

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**TEXAS STATE MEDICAID
FRAUD CONTROL UNIT:
2013 ONSITE REVIEW**



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**EXECUTIVE SUMMARY — TEXAS STATE MEDICAID FRAUD CONTROL UNIT:
2013 ONSITE REVIEW
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WHY WE DID THIS STUDY

The Office of Inspector General (OIG) oversees the activities of all 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 based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation of the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit Director and supervisors; (6) an onsite review of case files; and (7) an onsite review of Unit operations, conducted in August 2013.

WHAT WE FOUND

For fiscal years (FYs) 2010 through 2012, the Texas Unit reported recoveries of over \$844 million, 339 criminal convictions, and 48 civil judgments and settlements. Our review found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals. However, we found that the Unit did not transmit all conviction information to OIG in a timely manner.

WHAT WE RECOMMEND

We recommend that the Texas Unit ensure that it transmits information about all convictions to OIG for exclusion within 30 days of sentencing. The Unit concurred with our recommendation.

TABLE OF CONTENTS

Objective.....	1
Background.....	1
Methodology.....	4
Findings.....	5
For FYs 2010 through 2012, the Unit reported recoveries of over \$844 million, 339 criminal convictions, and 48 civil judgments and settlements.....	5
The Unit did not transmit all conviction information to OIG in a timely manner	6
Case files contained documentation indicating supervisory approval for opening and closing and supervisory reviews.....	6
The Unit maintained proper fiscal control of its resources.....	6
Other observation: The Unit does not require supervisory reviews for “preliminary open” cases, which are often open longer than 90 days ...	7
Other observation: The Unit implemented an outreach program to increase the visibility of the Unit and to generate referrals	7
Conclusion and Recommendations.....	8
Unit Comments and Office of Inspector General Response	9
Appendixes	10
A: 2012 Performance Standards	10
B: 1994 Performance Standards.....	17
C: Expanded Methodology	21
D: Referrals of Provider Fraud and Patient Abuse and Neglect to the Texas MFCU by Source, FYs 2010 Through 2012	23
E: Investigations Opened and Closed by Provider Category and Case Type, FYs 2010 Through 2012	24
F: Point Estimates and Confidence Intervals Based on Review of Case Files.....	26
G: Unit Comments	27
Acknowledgments.....	28

OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute fraud and patient abuse and neglect by Medicaid providers under State law.¹ Pursuant to Title XIX of the Social Security Act (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 Federal fiscal year (FY) 2012, combined Federal and State grant expenditures for the Units totaled \$217.4 million.⁴

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.⁵ Unit staff review complaints provided by the State Medicaid agency and other sources and determine their potential for criminal prosecution and/or civil action. In FY 2012, the 50 Units collectively reported 1,337 convictions, 823 civil settlements or judgments, and recoveries of approximately \$2.9 billion.⁶

¹ Social Security Act (SSA) § 1903(q)(3).

² Ibid., §§ 1902(a)(61) and 1903(q)(3). 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. Office of Inspector General (OIG), *Medicaid Fraud Control Units*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp> on May 22, 2013.

⁴ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2012-statistical-chart.htm on November 12, 2013.

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

⁶ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on November 20, 2012. Recoveries are defined as the amount of money that defendants are required to pay as a result of a settlement, judgment, or pre-filing 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.

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.⁷ Currently, MFCUs operate in 49 States and in the District of Columbia. Forty-four of the MFCUs (including the Texas MFCU) are located within offices of State Attorneys General; the remaining 6 MFCUs operate within other State agencies.⁸ Each Unit must be a single, identifiable entity of State government, distinct from the single State Medicaid agency, and must develop a formal agreement (i.e., Memorandum of Understanding) that describes its relationship with that agency.⁹

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 certified Units.¹⁰ All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹¹ To receive Federal reimbursement, each Unit must submit an application to OIG.¹² OIG reviews the application and notifies the Unit whether it is approved and the Unit is certified. Approval and certification are valid for a 1-year period; the Unit must be recertified each year thereafter.¹³

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁴ OIG developed and issued 12 performance standards to define the criteria it applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements.¹⁵ Examples of standards include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all professional disciplines,

⁷ SSA § 1903(q)(1).

