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Idaho Medicaid Fraud Control Unit: 2018 Onsite Inspection

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What OIG Found

The Idaho Medicaid Fraud Control Unit (MFCU or Unit) reported 13 indictments, 11 convictions, 28 civil settlements and judgments, and nearly $5.3 million in recoveries for fiscal years (FYs) 2015–2017. From the information we reviewed, we found that the Unit operated in accordance with applicable laws, regulations, and policy transmittals. However, we made three findings involving the Unit's adherence to the MFCU performance standards.

1. Although the Unit established a more frequent and robust practice for conducting periodic supervisory review of case files, it had not updated its policies and procedures manual to reflect the updated practices.

2. Some of the Unit's cases had significant unexplained investigative delays.

3. Nearly a quarter of case files lacked documentation of periodic supervisory review.

Unit Case Outcomes

FYs 2015–2017

- 13 indictments
- 11 convictions
- 28 civil settlements and judgments
- $5.3 million in recoveries

Unit Snapshot

The Unit is part of the Office of Attorney General's Criminal Law Division

9 MFCU staff—2 attorneys, 4 investigators, 1 auditor, and 2 support staff—located in Boise

Unit was founded in 2007

In addition to the findings, we made a number of observations regarding Unit operations and practices, including two observations about barriers to pursuing certain cases as well as a beneficial practice that may be of interest to other MFCUs.

- The Unit reported barriers that limited its ability to investigate and prosecute cases of patient abuse or neglect, including the Idaho statute's definition of vulnerable adults.

- The Unit reported that Idaho's civil recovery statute limited its ability to pursue civil cases.

- In addition to reporting its own convictions to OIG, the Unit reported convictions of patient abuse or neglect obtained by local authorities for possible program exclusion.

What OIG Recommends and How the Unit Responded

To address the three findings, we recommend that the Unit: (1) update its policies and procedures manual to reflect current Unit practices for periodic supervisory case file review; (2) take steps to ensure that investigation delays are limited to situations imposed by resource constraints or other exigencies and that delays are documented in the case management system; and (3) ensure that the case management system includes documentation of supervisory oversight. The Unit concurred with all three recommendations.

Full report can be found at oig.hhs.gov/oei/reports/oei-12-18-00320.asp

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BACKGROUND

Objective

To examine the performance and operations of the Idaho Medicaid Fraud Control Unit

Medicaid Fraud Control Units

Medicaid Fraud Control Units (MFCUs or Units) investigate (1) Medicaid provider fraud and (2) patient abuse or neglect in facility settings, and prosecute those cases under State law or refer them to other prosecuting offices.[1, 2] Under the Social Security Act (SSA), a MFCU must be a "single, identifiable entity" of State government, "separate and distinct" from the State Medicaid agency, and employ one or more investigators, attorneys, and auditors.[3] Each State must operate a MFCU or receive a waiver.[4] Currently, 49 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate MFCUs.[5] Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.[6] In Federal fiscal year (FY) 2018, combined Federal and State expenditures for the Units totaled approximately $294 million.[7]

[1] SSA § 1903(q)(3). Regulations at 42 CFR § 1007.11(b)(1) clarify that a Unit's responsibilities include the review of complaints of misappropriation of patients' private funds in health care facilities.

[2] References to "State" in this report refer to the States, the District of Columbia, and the U.S. territories.

[3] SSA § 1903(q).

[4] SSA § 1902(a)(61).

[5] North Dakota and the territories of American Samoa, Guam, and the Northern Marianas Islands have not established Units.

[6] SSA § 1903(a)(6). For a Unit's first 3 years of operation, the Federal government contributes 90 percent of funding and the State contributes 10 percent. Thereafter, the Federal government contributes 75 percent and the State contributes 25 percent.

[7] OIG analysis of MFCU annual statistical reporting data for FY 2018. The Federal FY 2018 was from October 1, 2017 through September 30, 2018.

OIG Grant Administration and Oversight of MFCUs

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.[8, 9] As part of its oversight, OIG reviews and recertifies each Unit annually and conducts periodic onsite reviews or inspections, such as this inspection.

In its recertification review, OIG examines the Unit's reapplication, case statistics, and questionnaire responses from Unit stakeholders. Through the recertification review, OIG assesses a Unit's performance, as measured by the Unit's adherence to published performance standards;[10] the Unit's compliance with applicable laws, regulations, and OIG policy transmittals;[11] and the Unit's case outcomes. (See Appendix A for MFCU performance standards, including performance indicators for each standard.)

OIG further assesses Unit performance by conducting onsite Unit reviews that may identify findings and make recommendations for improvement. During an onsite review, OIG also makes observations regarding Unit operations and practices, and may identify beneficial practices that may be useful to share with other Units. Finally, OIG provides training and technical assistance to Units while onsite, as appropriate, and on an ongoing basis.

Idaho MFCU

The Idaho MFCU is located in Boise and is part of the Office of Attorney General's Criminal Law Division. At the time of our July 2018 review, the Unit employed two attorneys (one of whom is the director), four investigators (one of whom is the lead investigator), an investigative auditor, a legal secretary, and an administrative assistant. The lead investigator supervises the investigators, and the Unit director supervises the rest of the staff. During our review period of FYs 2015-2017, the Unit spent $2,508,162, with a State share of $627,017.

