately safeguard some of its case files

According to Performance Standard 1, a Unit will conform to "all applicable statutes, regulations, and policy transmittals." Pursuant to Federal regulations and OIG policy, a Unit must "prevent the misuse of information under the Unit's control" by safeguarding the privacy rights of witnesses, victims, and informants.[30] A Unit must also safeguard the identities of suspects when the allegations are unsubstantiated, unless such identities are already in the public record or the individuals clearly consented to the release of their private information.[31] In addition, the Unit's policies and procedures manual states that "personnel will at no time leave case material unattended in the public areas of the office."

[28] For the purposes of this report, supervisory approval to open and close a case does not constitute a periodic supervisory review. Periodic supervisory reviews are demonstrated by a supervisor's reviewing a case more than once between the case's opening and closing and documenting those reviews in the case file.

[29] Performance Standard 6(c) does not define "periodically" for the purpose of case file reviews. Because Unit practice is to conduct supervisory reviews three times a year, we excluded case files that were open for less than 1 year.

[30] 42 CFR § 1007.11(f); *OIG State Fraud Policy Transmittal 99-02, Public Disclosure Requests and Safeguarding of Privacy Rights* (December 22, 1999).

[31] Ibid.

However, we observed that some Unit case file boxes labeled with personally identifiable information were stored unlocked in public areas of the office. Although individuals must use a coded access card to enter the public areas of the Unit's office, non-Unit staff share this office space, and other non-Unit personnel (such as cleaning staff and information technology contractors) can gain access to areas where these unlocked case files are located.

The Unit did not investigate 5 percent of cases before the statute of limitations expired

According to Performance Standard 5(a), the Unit should "take steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases." However, five cases in our sample (5 percent) were closed because the Unit did not investigate them before the statute of limitations expired. According to Unit management, these five cases were investigations of patient abuse and neglect that were considered to be lower priority because during their initial review, management determined that the cases were unlikely to have sufficient evidence for investigation and prosecution.[32]

The Unit may not have enough investigators assigned to cases of patient abuse and neglect

According to 2012 Performance Standard 2(c), the Unit should employ "an appropriate mix and number of attorneys, auditors, investigators, and other professional staff… that allows the Unit to effectively investigate and prosecute… an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect." At the time of our review, the Unit had seven investigators specializing in cases of patient abuse and neglect and seven investigators specializing in cases of provider fraud. However, in FY 2013, the Mississippi Unit received the third-highest number among the 50 Units of referrals of patient abuse and neglect and had the highest number of ongoing investigations of patient abuse and neglect.[33] The Unit also had the highest proportion of cases of

[32] Unit management reported that because the Unit has a large caseload of cases of patient abuse and neglect, the Chief Investigator assigns each incoming case a priority level. Any complaints involving the death or sexual assault of a patient are assigned the highest priority.

[33] In the fourth quarter of FY 2013, the Mississippi Unit had 611 ongoing investigations of patient abuse and neglect. California had the second-highest number of such investigations, with 439.

patient abuse and neglect to cases of fraud—89 percent to 11 percent—of the 50 Units.[34]

Members of Unit management and staff reported that Mississippi's mandatory reporting requirement for patient abuse and neglect created large caseloads that may have limited the Unit's ability to effectively investigate all of its cases. Unit management reported that fraud investigators in the Unit each had caseloads of between 8 and 15 cases, whereas the Unit's investigators of patient abuse and neglect each had caseloads of between 60 and 80 cases. Unit management reported that the ideal caseload would be 50 or fewer cases per investigator of patient abuse and neglect. According to one staff member, "[W]ith around 1,800 neglect/abuse and exploitation complaints fielded annually… the number of investigators is inadequate to handle the caseload." Another staff member reported that "the number of cases opened by our Unit seems to increase each year… I feel that our unit could use more manpower to handle the increased volume of cases."