⁸ OIG, *Medicaid Fraud Control Units*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp> on May 21, 2013.

⁹ SSA § 1903(q)(2); 42 CFR §§ 1007.5 and 1007.9(d).

¹⁰ The portion of funds reimbursed to States by the Federal government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called Federal Financial Participation (FFP) .

¹¹ SSA § 1903(a)(6)(B).

¹² 42 CFR § 1007.15(a).

¹³ 42 CFR § 1007.15(b) and (c).

¹⁴ SSA § 1902(a)(61).

¹⁵ 77 Fed. Reg. 32645 (June 1, 2012). Accessed at <http://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf> on November 6, 2013. Previous performance standards, established in 1994, are found at 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf> on November 15, 2013.

and establishing policy and procedure manuals to reflect the Unit's operations. See Appendix A for a complete list of the 2012 performance standards and Appendix B for a complete list of the 1994 performance standards.

Texas Medicaid Program

The Texas Medicaid program is housed within the Texas Health and Human Services Commission. The Texas Medicaid program provides services to over 4.4 million beneficiaries, 75 percent of whom are enrolled in managed care.¹⁶ Total Texas Medicaid expenditures for FY 2012 were over \$28 billion.¹⁷

Texas Unit

The Texas Unit is housed within the Texas Office of the Attorney General (OAG). For FY 2012, the State and Federal Governments awarded the Unit a combined total of approximately \$15.9 million.¹⁸ At the time of our August 2013 review, the Unit employed 187 staff members—1 director, 1 deputy director, 12 regional investigative managers, 14 attorneys, 82 investigators, and 36 auditors. The Unit headquarters is located in Austin, Texas's capital. The Unit has 12 regional investigative teams: 1 located with headquarters staff in Austin, 2 in Dallas, 3 in Houston, and 1 in each of 6 other cities (Corpus Christi, Dallas, El Paso, Houston, Lubbock, McAllen, San Antonio, and Tyler).

OAG has the authority to investigate criminal cases of Medicaid fraud and cases of patient abuse and neglect, and the agency presents these cases to local district attorneys and the United States Attorneys' Offices for prosecution. For civil cases of Medicaid fraud, including "global"—i.e., multi-State—cases, OAG delegates litigation authority to its Civil Medicaid Fraud Division (CMFD), which operates separately from the Unit.¹⁹ The Unit provides investigative support to the CMFD through data analysis, record reviews, and interviews.

¹⁶ Center for Medicaid and CHIP Services, *Medicaid.gov Texas Medicaid Statistics*. Accessed at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/texas.html> on September 16, 2013.

¹⁷ OIG, *MFCU Statistical Data for FY 2012*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/maps/interactive-map2012.asp> on November 11, 2013.

¹⁸ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2012-statistical-chart.htm on September 16, 2013.

¹⁹ *Texas Human Resources Code*, ch. 36, "Medicaid Fraud Prevention." Accessed at <http://www.statutes.legis.state.tx.us/Docs/HR/htm/HR.36.htm> on November 12, 2013.

METHODOLOGY

We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation of the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit Director and supervisors; (6) an onsite review of case files; and (7) an onsite review of Unit operations, conducted in August 2013. See Appendix C for a complete description of the methodology.

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.

FINDINGS

For FYs 2010 through 2012, the Unit reported recoveries of over \$844 million, 339 criminal convictions, and 48 civil judgments and settlements

For FYs 2010 through 2012, the Unit reported combined criminal and civil recoveries of over \$844 million. See Table 1. During the review period, criminal recoveries ranged from \$67 million in FY 2010 to \$199 million in 2012. Civil recoveries, including “global” and nonglobal civil recoveries, accounted for over \$451 million during FYs 2010 through 2012.^{20, 21}

During the review period, total recoveries ranged from nearly \$180 million in FY 2010 to over \$473 million in FY 2012.