Referrals. The Unit receives fraud referrals from a number of sources, including the State Medicaid agency and private citizens. A key source of referrals of patient abuse and neglect is Idaho's survey and certification agency, known as Bureau of Facility Standards (BFS) which is part of the Idaho Department of Health and Welfare (DHW). When the Unit receives a referral, the lead investigator reviews and makes a recommendation to the

[8] As part of grant administration, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal Financial Reports that detail MFCU income and expenditures.

[9] The SSA authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979.

[10] MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012). The performance standards were developed by OIG in conjunction with the MFCUs and were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

[11] OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals are located at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

director. The director decides whether to open or decline an investigation or refer the matter to another agency.

Investigations and Prosecutions. After the Unit opens an investigation, the director assigns an investigator and/or an investigative auditor and an attorney. The assigned investigator or investigative auditor completes a checklist containing anticipated investigative steps. The Unit stores case records—including opening documentation, investigative activity reports, emails, and case closing memoranda requests—in the Unit's case management system. If the assigned attorney determines that charges should be filed, she or he prepares a charging memorandum and provides it to the director. If the director agrees that charges should be filed, he forwards the charging memorandum to the Chief of the Criminal Law Division for approval.

Idaho Medicaid Program

Idaho Department of Health and Welfare, Division of Medicaid. The Idaho Department of Health and Welfare includes the Division of Medicaid. Medicaid participants have access to benefits through different benefit plans, depending on individual health needs. The Idaho Medicaid program relies upon managed care organizations to provide dental services, medical transportation, and outpatient behavioral health, as well as comprehensive managed care for persons dually eligible for Medicaid and Medicare. Enrollment in the Medicaid program averaged 300,838 participants per month during State FY 2017.[12] In Federal FY 2018, total Medicaid expenditures were just over $2.0 billion.[13]

Prior OIG Report

OIG conducted a previous onsite review of the Idaho Unit in 2012.[14] In that review, OIG found that the Unit: (1) lacked adequate safeguards to secure case files; (2) had not updated its policies and procedures manual to reflect current operations; and (3) had not updated its Memorandum of Understanding (MOU) with DHW to reflect current law and practice. OIG recommended that the Unit: (1) ensure that its case files are secure; (2) revise its policies and procedures manual to reflect current Unit operations; and (3) revise its MOU with DHW to reflect current law and practices. In response to the recommendations, the Unit secured its case files, updated its internal policies and procedures, and revised its MOU with DHW.

[12] Idaho Department of Health and Welfare, *Facts, Figures, and Trends: 2017-2018*, pages 81-85. Accessed at https://healthandwelfare.idaho.gov/Portals/0/AboutUs/Publications/FFT2017_2018.pdf on September 28, 2018. The State fiscal year is July 1—June 30.

[13] OIG, *MFCU Statistical Data for FY 2018*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2018-statistical-chart.pdf on April 19, 2019.

[14] Office of Inspector General, *Idaho State Medicaid Fraud Control Unit: 2012 Onsite Review*. Accessed at https://oig.hhs.gov/oei/reports/oei-09-12-00220.asp on June 20, 2019.

Methodology

OIG conducted the onsite inspection of the Idaho MFCU in July 2018. Our review covered the 3-year period of FYs 2015-2017. We based our inspection on an analysis of data and information from seven sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's managers and selected staff; (5) a review of a random sample of 68 case files that were open at some point during the review period; (6) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (7) observation of Unit operations. (See Appendix B for a detailed methodology.) In examining the Unit's operations and performance, we applied the published performance standards in Appendix A, but we did not assess adherence to every performance indicator for every standard.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program, but they are subject to the same internal quality controls as other OIG evaluations, including internal and external peer review.

PERFORMANCE ASSESSMENT

Below are the results of OIG's assessment of the performance and operations of the Idaho Unit. OIG identified the Unit's case outcomes, found that the Unit complied with legal and policy requirements, and, for each of the performance standards, offered either a finding or observation(s), including highlighting a beneficial practice.

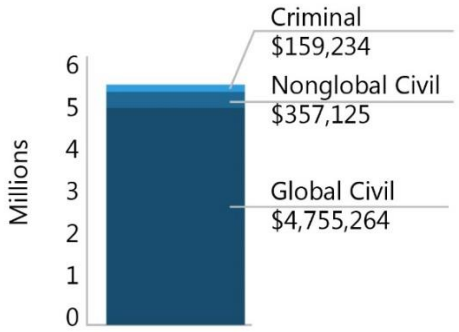
CASE OUTCOMES

Observations

The Unit reported 13 indictments, 11 convictions, and 28 civil settlements and judgments from FYs 2015 through 2017. From the 11 convictions, 9 convictions involved provider fraud and 2 involved patient abuse or neglect.

The Unit reported total recoveries of nearly $5.3 million from FYs 2015 through 2017. (See Exhibit 1 for the sources of those recoveries.)

Exhibit 1: The Unit reported combined civil and criminal recoveries of nearly $5.3 million (FYs 2015–2017).



Source: OIG analysis of Unit statistical data FYs 2015–2017.