Unit management reported that the Unit is trying to get the caseload for each investigator of patient abuse and neglect down to a "manageable level." Management reported that as part of this effort, the Unit implemented a new intake procedure that screens potential cases of patient abuse and neglect for sufficiency of evidence and consistency with the Unit's statutory functions. Management also reported that they have made an effort to close out unsubstantiated cases and have begun assigning teams of investigators to work on complex and/or high-priority cases. For example, the Chief Investigator may ask all Unit investigators to conduct interviews for a single case of fraud or of patient abuse and neglect to ensure that it is completed in a timely manner.

The Unit did not refer 11 sentenced individuals to OIG for program exclusion within an appropriate timeframe

According to Performance Standard 8(d), when a convicted individual 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, 36]

[34] In the fourth quarter of FY 2013, Alabama had the second-highest proportion of cases of patient abuse and neglect to cases of fraud—63 percent to 37 percent.

[35] Pursuant to section 1128(a) of the SSA, 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.

The Unit reported 174 total convictions within the review period, but did not refer 11 of those sentenced individuals to OIG for program exclusion within an appropriate timeframe. Each of these 11 individuals had been sentenced at least 4 months prior to our onsite review. However, they were referred to OIG more than 60 days after their sentencing dates, including two individuals who were referred more than 180 days after their sentencing dates.

The Unit's policies and procedures manual did not reflect current Unit operations

According to 2012 Performance Standard 3(a), the Unit should have written guidelines or manuals that contain current policies and procedures for its operations that are consistent with the performance standards. The Unit's policies and procedures manual was finalized approximately 3 years prior to our onsite review, and management reported that the manual is continually updated. However, the manual did not address procedures for supervisory approval to open and close cases or for documenting periodic supervisory reviews in the Unit's case files.

[36] According to 2012 Performance Standard 8(f), all referrals for exclusion should be transmitted to OIG "within 30 days." Unlike its 1994 counterpart, the 2012 standard does not include an additional option for transmitting such referrals within an unspecified "other reasonable time period."

CONCLUSION AND RECOMMENDATIONS

From FY 2011 through FY 2013, the Unit reported recoveries of $52 million, 174 convictions, and 37 civil judgments and settlements. A Unit supervisor approved the opening and closing of most case files.

Opportunities for Unit improvement exist. Unit case files did not consistently contain documentation of periodic supervisory reviews, and the Unit did not adequately safeguard some of its case files. The Unit did not investigate 5 percent of cases before the statute of limitations expired and may not have enough investigators assigned to patient abuse and neglect cases. In addition, the Unit also did not refer all sentenced individuals to OIG for program exclusion within an appropriate timeframe. Finally, the Unit's policies and procedures manual did not reflect current Unit operations. Other than with regard to case file security, we found no evidence of noncompliance with applicable laws, regulations, or policy transmittals.

We recommend that the Mississippi Unit:

Ensure that supervisors approve the opening and closing of cases and that periodic supervisory reviews are conducted and documented in Unit case files

The Unit should ensure that supervisors are approving the opening and closing of cases and periodically reviewing case files, and these periodic supervisory reviews should be documented in the case files.

Ensure that case files are secure

The Unit should store its case files and other documentation containing personally identifiable information in a locked room or in locked storage cabinets when not in use.

Ensure that all cases are investigated or closed, as appropriate, before the statute of limitations expires

The Unit should establish policies and procedures to track open cases to ensure that they are investigated or closed, as appropriate, before the statute of limitations expires.

Assess the allocation of existing staff levels and take appropriate action

The Unit should assess whether existing staff levels are efficiently allocated between cases of provider fraud and cases of patient abuse and neglect. The Unit should also assess whether existing staff allocations are sufficient to respond to the volume of referrals and to investigate and prosecute the Unit's cases in a timely manner. The Unit should take appropriate action on the

basis of these assessments. For example, if appropriate, the Unit could hire additional staff.

Ensure that letters referring providers for exclusion are submitted to OIG within an appropriate timeframe

The Unit should ensure that letters referring individuals and entities for exclusion are sent within 30 days of defendant sentencing, consistent with Standard 8(f) of the 2012 Performance Standards.