Table 1: Texas MFCU Recoveries, FYs 2010 Through 2012

Recovery Type	FY 2010	FY 2011	FY 2012	Total Recoveries
Criminal	\$67,089,463	\$125,986,255	\$199,406,572	\$392,482,290
Global Civil	\$28,528,838	\$26,200,896	\$45,541,149	\$100,270,883
Non-Global Civil	\$84,235,510	\$38,681,619	\$228,738,021	\$351,655,150
Total Recoveries	\$179,853,811	\$190,868,770	\$473,685,742	\$844,408,323

Source: OIG analysis of Unit self-reported data, FYs 2010 through 2012.

The Unit reported 339 criminal convictions and 48 civil judgments and settlements during FYs 2010 through 2012. See Table 2.

Table 2: Texas MFCU Convictions and Civil Judgments and Settlements, FYs 2010 Through 2012

Outcomes	FY 2010	FY 2011	FY 2012	Total
Criminal Convictions	92	118	129	339
Civil Judgments and Settlements	16	15	17	48

Source: OIG analysis of Unit Quarterly Statistical Reports, FYs 2010 through 2012.

²⁰ Global civil recoveries include only the State share of funds recovered from multi-State, or “global,” civil false claims cases, including cases on which Unit staff assisted the CMFD, cases worked directly by the Unit, and cases worked by staff from other Units.

²¹ In 2012, the CMFD finalized a \$158 million settlement from Johnson & Johnson and its subsidiaries for defrauding the Texas Medicaid program.

The Unit did not transmit all conviction information to OIG in a timely manner

According to Performance Standard 8, the Unit should transmit to OIG reports of all convictions for the purpose of exclusion from Federal health care programs. The 1994 Performance Standards indicate that convictions should be reported within 30 days of sentencing “or other reasonable time period”; the 2012 Performance Standards stipulate that convictions should be reported within 30 days of sentencing.

The Unit transmitted information on nearly all (321 of 324) of the convictions that should have been sent to OIG for exclusion.²² However, for many of the cases, the Unit did not transmit this information in a timely manner. Specifically, the Unit transmitted conviction information to OIG more than 90 days after sentencing for 22 percent of convictions (70 of 324).

Case files contained documentation indicating supervisory approval for opening and closing and supervisory reviews

According to Performance Standard 5(b), Unit supervisors should approve the opening and closing of cases to ensure a continuous case flow and the timely completion of cases. We found that 96 percent of case openings and 100 percent of case closings contained documentation of supervisory approval. Additionally, according to Performance Standard 6(c), supervisory review should be conducted periodically and noted in the case file to ensure timely completion of cases. The Unit director reported that the Unit’s standard is for supervisory reviews to be conducted on cases every 90 days. In on our review of 77 case files that were open 90 days or longer, 99 percent of cases received supervisory reviews and included documentation of reviews in the case file.

The Unit maintained proper fiscal control of its resources

According to Performance Standard 11, the Unit should exercise proper fiscal control over the Unit’s resources, such as maintaining an equipment inventory and applying accepted accounting principles in its control of Unit funding. We did not identify any deficiencies with internal controls related to accounting, budgeting, personnel, procurement, and property.

²² At the time of our review, the Unit was either waiting on additional documentation or did not have documentation on the remaining three convictions.

Other observation: The Unit does not require supervisory reviews for “preliminary open” cases, which are often open longer than 90 days

Twenty of the Unit’s open cases were designated “preliminary open” cases. Preliminary open cases are cases in which investigative activity occurs, but supervisors have not yet decided whether to open a full investigation. Although Unit procedures require supervisory reviews every 90 days for cases open under full investigation, the Unit did not have a procedure for supervisory review of preliminary open cases. We found that almost all of the Unit’s preliminary open cases (18 of 20 cases) were open longer than 90 days. Further, 16 of the 20 preliminary open cases did not receive supervisory reviews.