Note: "Global" civil recoveries derive from civil settlements or judgments involving the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

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

Observation

From the information we reviewed, the Idaho Unit complied with applicable laws, regulations, and policy transmittals. We did not identify any legal or compliance concerns related to Unit operations.

STANDARD 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.

Observation

The Unit was fully staffed at the time of our review but had vacancies during the review period. During the review period, the Unit was approved by OIG for nine staff. At the time of our review and during FY 2015, the Unit was staffed in accordance with the staffing allocations approved by OIG. However, the Unit experienced vacancies during FY 2016 (two vacancies) and FY 2017 (one vacancy).

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

Finding

Although the Unit established a more frequent and robust practice for conducting periodic supervisory review of case files, it had not updated its policies and procedures manual to reflect the updated practices. Performance Standard 3(a) states that a Unit have written guidelines or manuals that contain current policies and procedures. The Unit used an Operations Manual for general operations and for investigating cases. We found that the Unit's Operations Manual contained a policy that required a quarterly supervisory review of each investigator's "top 3" cases. However, Unit management reported that, during the review period, the Unit began reviewing *all* cases on a quarterly basis and had phased out reviews of only the "top 3" cases. In addition, the Unit director reported establishing another new practice for conducting supervisory reviews in February 2018 (after the end of the review period). This new practice involved a *monthly* meeting in which all staff (including supervisors) reviewed a case list organized by the age of the case, discussed investigative steps taken in the prior month on each case, and established relative priorities for all cases. The Operations Manual had not been updated to include procedures for conducting and documenting this more frequent and robust review of all

open cases. See also Performance Standard 7 for a related finding on documentation of periodic supervisory reviews (page 10).

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

Observation

The Unit took steps to maintain an adequate volume and quality of referrals, but the total volume of referrals to the Unit dropped during the review period. The Unit director met monthly with the Medicaid agency's program integrity unit director to discuss fraud referrals and provided yearly training to the program integrity unit on the elements of a quality referral. The Unit director also attended a quarterly meeting with the Bureau of Facility Standards chief to discuss potential referrals of patient abuse or neglect. In addition, the Unit conducted regular outreach to local law enforcement, offices of prosecuting attorneys, and provider groups to inform them of the existence of the Unit and its mission. For example, the Unit sent outreach materials to all sheriff's departments and gave a presentation to the Boise State University nursing program.

Notwithstanding these efforts, the total number of fraud referrals to the Unit dropped during the review period. The Unit received similar totals of fraud referrals in FY 2015 (69) and FY 2016 (68), but fraud referrals declined in FY 2017 (50).

The total number of referrals of patient abuse or neglect also declined over the review period, from 20 in FY 2015 to 15 in FY 2016 to 8 in FY 2017, including referrals from the Bureau of Facility Standards, the Unit's primary source of these referrals.

See Appendix C for all sources of fraud and patient abuse or neglect referrals during FYs 2015-2017.

STANDARD 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.

Finding

Some of the Unit's cases had significant unexplained investigative delays. Our review found that 10 percent of investigations had significant delays that were not explained in the case file. Performance Standard 5(c) states that delays in investigation and prosecution should be "limited to situations imposed by resource constraints or other exigencies." Of the 8 (of 68) cases in our sample that had unexplained delays, 4 had delays of approximately 2 years and 3 had delays of at least 1 year.

Observation

All case files contained documentation of supervisory approval to open and close cases, as appropriate. All cases contained documentation of supervisory approval to open them. All of the cases that were closed at the time of our review (68 percent) contained documentation of supervisory approval to close them.

STANDARD 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.

Observations

The Unit investigated many more cases of provider fraud than cases of patient abuse or neglect. Of the 277 cases that were open during our review period, 92 percent (254 cases) involved provider fraud and 8 percent (23 cases) involved patient abuse or neglect. According to Performance Standard 6, the Unit's case mix should cover all significant provider types and include a balance of fraud and patient abuse or neglect cases.

The Unit reported barriers that limited its ability to investigate and prosecute cases of patient abuse or neglect, including the Idaho statute's definition of vulnerable adults. The Unit director reported to us that the Idaho statute's definition of a "vulnerable adult" presented a barrier to its ability to prosecute patient abuse or neglect. Specifically, the Idaho criminal code offense of "Abuse, Exploitation, or Neglect of a Vulnerable Adults" defines a vulnerable adult as an adult "unable to protect himself from abuse, neglect or exploitation due to physical or mental impairment which affects the person's judgment or behavior. . . ."[15] The Unit director stated that because of this definition, the prosecution must prove that a victim has a sufficient level of physical or mental impairment to convict a criminal defendant on a charge of abuse, neglect, or exploitation. The Unit director had drafted a legislative amendment that would permit the MFCU to pursue a charge of abuse, exploitation or neglect without specifically demonstrating that the victim has such a physical or mental impairment. The proposed amendment had not yet been introduced to the Idaho legislature as of April 2019.