Revise its policies and procedures manual to reflect current Unit operations

The Unit should revise its policies and procedures manual to include current Unit procedures. Specifically, to be consistent with the current performance standards, the Unit should revise its policies and procedures manual to include procedures for supervisory approval to open and close cases and for documenting periodic supervisory reviews in the Unit's case files.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with the six report recommendations.

Regarding the first recommendation, the Unit reported that it has implemented new procedures to ensure that the case files include documentation of supervisory approval to open and close cases and of supervisory reviews.

Regarding the second recommendation, the Unit reported that it will ensure that files are not left unattended in the areas of the office that are open to non-Unit staff.

Regarding the third recommendation, the Unit reported that each case is assigned a priority level upon initial review and that the cases mentioned in the third recommendation did not have sufficient evidence for investigation or prosecution.

Regarding the fourth recommendation, the Unit reported that it has requested additional investigators for FY 2015 and that these investigators will be assigned to cases of patient abuse and neglect.

Regarding the fifth recommendation, the Unit reported that it has implemented new procedures to ensure that all sentenced individuals are reported to OIG within an appropriate timeframe.

Regarding the sixth recommendation, the Unit reported that it is in the process of updating its policies and procedures manual to reflect current operations.

The full text of the Unit's comments is provided in Appendix G.

APPENDIX A

Performance Standards for MFCUs (Units)[37]

1. **A Unit will be in conformance with all applicable statutes, regulations, and policy transmittals.** In meeting this standard, the Unit must meet, but is not limited to, the following requirements:
   a. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.
   b. The Unit must be separate and distinct from the single State Medicaid agency.
   c. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.
   d. The Unit must submit annual reports, with appropriate certifications, on a timely basis.
   e. The Unit must submit quarterly reports on a timely basis.
   f. The Unit must comply with the Americans with Disabilities Act, the Equal Employment opportunity requirements, the Drug Free workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.
2. **A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.** In meeting this standard, the following performance indicators will be considered:
   a. Does the Unit employ the number of staff that was included in the Unit's budget as approved by the Office of Inspector General (OIG)?
   b. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?
   c. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?
   d. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?
3. **A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.** In meeting this standard, the following performance indicators will be considered:

[37] 59 Fed. Reg. 49080 (Sept. 26, 1994). These performance standards were in effect during most of our review period 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 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

Revised 2012 Performance Standards for MFCUs[38]

1. A Unit conforms with all applicable statutes, regulations, and policy directives, including:

a. Section 1903(q) of the Social Security Act, containing the basic requirements for operation of a MFCU;

b. Regulations for operation of a MFCU contained in 42 CFR part 1007;

c. Grant administration requirements at 45 CFR part 92 and Federal cost principles at 2 CFR part 225;

d. OIG policy transmittals as maintained on the OIG Web site; and

e. Terms and conditions of the notice of the grant award.

2. A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.

a. The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.

b. The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.

c. The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.

d. The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.

e. To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately

[38] 77 Fed. Reg. 32645 (June 1, 2012).

staffed, commensurate with the volume of case referrals and workload for each location.

3. **A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.**

   a. The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.

   b. The Unit adheres to current policies and procedures in its operations.

   c. Procedures include a process for referring cases, when appropriate, to Federal and State agencies. Referrals to State agencies, including the State Medicaid agency, should identify whether further investigation or other administrative action is warranted, such as the collection of overpayments or suspension of payments.

   d. Written guidelines and manuals are readily available to all Unit staff, either online or in hard copy.

   e. Policies and procedures address training standards for Unit employees.

4. **A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.**

   a. The Unit takes steps, such as the development of operational protocols, to ensure that the State Medicaid agency, managed care organizations, and other agencies refer to the Unit all suspected provider fraud cases. Consistent with 42 CFR 1007.9(g), the Unit provides timely written notice to the State Medicaid agency when referred cases are accepted or declined for investigation.

   b. The Unit provides periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.

   c. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).

d. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.

e. The Unit provides timely information, when requested, to those agencies identified in (D) above regarding the status of referrals.

f. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.