Other observation: The Unit implemented an outreach program to increase the visibility of the Unit and to generate referrals

The Unit recently instituted an outreach program to ensure that the public is aware of the Unit’s presence and mission for the purpose of increasing the number of referrals to the Unit. The Unit requires all investigators and investigative auditors to make one outreach contact per month, or 12 contacts per year. Unit employees make these contacts in a variety of ways, including meeting with staff from various law enforcement agencies or other public agencies; presenting information about the Unit to associations or at conferences; or hosting a MFCU information booth at a conference. The Unit reported that the outreach program’s purpose is to increase its presence and that it has received referrals as a result of these outreach contacts, although we did not verify the number of these referrals.

CONCLUSION AND RECOMMENDATIONS

For FYs 2010 through 2012, the Texas Unit reported recoveries of over \$844 million, 339 criminal convictions, and 48 civil judgments and settlements. Additionally, the Unit reported implementing an outreach program to increase MFCU visibility and referrals.

Our review of compliance issues found no evidence of significant noncompliance with applicable laws or regulations. However, we found one opportunity for improvement in the Unit's operations. As a result, we recommend that the Texas Unit:

Ensure that it transmits information about all convictions to OIG for exclusion within 30 days of sentencing

The Unit should ensure that it transmits information about individuals convicted of fraud, abuse, or neglect within 30 days of sentencing, consistent with MFCU performance standard 8(f).

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with the report recommendation.

The Unit identified changes that it is implementing to ensure timely submission of conviction information to OIG, including placing a priority on conviction notifications and establishing a new tracking process.

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

APPENDIX A

2012 Performance Standards

[77 Fed. Reg. 32645, June 1, 2012]

- 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 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 pre-filing 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 B

Performance Standards for Medicaid Fraud Control Units

[59 Fed. Reg. 49080, Sept. 26, 1994]

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 OIG?
 - b. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?
 - c. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?
 - d. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?
3. **A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.** In meeting this standard, the following performance indicators will be considered:
 - a. Does the Unit have policy and procedure manuals?

- 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 C

Expanded Methodology

We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation of the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit director and supervisors; (6) an onsite review of case files; and (7) an onsite review of Unit operations conducted in August 2013.

We analyzed data from all seven sources to describe the caseload and assess the performance of the Unit. We also analyzed data to identify any opportunities for improvement and identify any instances in which the Unit did not meet the performance standards or was not operating in accordance with laws, regulations, and policy transmittals.²³

In addition, we noted any practices that appeared to benefit the Unit. We based these observations on statements from Unit staff, data analysis, and our own judgment. We did not independently verify the effectiveness of these practices, but included the information because it may be useful to other Units in their operations.

Data Collection and Analysis

Review of Unit Documentation. We reviewed policies, procedures, and documentation of the Unit's operations, staffing, and cases, including its annual reports, quarterly statistical reports, and responses to recertification questionnaires.

Review of Financial Documentation. We reviewed Unit policies and procedures related to budgeting, accounting systems, cash management, procurement, property, and personnel. We obtained from the Unit its claimed grant expenditures for FYs 2010 through 2012 so that we could (1) reconcile final Financial Status Reports and the supporting documentation; (2) purposively select and review transactions within direct-cost categories to determine whether costs were allowable; and (3) verify that indirect costs were accurately computed using the approved indirect cost rate. Finally, we verified that the Unit properly reported its program income received directly from cases.

Interviews with Key Stakeholders. We conducted structured interviews with key stakeholders who were familiar with the operations of the Unit.

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

Specifically, we interviewed staff from the Office of Inspector General within the Texas Health and Human Services Commission, Department of Human Services; the Department of Aging and Disability Services; an Assistant District Attorney; two Assistant U.S. Attorneys; two HHS OIG investigators who worked closely with the Unit during the review period; one managed care organization (AmeriGroup) that operates in Texas; and a Federal Bureau of Investigation agent who worked closely with the Unit during the review period. These interviews focused on the Unit's interaction with external agencies.

Survey of Unit Staff. We administered an electronic survey to Unit staff in the weeks leading up to the onsite review. We requested and received responses from 170 of 183 nonmanagerial staff members, a 93-percent response rate. Our questions focused on operations, opportunities for improvement, and effective practices.