Unit management identified a second barrier to investigating cases of patient abuse or neglect that involved the untimely receipt of referrals. The Bureau of Facility Standards, which enforces State and Federal regulations in health care facilities and identifies alleged complaints of patient abuse and

[15] Idaho Code § 18-1505. Accessed at https://legislature.idaho.gov/statutesrules/idstat/Title18/T18CH15/SECT18-1505/ on October 17, 2018.

neglect, has a policy of referring complaints of patient abuse or neglect to local law enforcement and to local prosecutors.[16] While the Bureau of Facility Standards can make concurrent referrals to the Unit, it does not, despite requests from the Unit. It typically notified the Unit about cases six months to a year after making the referral to local law enforcement. In most cases, by the time the Bureau of Facility Standards notified the Unit, local law enforcement had completed most of its investigation and the case had already been reviewed by the local county prosecuting attorney.

In addition to the untimely notice of cases to the MFCU, Unit management reported that the Unit will not get involved in cases handled by local law enforcement unless asked. Nevertheless, Unit management reported that when made aware of cases, even from media sources, the Unit offered assistance to the local agencies whenever possible. The Unit had also begun educating local law enforcement on assistance the Unit could provide on these cases and planned more such outreach.

As a final barrier identified by Unit management, officials in the Office of the Attorney General (OAG) had expressed concerns relating to the practice in Idaho of the State operating most long term care facilities. OAG officials expressed that the Unit's prosecution of some cases of patient abuse or neglect presented a potential conflict of interest since attorneys in other OAG divisions represented the Department of Health and Welfare in these cases. Unit management reported that the OAG is exploring remedies to address the potential conflict.

The Unit reported that Idaho's civil recovery statute limited its ability to pursue civil cases. From FY 2015 to FY 2017, the Unit had just two civil cases open that were not global cases.[17] Performance Standard 6(e) states that as part of its case mix, a Unit seek to maintain, consistent with legal authorities, a balance of criminal and civil fraud cases.

The Unit director reported that Idaho's civil recovery statute required the Unit to prove civil cases with a standard of criminal intent, thus severely limiting the Unit's ability to pursue civil cases.[18] The Unit director had drafted a State civil recovery statute for false Medicaid claims, modeled after

[16] The Unit's explanation for this protocol was that Idaho law provides primary jurisdiction to local law enforcement and prosecutors for all criminal offenses in the State. Idaho Code § 31-2227. Accessed at https://legislature.idaho.gov/statutesrules/idstat/Title31/T31CH22/SECT31-2227/ on February 13, 2019.

[17] Global cases are civil false claims actions that involve the U.S. Department of Justice and a group of State MFCUs. The Idaho MFCU participated in 126 global cases during the review period.

[18] Idaho Code § 56-227B https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-227B/ accessed on December 5, 2018.

the Federal civil False Claims Act.[19] However, this draft legislation had not been introduced to the Idaho legislature as of April 2019.

STANDARD 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.

Finding

Nearly a quarter of case files lacked documentation of periodic supervisory reviews. Performance Standard 7(a) states that supervisory reviews should be conducted periodically, consistent with MFCU policies and procedures, and noted in the case file. As found under Performance Standard 3 (page 6), the Unit's written policy required a quarterly review of each investigator's "top 3" cases, but Unit management reported that during the review period, the Unit began reviewing all cases on a quarterly basis. In our review of the case files, we applied the Unit's practice of reviewing all case files on a quarterly basis. Our review found that 24 percent of case files that were open more than 90 days contained either no documentation of periodic supervisory reviews or contained some documentation, but less than quarterly documentation of supervisory reviews. Specifically, 14 percent of case files contained no documentation of periodic supervisory review. An additional 11 percent of case files contained some documentation of periodic review, but did not reflect the Unit's written policy of quarterly reviews.[20] Of the case files in our sample that had some documentation of supervisory reviews but not of quarterly reviews, gaps between periodic reviews ranged from 8 months to 2 years.

As also found under Performance Standard 3 (page 6), in February 2018, the Unit director established a new practice for supervisory reviews involving a review of the status and priority of all open cases at a monthly Unit staff meeting, using an "aged case list." The Unit director reported that the Unit maintained a record of the monthly meeting which included the "aged case list" with status updates for each case. The Unit first maintained hard copies of the list in binders and then, beginning in May 2018, electronically in a separate file in the Unit's case management system.[21]

Whether quarterly or monthly, periodic supervisory review of cases is important to help ensure the timely completion of cases. Moreover,

[19] 31 U.S.C. §§ 3729–3733

[20] Because of rounding, percentages do not sum precisely. See Appendix D for further details on point estimates.

[21] During our review of case files in July 2018, we did not assess whether the record of this new monthly meeting was documented in the case management system.

documenting those reviews in the case management system is important to ensure that cases are properly managed.

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

Observations

The Unit reported all convictions and adverse actions during the review period to Federal partners within 30 days. Performance Standard 8(f) states that the Unit should transmit information on convictions to OIG within 30 days of sentencing for exclusion from Federal health care programs. The Unit reported all 11 convictions within 30 days. Additionally, Federal regulations require that Units report any adverse actions resulting from investigations or prosecution of healthcare providers to the National Practitioner Data Bank (NPDB) within 30 calendar days of the date of the final adverse action.[22] Performance Standard 8(g) also states that the Unit should report qualifying cases to the NPDB.[23] During our review period, the Unit reported 19 adverse actions; all were reported within 30 days of the qualifying action.