5. A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.

a. Each stage of an investigation and prosecution is completed in an appropriate timeframe.

b. Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.

c. Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.

6. A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

a. The Unit seeks to have a mix of cases from all significant provider types in the State.

b. For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.

c. The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.

d. As part of its case mix, the Unit maintains a balance of fraud and patient abuse and neglect cases for those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases.

e. As part of its case mix, the Unit seeks to maintain, consistent with its legal authorities, a balance of criminal and civil fraud cases.

7. A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.

a. Reviews by supervisors are conducted periodically, consistent with MFCU policies and procedures, and are noted in the case file.

b. Case files include all relevant facts and information and justify the opening and closing of the cases.

c. Significant documents, such as charging documents and settlement agreements, are included in the file.

d. Interview summaries are written promptly, as defined by the Unit's policies and procedures.

e. The Unit has an information management system that manages and tracks case information from initiation to resolution.

f. The Unit has an information management system that allows for the monitoring and reporting of case information, including the following:

1. The number of cases opened and closed and the reason that cases are closed.

2. The length of time taken to determine whether to open a case referred by the State Medicaid agency or other referring source.

3. The number, age, and types of cases in the Unit's inventory/docket.

4. The number of referrals received by the Unit and the number of referrals by the Unit to other agencies.

5. The dollar amount of overpayments identified.

6. The number of cases criminally prosecuted by the Unit or referred to others for prosecution, the number of individuals or entities charged, and the number of pending prosecutions.

7. The number of criminal convictions and the number of civil judgments.

8. The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of

recoveries and the types of relief obtained through civil judgments or prefiling settlements.

8. A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.

a. The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.

b. The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, cases involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.

c. The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.

d. For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.

e. For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.

f. The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.

g. The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.

9. A Unit makes statutory or programmatic recommendations, when warranted, to the State government.

a. The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.

b. The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.

10. A Unit periodically reviews its Memorandum of Understanding (MOU) with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.

a. The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.

b. The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR 455.23, "Suspension of payments in cases of fraud."

c. The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).

d. Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.

e. The MOU incorporates by reference the CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit.

11. A Unit exercises proper fiscal control over Unit resources.

a. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.

b. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.

c. The Unit maintains an effective time and attendance system and personnel activity records.

d. The Unit applies generally accepted accounting principles in its control of Unit funding.

e. The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.

12. A Unit conducts training that aids in the mission of the Unit.

a. The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.

b. The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.

c. Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.

d. The Unit participates in MFCU related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.

e. The Unit participates in cross training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

APPENDIX C

Referrals of Provider Fraud and Patient Abuse and Neglect to the Mississippi MFCU by Source, FYs 2011 Through 2013

Table C-1: Total MFCU Referrals of Fraud and Abuse and Annual Average

Case Type	FY 2011	FY 2012	FY 2013	3-Year Total	Annual Average*
Patient Abuse and Neglect	1,930	1,806	1,920	**5,656**	**1,885**
Provider Fraud	49	32	42	**123**	**41**
Total	**1,979**	**1,838**	**1,962**	**5,779**	**1,926**

Source: Unit response to OIG data request.

*Averages in this table are rounded.

Table C-2: MFCU Referrals, by Referral Source

	FY 2011		FY 2012		FY 2013			
Referral Source	**Fraud**	**Abuse and Neglect**	**Fraud**	**Abuse and Neglect**	**Fraud**	**Abuse and Neglect**	**Total**	**Percentage of All Referrals***
Providers	5	1,929	1	1,806	4	1,920	**5,665**	98.0%
Private Citizens	14	1	14	0	9	0	**38**	0.7%
Other	13	0	5	0	16	0	**34**	0.6%
Medicaid Agency – SUR/S[39]	7	0	4	0	12	0	**23**	0.4%
Law Enforcement	4	0	3	0	0	0	**7**	0.1%
Licensing Board	3	0	1	0	1	0	**5**	0.1%
OIG	2	0	3	0	0	0	**5**	0.1%
State Survey and Certification	0	0	1	0	0	0	**1**	0.0%
Prosecutors	1	0	0	0	0	0	**1**	0.0%
Total	49	1,930	32	1,806	42	1,920	**5,779**	100%
Annual Total		**1,979**		**1,838**		**1,962**		
Annual Average*						**1,926**		

Source: Unit response to OIG data request.