Interviews with Unit Management and Staff. We conducted structured interviews with the Unit Director, the Unit Deputy Director, the Chief Investigator, the Chief Auditor, the Director of Law Enforcement for the OAG, a Regional Investigative Manager, and an Assistant Attorney General. We asked respondents to provide information to better illustrate the Unit's operations, identify opportunities for improvement and effective practices, and clarify information we obtained from other data sources.

Onsite Review of Case Files. We selected a statistically valid, simple random sample of 100 case files from the 3,332 cases that were open at any point during FYs 2010 through 2012. From these 100 case files, we selected another simple random sample of 50 files for a more in-depth review. After initial examination of all 3,332 case files, we found that 57 case files were CMFD cases and were outside the scope of our review. We excluded one CMFD case that appeared in our sample of 100. There were no CMFD cases in the sample of 50 case files that received an in-depth review. Our results project to the population of 3,275 cases.

We reviewed 99 sampled case files for documentation of supervisory approval for the opening and closing of cases, periodic supervisory reviews, timeliness of case development, and the Unit's processes for monitoring the status and outcomes of cases. We reviewed the 50 sampled case files for selected issues, such as the appropriateness and timeliness of investigations. See Appendix E for point estimates and 95-percent confidence intervals.

Onsite Review of Unit Operations. We reviewed the Unit's operations during our onsite visit. Specifically, we reviewed the process for receiving referrals, electronic case management, security of case files, and general functioning of the Unit.

APPENDIX D

Referrals of Provider Fraud and Patient Abuse and Neglect to the Texas MFCU by Source, FY 2010 Through 2012

Table D-1: Total MFCU Referrals of Fraud and Abuse

Case Type	FY 2010	FY 2011	FY 2012
Provider Fraud	589	438	344
Patient Abuse and Neglect	197	117	82
Total	786	555	426

Source: Texas MFCU response to OIG data request.

Table D-2: MFCU Referrals, by Referral Source

Referral Source	FY 2010		FY 2011		FY 2012	
	Provider Fraud	Patient Abuse and Neglect	Provider Fraud	Patient Abuse and Neglect	Provider Fraud	Patient Abuse and Neglect
Medicaid Agency	170	0	85	0	54	0
State Survey/Certification	63	173	71	94	43	62
State Agencies – Other	7	1	1	0	5	0
Licensing Boards	5	0	7	0	1	0
Law Enforcement	60	4	25	7	39	6
HHS OIG	36	0	57	0	23	0
Prosecutors	0	2	0	1	0	2
Providers	17	0	15	1	17	3
Private Health Insurers	1	0	1	0	2	0
Ombudsman	5	0	2	0	0	0
Adult Protective Services	0	8	0	4	1	3
Private Citizens	36	4	50	7	29	5
MFCU Hotline	2	0	2	0	1	0
Other	187	5	122	3	129	1
Total Referrals Received	589	197	438	117	344	82

Source: Texas MFCU response to OIG data request.

APPENDIX E

Investigations Opened and Closed by Provider Category and Case Type, FY 2010 Through 2012

Table E-1: Total Annual Opened and Closed Investigations

Case Type	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Provider Fraud	588	551	434	500	343	421
Patient Abuse and Neglect	197	315	117	144	82	121
Total	785	866	551	644	425	542

Source: Texas MFCU response to OIG data request.

Table E-2: Investigations of Patient Abuse and Neglect

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing Facilities	52	58	31	38	29	35
Other Long-Term-Care Facilities	2	3	5	4	6	4
Nurses/Physician's Assistants/Nurse Practitioners/Certified Nurse Aides	86	147	49	55	30	50
Home Health Aides	2	3	0	0	0	2
Other	55	104	32	47	17	30
Total	197	315	117	144	82	121

Source: Texas MFCU response to OIG data request.