Beneficial Practice

In addition to reporting its own convictions to OIG, the Unit reported convictions of patient abuse or neglect obtained by local authorities for possible program exclusion. The Unit's legal secretary monitored local news sources for convictions of patient abuse or neglect in which the Unit had no involvement in the investigation or prosecution. When the legal secretary identified a conviction, she obtained the police reports and court documents related to the conviction. The Unit director reviewed these documents and court proceedings. Upon approval from the Unit director, the legal secretary submitted the documents to OIG, whereby OIG determined whether it had a basis to exclude the parties from participation in Federal health care programs. Since 2013, seven individuals had been excluded from Federal health care programs because of the Unit's efforts.

[22] 45 CFR § 60.5. Examples of adverse actions include but are not limited to convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(a) and (g)(1).

[23] The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions.

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

Observations

The Unit made recommendations to the Medicaid agency. Performance Standard 9(b) states that the Unit, when warranted and appropriate, make recommendations regarding program integrity issues to the Medicaid agency. The Unit informed DHW of potential program integrity deficiencies identified through the Unit's investigations. For example, during the review period, the Unit sent a letter to DHW with recommendations to improve the definitions and coding of one-on-one services provided to Medicaid beneficiaries by community support workers. In response, DHW reported it will develop policies to address the recommendations. As another example of a Unit recommendation, the Unit proposed amendments to a managed care contract that was under consideration, some of which DHW incorporated into the contract.

Unit management drafted legislative proposals to improve the Unit's effectiveness. Performance Standard 9(a) states that the Unit, when warranted and appropriate, make recommendations to the State legislature to improve the operation of the Unit. The Unit director drafted both a legislative amendment that would expand the definition of vulnerable adults and an amendment to the State civil recovery statute, as also discussed under Performance Standard 6 (pages 8-10). In addition, the Unit director drafted a State anti-kickback statute as well as a State health care fraud statute modeled on the Federal health care fraud statutes. As of April 2019, the four legislative proposals had not yet been introduced to the State legislature.

STANDARD 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.

Observation

The Unit's MOU with the Medicaid agency reflected current practice, policy, and legal requirements. The Office of the Attorney General and the Idaho Department of Health and Welfare had a current MOU, amended on February 20, 2018. The MOU reflected all policy and legal requirements as well as the current practices between the parties.

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

Observation

From our limited review, we identified no deficiencies in the Unit's fiscal control of its resources. From the responses to a detailed fiscal-controls questionnaire and interviews with fiscal staff, we identified no issues related to the Unit's budget process, accounting system, cash management, procurement, electronic data security, property, or personnel. In our inventory review, we located 30 of the 30 sampled inventory items.

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

Observation

The Unit's training plan included an in-house training program. The Unit had a training plan for attorneys, investigators, and auditors, pursuant to Performance Standard 12(a), which states that the Unit maintain a training plan that includes an annual minimum number of training hours and is at least as stringent as required for professional certification. As part of basic training, the Unit offered an in-house orientation program that addressed a variety of topics, including a Medicaid overview, MFCU jurisdiction and venue, the MFCU Operations Manual, the case management system, patient abuse and neglect investigations, Medicaid managed care, and Medicaid information systems. In addition, the in-house orientation program included the shadowing of a Unit professional staff member for up to a year.

CONCLUSION AND RECOMMENDATIONS

From the information we reviewed, we found that the Idaho Unit complied with applicable legal requirements and generally adhered to performance standards, but we identified three areas in which the Unit should improve its adherence to standards. We found that although the Unit established a more frequent and robust practice for conducting periodic supervisory review of case files, it had not updated its policies and procedures manual to reflect the updated practices. We also found that nearly one quarter of case files did not contain documented periodic supervisory review. We also found that some of the Unit's cases had significant unexplained investigative delays.

Additionally, the Unit reported barriers that limited its ability to investigate and prosecute cases of patient abuse or neglect and civil cases. OIG encourages and supports the Unit's efforts to remove any barriers that prevent the Unit from investigating and prosecuting all cases within their authority, as appropriate. The Unit drafted amendments to provisions of the Idaho code that may warrant consideration for introduction to the Idaho Legislature.

To address the three findings, we recommend that the Idaho Unit:

Update its policies and procedures manual to reflect current Unit practices for periodic supervisory case file review

The Unit should update its Operations Manual to include its current procedures for periodic supervisory reviews that involve a monthly review of all cases during a staff meeting and for documenting these reviews in the Unit's case management system.

Take steps to ensure that investigation delays are limited to situations imposed by resource constraints or other exigencies and that delays are documented in the case management system

Except for delays imposed by resource constraints or other exigencies, the Unit should avoid extended delays to investigations. To demonstrate that extended delays were imposed by resource constraints or other exigencies, the Unit should document such occurrences in the case management system.

Ensure that the case management system includes documentation of supervisory oversight

After the Unit revises its Operations Manual to include procedures for documenting periodic supervisory review (as recommended in the first recommendation), the Unit should take steps to ensure that periodic

supervisory reviews of cases are consistently documented in the case management system. This may include a master listing, such as the Unit's "aged case list," that includes such information, as long as that list is readily accessible in the case management system.

UNIT COMMENTS AND OIG RESPONSE

The Idaho Unit concurred with all three of our recommendations.