*These figures are rounded.

[39] SUR/S refers to the Surveillance and Utilization Review Subsystem division of the State Medicaid agency.

APPENDIX D

Investigations Opened and Closed by the Mississippi MFCU, by Provider Category and Case Type, FYs 2011 Through 2013

Table D-1: Total Annual Opened and Closed Investigations

Case Type	FY 2011	FY 2012	FY 2013	3-Year Total	Annual Average*
Opened	175	223	344	742	247
Patient Abuse and Neglect	126	184	310	620	207
Provider Fraud	49	39	34	122	41
Closed	344	433	614	1,389	463
Patient Abuse and Neglect	320	416	589	1,325	442
Provider Fraud	22	17	25	64	21

Source: Unit response to OIG data request.

*Averages in this column are rounded.

Table D-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2011		FY 2012		FY 2013	
	Opened	Closed	Opened	Closed	Opened	Closed
Home Health Aides	0	0	1	2	1	86
Nondirect Care	2	14	1	8	0	9
Nurses/Doctors' Assistants	48	87	94	131	112	253
Nursing Facilities	12	70	17	113	26	111
Other Long-Term Care Facilities	15	40	24	68	22	64
Other	49	109	47	94	40	66
Total	**126**	**320**	**184**	**416**	**201**	**589**

Source: Unit response to OIG data request.

Table D-3: Provider Fraud Investigations

Provider Category	FY 2011		FY 2012		FY 2013	
Facilities	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Hospitals	1	0	2	0	1	1
Other Facilities	2	3	0	0	7	0
Subtotal	**3**	**3**	**2**	**0**	**8**	**1**
Practitioners	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Counselors/ Psychologists	5	0	2	2	2	0
Dentists	2	1	4	2	3	3
Doctors of Medicine or Osteopathy	9	0	5	1	2	3
Optometrists/Opticians	1	0	0	0	1	0
Podiatrists	0	0	0	0	1	1
Subtotal	**17**	**1**	**11**	**5**	**9**	**7**
Medical Support	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Durable Medical Equipment Suppliers	3	0	4	0	0	0
Home Health Care Agencies	2	0	1	0	0	1
Home Health Care Aides	5	3	0	4	3	0
Nurses/Doctors' Assistants	2	2	2	0	2	3
Pharmaceutical Manufacturers	12	12	9	8	9	10
Pharmacies	0	0	2	0	1	1
Transportation Services	0	1	0	0	0	0
Other Medical Support	5	0	7	0	2	1
Subtotal	**29**	**18**	**25**	**12**	**17**	**16**
Program Related	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Billing Company	0	0	1	0	0	1
Subtotal	**0**	**0**	**1**	**0**	**0**	**1**
Total	**49**	**22**	**39**	**17**	**34**	**25**

Source: Unit response to OIG data request.

APPENDIX E

Methodology

We analyzed data from 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/or policy transmittals.[40] In addition, we noted practices that appeared to benefit the Unit. We based these observations on statements from Unit staff and an analysis of collected data.

Data Collection and Analysis

Review of Unit Documentation. We collected and reviewed (1) Unit documentation, including policies and procedures related to the Unit's operations, staffing, and cases; (2) the Unit's annual reports and quarterly statistical reports; and (3) the Unit's responses to recertification questionnaires. The documentation also included data such as the number of referrals received by the Unit and the number of investigations opened and closed. We reviewed the documentation to determine how the Unit investigates and prosecutes Medicaid cases. Additionally, we confirmed with the Unit Director that the documentation we had was current at the time of our review and requested any additional data or clarification, as needed. The data we collected from the Unit was current as of January 27, 2014. Subsequent changes to the data would therefore not be included in our analyses.