Table E-3: Investigations of Provider Fraud

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Facilities						
Hospitals	10	7	8	8	13	8
Nursing Facilities	11	17	17	9	1	6
Other Long-Term-Care Facilities	6	2	0	1	0	0
Substance Abuse Treatment Centers	4	4	0	5	2	6
Other Facilities	19	24	11	16	17	16
Practitioners						
Doctors of Medicine or Osteopathy	86	87	57	71	62	60
Dentists	50	33	49	44	59	20
Podiatrists	0	2	2	2	8	2
Optometrist/Opticians	4	2	0	3	0	3
Counselors/Psychologists	12	15	9	5	7	8
Chiropractors	0	2	0	1	1	0
Other Practitioners	9	4	6	3	5	8
Medical Support						
Pharmacies	28	10	9	8	9	13
Pharmaceutical Manufacturers	16	15	9	12	4	19
Suppliers of Durable Medical Equipment	113	93	77	92	30	105
Laboratories	6	13	1	9	1	0
Transportation Services	8	21	15	35	24	25
Home Health Care Agencies	111	56	52	82	44	52
Nurses/Physician's Assistants/Nurse Practitioners/Certified Nurse Aides	49	75	73	72	40	38
Radiologists	0	2	0	1	1	2
Other Medical Support	38	57	22	19	12	18
Program Related						
Managed Care	0	1	1	0	0	1
Medicaid Program Administration	5	1	15	0	2	11
Billing Company	3	8	1	2	1	0
All Fraud Investigations						
Total	588	551	434	500	343	421

Source: Texas Unit response to OIG data request.

APPENDIX F

Point Estimates and Confidence Intervals Based on Review of Case Files

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
CMFD case files outside the scope of our review	100	1.00%	0.03%	5.45%
Open case files containing documentation of supervisory approval for opening*	79	96.20%	89.30%	99.21%
Closed case files containing documentation of supervisory approval for closing*	52	100.00%	93.25%	100%
Open cases files that were open longer than 90 days containing documentation of supervisory review*	77	98.70%	92.98%	99.97%

Source: OIG analysis of Unit case files, 2013.

* We excluded the 20 "preliminary open" cases from this analysis.

APPENDIX G

Unit Comments



ATTORNEY GENERAL OF TEXAS
GREG ABBOTT

March 18, 2014

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

RE: Texas MFCU 2013 Onsite Review

Dear Mr. Wright:

We appreciate the opportunity to review and comment on the 2013 Onsite Review and the exceptional professionalism exhibited by your review staff. Pursuant to your request, we offer the following comments on the single recommendation presented in the report:

Recommendation

Ensure that the Texas MFCU transmits information about all convictions to OIG for exclusion within 30 days of sentencing.

Comments

We concur with this recommendation. Immediately following the identification of this issue, we revised the closing process to place a priority on conviction notifications. We also established a tracking process ensure compliance. While a majority of the cases that did not meet the 30-day reporting rule were without mitigation, a significant number would have been in compliance under the previous standard of "30 days or other reasonable time period." The previous standard recognized that in some cases it is impossible for MFCUs to report a conviction within 30 days. In Texas, this is due to size of our state and the fact we do not have original prosecution jurisdiction. We depend on 150 district attorney's offices in 254 counties and 27 U.S. Attorney's Offices for the prosecution of our cases. In remote locations it is often difficult to obtain judgment documentation in a timely manner. We would recommend that the 30-day rule be amended to allow for situations in which the timely submission is out of the control of a unit.

The Texas Medicaid Fraud Control Unit appreciates the efforts of HHS-OIG to provide guidance and positive input to assist us in achieving the highest standards possible.

Sincerely yours,

/S/

W. Rick Copeland
Director, Medicaid Fraud Control Unit

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Lyndsay Patty served as the Team Leader for this study and Ben Gaddis served as the Lead Analyst. Other Office of Evaluation and Inspections staff who provided support include Maria Balderas. Office of Investigations staff who provided support includes Lynn Melear and Jason Weinstock. Office of Audit Services staff who provide support include Nancy Bibb, Francine Olguin, Jenny Potter, John Retzloff, and Sylvie Witten. Central office staff who provided support include Thomas Brannon, Kevin Farber, Christine Moritz, Richard Stern, and Sherri Weinstein.

Office of Inspector General

<http://oig.hhs.gov>

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