First, the Unit concurred with our recommendation to update its policies and procedures manual to reflect current Unit practices for periodic supervisory case file review. The Unit stated that it will update its Operations Manual with procedures for its monthly meeting during which all Unit staff, including the Unit director and investigations supervisor, review all individual cases. The Unit also explained that it will update its Operations Manual to include a procedure for saving the "aged case list," which serves as the "documentary product of [the] . . . monthly reviews," in the case management system.

Second, the Unit concurred with our recommendation to take steps to ensure that investigation delays are limited to situations imposed by resource constraints or other exigencies and that delays are documented in the case management system. The Unit stated its belief that this objective is now being addressed with the monthly review process (introduced after the review period) and is documented on the "aged case list," which includes recent investigative steps, the level of investigative activity, as well as reasons for any delays in case progression. We will assess the adequacy of these steps to limit investigative delays in our follow-up to the recommendation.

Finally, the Unit concurred with our recommendation to ensure that the case management system includes documentation of supervisory oversight. As stated in response to our first recommendation, the Unit will document its monthly review of cases by retaining the "aged case list" in the case management system. We will assess the accessibility of this list in the case management system in our follow-up to the recommendation.

For the full text of the Unit's comments, see Appendix E.

APPENDIX A: MFCU Performance Standards[24]

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; [25]
D) OIG policy transmittals as maintained on the OIG website; 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 Unite employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
D) The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
E) To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.

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

A) The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.
B) The Unit adheres to current policies and procedures in its operations.
C) Procedures include a process for referring cases, when appropriate, to Federal and State agencies. Referrals to State agencies, including the State

[24] 77 Fed. Reg. 32645 (June 1, 2012).

[25] For FYs 2016 and later, grant administration requirements are found at 45 CFR pt. 75.

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 providers 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, case 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 B: Detailed Methodology

Data Collection and Analysis

We collected and analyzed data from the seven sources below to identify any opportunities for improvement and instances in which the Unit did not adhere to the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.[26] We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards.

Review of Unit Documentation. Prior to the onsite inspection, we reviewed the recertification analysis for FYs 2015–2017, which involved examining the Unit's recertification materials, including (1) the annual reports, (2) the Unit Director's recertification questionnaires, (3) the Unit's memorandum of understanding with the State Medicaid agency, (4) the Program Integrity Director's questionnaires, and (5) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for FYs 2015–2017. We examined the recommendations from the 2012 OIG onsite review report and the Unit's implementation of those recommendations.

Review of Unit Financial Documentation. We conducted a limited review of the Unit's control over its fiscal resources. Prior to the onsite review, we analyzed the Unit's response to an internal controls questionnaire and conducted a desk review of the Unit's financial status reports. While onsite, we followed up with Office of Attorney General and Unit officials to clarify issues identified in the internal controls questionnaire. We also selected a purposive sample of 30 items from the list of current inventory list of 116 items maintained in the Unit's office and verified those items onsite.

Interviews With Key Stakeholders. In June 2018, we interviewed key stakeholders, including officials in the Idaho Department of Health and Welfare, the Idaho Bureau of Facility Standards, and the U.S. Attorney's Office. We also interviewed the agents from OIG's Office of Investigations who work regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with the stakeholders as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management and staff.

[26] All relevant regulations, statutes, and policy transmittals are available online at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

Onsite Interviews With Unit Management and Selected Staff. We conducted structured onsite interviews with the Unit's management and selected staff in July 2018. We interviewed the Unit director, the attorney, the lead investigator, the auditor, one current and one former Unit investigator, and the legal secretary. In addition, we interviewed the supervisors of the Unit—the section chief and the division chief of the Criminal Division. We asked these individuals questions related to (1) Unit operations, (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance, (3) opportunities for the Unit to improve its operations and/or performance, (4) clarification regarding information obtained from other data sources, and (5) the Unit's training and technical assistance needs.

Onsite Review of Case Files. To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2015 through 2017 and to include the status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened and closed, if applicable. The total number of cases was 277.

We excluded all global cases from our review of the Unit's case files because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs. We excluded 126 global cases, leaving 151 case files.

We then selected a simple random sample of 68 cases from the population of 151 cases. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with an absolute precision of +/- 10 percent at the 95-percent confidence level. We reviewed the 68 case files for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals. During the onsite review of the sampled cases, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

Review of Unit Submissions to OIG and NPDB. We also reviewed all convictions submitted to OIG for program exclusion during the review period (11), and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period (19). We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and all adverse actions to the NPDB for FYs 2015–2017. We also assessed the timeliness of the submissions to OIG and the NPDB.

Onsite Review of Unit Operations. During the onsite inspection, we observed the Unit's workspace and operations of the Unit's office in Boise. We observed the Unit's offices and meeting spaces; security of data and case files; location of select equipment; and the general functioning of the Unit.