Review of Financial Documentation. We reviewed Unit financial practices to determine compliance with applicable laws and regulations and to determine the need for additional internal controls. Prior to the onsite review, we reviewed the Unit's financial policies and procedures; its response to an internal control questionnaire; and MFCU grant-related documents, such as financial status reports. During the onsite review, we reviewed a sample of the Unit's purchase and travel transactions. In addition, we reviewed vehicle records, the equipment inventory, and a sample of time and effort records.

Structured Interviews With Key Stakeholders. We conducted structured interviews with six individual stakeholders among five agencies who were familiar with Unit operations. Specifically, we interviewed the Mississippi Division of Medicaid's Bureau of Program Integrity Director, two Assistant U.S. Attorneys, a Mississippi Deputy Attorney General,[41] an

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

[41] The Deputy Attorney General supervises the Unit Director.

OIG Special Agent based in Mississippi, and an FBI Special Agent. 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 online survey of Unit staff.[42] We requested responses from 30 staff members and received responses from 29 staff members, a 97–percent response rate. Our questions focused on Unit operations, 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.

Structured Interviews With Unit Management and Selected Staff. We conducted structured interviews with the Unit's Director, Chief Investigator, Fraud Supervisor, and Analyst. We asked them to provide us with additional information to help us 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 to clarify information obtained from other data sources.

Onsite Review of Case Files. We selected a simple random sample of 100 case files from the 2,086 cases[43] that were open at any point from FY 2011 through FY 2013. The design of this sample allowed us to estimate the percentage of all 2,086 cases with various characteristics 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 the 100 case files in the initial sample, we selected another simple random sample of 50 files for a more comprehensive review to identify any potential issues from a qualitative perspective. We consulted Unit staff to address any apparent issues with individual case files, such as missing documentation.

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

[42] We did not survey the Unit Director or Chief Investigator.

[43] This figure includes cases opened before FY 2011 that remained open at some point during FYs 2011–2013. This figure does not include 35 multi-State ("global") civil false-claims cases, which consist of both those worked directly by the Unit and those worked by staff from the Federal government or other Units. For the purposes of our case file review, the Unit's global cases were not included as part of the Unit's case file population. Including global cases, the total number of Unit cases open during the review period was 2,121.

checked to ensure that the Unit referred sentenced individuals to OIG for program exclusion and that the Unit reported adverse actions to the National Practitioner Data Bank (NPDB).[44, 45]

[44] The NPDB was established by the Department of Health and Human Services as "a national health care fraud and abuse data collection program … for the reporting of certain final adverse actions … against health care providers, suppliers, or practitioners." SSA § 1128E(a) and 45 CFR § 61.1(2012). This portion of the NDPB used to be a separate databank called the Healthcare Integrity and Protection Databank (HIPDB). The HIPDB and the NPDB were merged into one databank in May 2013. 78 Fed. Reg. 20473 (April 5, 2013).

[45] Examples of adverse actions include criminal convictions; civil judgments (but not civil settlements); exclusions; and other negative actions or findings, including "any action or finding that under the State's law is publicly available information, and rendered by a licensing or certification authority, including but not limited to, limitations on the scope of practice, liquidations, injunctions and forfeitures." SSA § 1128E(g)(1) and 45 CFR § 61.3 (2012). We reviewed the reporting of adverse actions under HIPDB requirements because the HIPDB and the NPDB had not yet been merged during the period of our review (FYs 2010 through 2012). Current Unit requirements for reporting to the merged NPDB are in 45 CFR pt. 60.

APPENDIX F

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

Table F-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 2,086 nonglobal case files from the results of our review of the case files selected in our simple random samples. Table F-2 includes the estimate descriptions, sample sizes, point estimates, and 95-percent confidence intervals for these four estimates.