APPENDIX C: Unit Referrals by Source for Fiscal Years 2015 Through 2017

	FY 2015		FY 2016		FY 2017		Grand Totals	
Referral Source	**Fraud**	**Abuse or Neglect**	**Fraud**	**Abuse or Neglect**	**Fraud**	**Abuse or Neglect**	**Fraud**	**Abuse or Neglect**
Adult protective services	0	0	0	2	0	0	0	2
Anonymous	4	1	4	0	2	0	10	1
HHS-OIG	0	1	1	0	2	2	3	3
Law enforcement—other	0	3	0	1	0	1	0	5
Licensing board	0	0	1	0	0	0	1	0
Local prosecutor	1	0	0	0	0	0	1	0
Long-term-care ombudsman	0	0	0	1	0	0	0	1
Medicaid agency—PI/SURS[1]	4	0	18	0	6	0	28	0
Medicaid agency—other	0	0	2	0	0	0	2	0
Private citizen	24	2	12	5	13	0	49	7
Private health insurer	0	0	0	0	1	0	1	0
Provider	6	2	1	0	4	0	11	2
State agency—other	0	0	3	0	1	0	4	0
State survey and certification agency (Bureau of Facility Standards—BFS)	1	11	0	6	0	5	1	22
Other[2]	29	0	26	0	21	0	76	0
Total	**69**	**20**	**68**	**15**	**50**	**8**	**187**	**43**
Annual Total	**89**		**83**		**58**		**230**	

Source: OIG analysis of Unit Annual Statistical Reports, FYs 2015-2017.

[1] The abbreviation "PI" stands for program integrity; the abbreviation "SURS" stands for Surveillance and Utilization Review Subsystem.

[2] Most "Other" referrals (64 of 76) are global cases from the National Association of Medicaid Fraud Control Units.

APPENDIX D: Point Estimates and 95-Percent Confidence Intervals of Case File Reviews

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases with Investigative Delays	68	10.3%	5.3%	17.9%
Percentage Of All Cases Closed At The Time Of Our Review	68	67.6%	57.6%	76.2%
Percentage of All Cases That Had Supervisory Approval To Open	68	100%	95.4%	100%
Percentage of All Closed Cases That Had Supervisory Approval To Close	46	100%	94.1%	100%
Percentage of All Cases Opened Longer Than 90 Days	68	97.1%	91.4%	98.7%
Percentage of All Case Files Opened Longer Than 90 Days and Lacked Periodic Supervisory Review	66	24.2%	16.3%	34.0%
Percentage of All Case Files Opened Longer Than 90 Days and Contained No Periodic Review	66	13.6%	7.5%	21.8%
Percentage of All Case Files Opened Longer Than 90 Days and Contained Some Periodic Review, But Not Quarterly Review	66	10.6%	5.4%	18.4%

Source: OIG analysis of Idaho MFCU case files, 2018.

APPENDIX E: Unit Comments

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL
LAWRENCE G. WASDEN

August 5, 2019

Ms. Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections
Department of Health and Human Services
Room 5660, Cohen Building
300 Independence Avenue, SW
Washington, DC 20201

Re: Response to Final Draft of 2018 Onsite Review Report for Idaho Medicaid Fraud Control Unit, Report Number OEI-12-18-00320

Dear Ms. Murrin:

On behalf of the Office of the Idaho Attorney General and the Idaho Medicaid Fraud Control Unit (MFCU), we thank you for the opportunity to respond to the Final Draft of 2018 Onsite Review Report for Idaho Medicaid Fraud Control Unit. As is true with many of the Medicaid Fraud Control Units, we have undergone many changes in structure and personnel since the last onsite review of our unit was conducted in 2012. Since that time, we have taken the opportunity to review and revise some of the operational guidelines that were in place in an effort to provide a more thorough and robust system of tracking the investigative and prosecution activities undertaken by the unit. We would like to extend our thanks to you and your staff that conducted the onsite review. All parties involved in the process conducted themselves in a professional manner. Our investigators found the informal meetings with the OIG investigators involved in the process to be especially helpful.

In accordance with the request mentioned in your letter dated July 17, 2019, we are taking this opportunity to respond to the conclusion and recommendations set forth at pages 14-15 of the final draft report, including whether we concur or disagree with the recommendations, as well as explain the action we have taken to-date and those actions that will be implemented in the near future. We have also attempted to provide some background of the circumstances that led to the conclusions reached by the unit. We are addressing these recommendations as they are stated in the report.

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HHS-OIG's First Recommendation:

Update its policies and procedures manual to reflect current Unit practices for periodic supervisory case file review.

The Unit should update its Operations Manual to include its current procedures for periodic supervisory reviews that involve a monthly review of all cases during a staff meeting and for documenting these reviews in the Unit's case management system.

Unit Response to First Recommendation:

The Idaho MFCU concurs with the HHS-OIG recommendation regarding the need to update the unit's Operations Manual to include the monthly case reviews and incorporating documentation of this process into the Unit's case management system. Actual revision of the Operations Manual will commence upon conclusion on the current onsite review process. These revisions will include provisions addressing monthly staff meetings that are already taking place where the actual review of individual cases is conducted by individual unit personnel, including the Unit Director and Investigations Supervisor. The proposed revision will also contain an additional procedure where an aged case list, the documentary product of these monthly reviews, is saved in the Unit's electronic document management system, TimeMatters®, under a specific file titled "A – CASE LIST WITH STATUS."

HHS-OIG's Second Recommendation:

Take steps to ensure that investigation delays are limited to situations imposed by resource constraints or other exigencies and that delays are documented in the case management system.

Except for delays imposed by resource constraints or other exigencies, the Unit should avoid extended delays to investigations. To demonstrate that extended delays were imposed by resource constraints or other exigencies, the Unit should document such occurrences in the case management system.

Unit Response to Second Recommendation:

The Idaho MFCU concurs with the HHS-OIG recommendation regarding the need to ensure that investigative delays are limited to situations imposed by resource constraints that are documented in the Unit's case management system. It is the undersigned Director's belief that this objective is already being addressed in the monthly review process that has resulted in the creation of an aged case list that is saved in Unit's electronic document management system, TimeMatters®, under a specific file titled "A – CASE LIST WITH STATUS." The status entries in this documentation provides recent investigative steps undertaken by investigative staff as well as other indicators of the level of investigative activity in a particular investigation. The monthly status entries contained in finalized aged case reports provides more detailed information explaining the current status of a given case during that particular reporting period. It is also the Director's belief that this particular method of documenting case progression is easier for supervisors at all levels to have an up-to-date grasp of actual case status and the reason(s) for any delay(s) in that process.

HHS-OIG's Third Recommendation:

Ensure that the case management system includes documentation of supervisory oversight.

After the Unit revises its Operations Manual to include procedures for documenting periodic supervisory review (as recommended in the first recommendation), the Unit should take steps to ensure that periodic supervisory reviews of cases are consistently documented in the case management system. This may include a master listing, such as the Unit's "aged case list," that includes such information, as long as that list is readily accessible in the case management system.

Unit Response to Third Recommendation:

The Idaho MFCU concurs with HHS-OIG recommendation regarding the need to include procedures for documenting periodic supervisory review (as recommended in the first recommendation), the Unit should take steps to ensure that periodic supervisory reviews of cases are consistently documented in the case management system. We realize that this particular recommendation generated significant discussion between the members of the Onsite Inspection Team and the Idaho MFCU supervisors. We also recognize that the proposed response to this issue by the Idaho MFCU represented a vast departure from the supervisory review process contemplated in the current Operations Manual. We are appreciative of the Department's willingness to allow the Idaho MFCU to implement a different approach that is more responsive to the needs of the Unit as well as to the overall mission of the Office of the Idaho Attorney General.

As explained in the responses to your previous recommendations, the Idaho MFCU has already implemented "a more frequent and robust practice for conducting periodic supervisory review of case files . . ." We are also in agreement with the recommendation that the Unit's Operations Manual be revised to reflect these updated practices. Prior to the implementation of the current practice(s) of supervisory review, the Idaho MFCU operated on a policy that contemplated a quarterly supervisory review of each investigator's top three cases. The current Director of the MFCU and Criminal Division Chief came to the conclusion that such policy provided insufficient information to enable supervisory staff to allocate resources and personnel. To provide greater detailed reporting, the Idaho MFCU began a practice of conducting a monthly staff meeting where all staff (including supervisors) reviewed an aged case list of all MFCU cases, discussed investigative steps taken in the prior month for each case, and established relative priorities for all of the cases. The current Operations Manuals needs to be updated to reflect this current practice. As explained earlier, it is also current practice to save the finalized aged case list in the Unit's electronic document management system, TimeMatters®, under a specific file titled "A – CASE LIST WITH STATUS."

As explained in the Unit's response to the Department's first recommendation, actual revision of the Operations Manual will commence upon conclusion on the current onsite review process. We have set a target date of November 30, 2019, for these revisions to be accomplished and approved by the Director and the supervisory chain of command in the Office of the Idaho Attorney General. A copy of the proposed revisions will be sent to your office for your review as

well. These revisions will include provisions addressing the monthly staff meetings that are already taking place where the actual review of individual cases is conducted by individual unit personnel, including the Unit Director and Investigations Supervisor. The proposed revision will also contain an additional procedure where the finalized aged case list, the documentary product of these monthly reviews, will be saved in the Unit's electronic document management system, TimeMatters®, under a specific file titled "A – CASE LIST WITH STATUS."

Conclusion:

Again, the Medicaid Fraud Control Unit in the Office of the Idaho Attorney General offers our appreciation for the effort and dedication of the staff conducting the onsite review. We have reviewed and concur with all of the recommendations set forth at pages 14-15 of the Final Draft of 2018 Onsite Review Report for Idaho Medicaid Fraud Control Unit. As was noted in the review process and in the 2018 Onsite Review Report, the Idaho MFCU has either already implemented or will implement the appropriate actions to address all of the recommendations addressed in the draft report. We recognize the important role we play in protecting the integrity of the State's Medicaid program and see this as an opportunity to improve the level of services that we offer to the citizens of the State of Idaho.

Respectfully submitted,

Kenneth M. Robins
Director and Deputy Attorney General
Medicaid Fraud Control Unit
Office of the Idaho Attorney General

KR:kcb
cc: Lawrence G. Wasden, Attorney General

ACKNOWLEDGMENTS

Susan Burbach of the Medicaid Fraud Policy and Oversight Division served as the team leader for this inspection. Two agents from the Office of Investigations also participated in the inspection. Office of Evaluation and Inspections staff who provided support include Christina Lester and Kevin Farber.

This report was prepared under the direction of Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov

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