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

Case Type	Population Count and (%) n=2,086	Sample Count* and (%) n=100	Sample Count* and (%) n=50
Closed	1,491 (71%)	73 (73%)	33 (66%)
Open	595 (29%)	27 (27%)	17 (34%)
Civil (Nonglobal)	6 (0%)	1 (1%)	0 (0%)
Criminal	2,080 (100%)	99 (99%)	50 (100%)
Patient Abuse/Neglect	1,979 (95%)	97 (97%)	50 (100%)
Provider Fraud (Nonglobal)	107 (5%)	3 (3%)	0 (0%)

Source: The Mississippi Unit provided a list of all case files open during FYs 2011 through 2013.

* OIG generated this random sample.

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

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Case Files With No Documented Supervisory Approval for Opening	100	7%	2.9–13.8%
Case Files With No Documented Supervisory Approval for Closing	78	11.5%	5.5–20.6%
Case Files With No Documentation of Periodic Supervisory Reviews	100	44%	34.3–54.1%
Cases That Were Not Investigated Before the Statute of Limitations Expired	100	5%	1.7–11.1%

APPENDIX G

Unit Comments

STATE OF MISSISSIPPI

JIM HOOD
ATTORNEY GENERAL

June 20, 2014

Brian P. Ritchie
Acting Deputy Inspector General for Evaluation and Inspections
Office of Inspector General
Department of Health & Human Services
Washington, DC 20201

Re: *Mississippi State Medicaid Fraud Control Unit: 2014 Onsite Review, OEI-09-13-00700*

Dear Mr. Ritchie:

We are in receipt of your letter dated May 21, 2014, enclosing the *Mississippi State Medicaid Fraud Control: Unit 2014 Onsite Review, OEI-09-13-00700*. We commend the team for the professionalism exhibited during the onsite review; the team conducted the review with integrity, respect, and courtesy with minimal disruption to the daily operations of the Unit.

We appreciate the opportunity to respond to the report from the onsite review. Below you will find the recommendations followed by our responses.

Recommendation 1. Ensure that supervisors approve the opening and closing of cases and that periodic supervisory reviews are conducted and documented in Unit case files.

Response: We concur with both recommendations. In order to ensure proper documentation of the opening and closing of cases and supervisory reviews, the Unit has implemented new procedures to ensure that these events are accurately documented.

Recommendation 2. Ensure that case files are secure.

Response: We concur with this recommendation. We will ensure that any files in question are not left unattended in the public areas of the office; however, please note that the Unit's files are on a secure floor. We are also considering redistribution of office space and access to the Unit's area.

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Recommendation 3. Ensure that all cases are investigated or closed, as appropriate, before the statute of limitations expires.

Response: We concur with this recommendation. Upon initial review, each case is assigned a priority level. However, I would like to point out that the cases mentioned in the review did not have sufficient evidence for investigation and prosecution; therefore, the cases were not pursued and were not closed until after the statute of limitations.

Recommendation 4. Assess the allocation of existing staff levels

Response: We concur with this recommendation. We have requested additional investigators for the next fiscal year. These investigators will be assigned to abuse, neglect, and exploitation cases.

Recommendation 5. Ensure that it refers all sentenced individuals for exclusion to OIG within an appropriate time frame.

Response: We concur with this recommendation. The Unit has implemented new procedures to ensure that all sentenced individuals are reported within an appropriate time frame.

Recommendation 6. Revise its policies and procedures manual to reflect current operations

Response: We concur with this recommendation. The Unit is in the process of updating the policies and procedures manual to reflect current operations and to reflect the implementation of the recommendations from the on-site review.

The Mississippi MFCU would again like to express our appreciation of the review team and their professionalism exhibited during the review process. We also appreciate the opportunity to discuss and respond to this report. We look forward to continue to work with you to continue to combat fraud in healthcare programs.

Sincerely

/S/

Treasure R. Tyson
Special Assistant Attorney General
Medicaid Fraud Control Unit Director

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.

Rosemary Rawlins served as the lead analyst for this study. Other Office of Evaluation and Inspections staff who provided support from the San Francisco regional office include Matthew DeFraga. Central office staff who provided support include Susan Burbach, Kevin Farber, Christine Moritz, Andrew VanLandingham, and Sherri Weinstein. Office of Investigations staff who provided support include Ian Ives.

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