

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**MISSOURI STATE MEDICAID  
FRAUD CONTROL UNIT:  
2011 ONSITE REVIEW**



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**EXECUTIVE SUMMARY:  
REVIEW OF MISSOURI STATE MEDICAID FRAUD CONTROL UNIT:  
2011 Onsite Review  
OEI-07-11-00750**

**WHY WE DID THIS STUDY**

The Office of Inspector General (OIG) oversees all Medicaid Fraud Control Units (MFCU or Unit) with respect to Federal grant compliance. As part of this oversight, OIG reviews all Units. These reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor Unit compliance with Federal grant requirements. This is a review of the Missouri Unit.

**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's management; (6) an onsite review of case files; and (7) an onsite review of Unit operations.

**WHAT WE FOUND**

For Federal fiscal years (FY) 2008 through 2010, the Missouri Unit reported recoveries of \$135 million, 13 convictions, and 36 civil settlements. The Unit exercised proper fiscal controls over its resources. The Unit expanded its definition of referrals and changed its process for closing older cases during FYs 2008 through 2010. It did not establish annual training plans for its professional disciplines. One-third of case files lacked documentation of supervisory approval for key stages of the investigation, and nearly all lacked documentation of periodic supervisory reviews. Finally, the Unit lacked safeguards to secure case files. At the same time, our review found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals.

**WHAT WE RECOMMEND**

Based on these findings, the Missouri Unit should: (1) establish annual training plans for professional disciplines, (2) ensure that case files contain documented supervisory approval and periodic supervisory reviews, and (3) ensure that case files are not vulnerable to unauthorized access. The Missouri Unit concurred with all of our recommendations.

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## OBJECTIVE

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

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## BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.<sup>1</sup> Under the Medicaid statute, each State must maintain a certified Unit unless the Secretary of Health & Human Services (HHS) determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State; and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.<sup>2</sup> Currently, 49 States and the District of Columbia (States) have created such Units.<sup>3</sup> In Federal fiscal year<sup>4</sup> (FY) 2010, the combined Federal and State grant expenditures for the Units totaled \$205.5 million, of which Federal funds represented \$153.8 million.

Each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney to carry out its duties and responsibilities in an effective and efficient manner.<sup>5</sup> The staff reviews complaints provided by the State Medicaid agency and other sources and determines their potential for criminal prosecution. Collectively, in FY 2010, the 50 Units obtained 1,329 convictions and 1,090 civil settlements or judgments.<sup>6</sup> That year, the Units reported recoveries of more than \$1.9 billion.<sup>7, 8</sup>

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<sup>1</sup> Social Security Act (SSA), § 1903(q)(3).

<sup>2</sup> SSA §§ 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.

<sup>3</sup> 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.

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

<sup>5</sup> SSA § 1903(q)(6) and 42 CFR § 1007.13.

<sup>6</sup> Office of Inspector General (OIG), *State Medicaid Fraud Control Units Fiscal Year 2010 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on April 17, 2012.

<sup>7</sup> Ibid.

<sup>8</sup> Pursuant to 42 CFR § 1007.17, Units report the total amount of recovered funds in their annual reports to OIG. The annual total does not include court-ordered payments not yet received. However, the annual total may include payments ordered in a prior year, because it may take a year or more for a Unit to receive ordered payments.

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.<sup>9</sup> In Missouri and 42 other States, the Units are located within offices of State Attorneys General; in the remaining 7 States, the Units are located in other State agencies.<sup>10</sup> Generally, Units outside of the Attorneys General offices must refer cases to other offices with prosecutorial authority.

Each Unit must be a single, identifiable entity of State government, distinct from the single State Medicaid agency, and each Unit must develop a formal agreement (e.g., a memorandum of understanding) that describes the Unit's relationship with that agency.<sup>11</sup>

### **Oversight of the MFCU Program**

The Secretary of HHS delegated to OIG the authority to both annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.<sup>12</sup> All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.<sup>13</sup> To receive Federal reimbursement, each Unit must submit an application to OIG.<sup>14</sup>

OIG reviews the application and notifies the Unit if it is approved and the Unit is certified. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.<sup>15</sup>

Under the Medicaid statute, States must operate Units that effectively carry out their statutory functions and meet program requirements.<sup>16</sup> 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.<sup>17</sup> Examples of criteria include maintaining an adequate caseload through referrals from several sources,

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<sup>9</sup> SSA § 1903(q)(1).

<sup>10</sup> In most States, the Unit shares responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States also establish an Office of Medicaid Inspector General that conducts and coordinates fraud, waste, and abuse activities for the State agency.

<sup>11</sup> SSA § 1903(q)(2); 42 CFR §§ 1007.5 and 1007.9(d).

<sup>12</sup> 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.

<sup>13</sup> SSA § 1903(a)(6)(B).

<sup>14</sup> 42 CFR § 1007.15(a).

<sup>15</sup> 42 CFR § 1007.15(b) and (c).

<sup>16</sup> SSA § 1902(a)(61).

<sup>17</sup> 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 22, 2011. OIG revised these standards on June 1, 2012 (see 77 Fed. Reg. 77106). The standards referred to throughout this report are those from 1994, which were in effect at the time of our review.

maintaining an annual training plan for all professional disciplines, and establishing policy and procedure manuals to reflect the Unit's operations. See Appendix A for a complete list of the performance standards.

### **Missouri State MFCU**

The Missouri Unit is located within the Public Safety Division of the State Attorney General's Office. It has authority to prosecute Medicaid fraud and cases of patient abuse and neglect. At the time of our review,<sup>18</sup> the Unit's 21 employees were located in the State capital of Jefferson City. The Missouri Unit was authorized \$1.7 million in Federal funds and expended a total of \$1.6 million in combined Federal and State funds for FY 2010.<sup>19</sup> Total Medicaid expenditures in Missouri increased from \$7 billion in FY 2008 to \$8.3 billion in FY 2010.<sup>20</sup>

Historically, the Unit received referrals of fraud, abuse, or neglect from the State Medicaid Agency, which included the Program Integrity Unit. Beginning in January 2011, the program integrity function was moved out of the State Medicaid Agency and into the Department of Social Services, Office of the Director, and renamed the Missouri Medicaid Audit and Compliance (MMAC) Unit. The MMAC Unit is now a source of referrals.<sup>21</sup> Other sources include calls to the Unit hotline; other State and Federal law enforcement agencies; the State Ombudsman; and the Missouri Department of Health and Senior Services (DHSS), which provides patient abuse referrals. For FYs 2008 through 2010, the Unit received an average of 298 referrals each year.

Upon determining that a referral merits a full investigation, the Unit opens a case and assigns an attorney(s) and investigator(s). The Unit may close a case through civil action, criminal prosecution, a determination of insufficient evidence, referral, or other administrative action. With respect to convalescent, nursing, and boarding homes, State law requires that "the attorney general shall review each complaint and may initiate legal action...."<sup>22</sup>

### **Previous Review**

In 2005, OIG conducted an onsite review of the Missouri Unit and found that: (1) the Unit lacked a standardized case filing system to identify

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<sup>18</sup> Our onsite review occurred in December 2011.

<sup>19</sup> OIG analysis of State Form SF-269 for FY 2010.

<sup>20</sup> Keeping America Healthy. Accessed at <http://www.medicaid.gov/> on March 1, 2012. Medicaid Fraud Control Units FY 2010 Statistical Chart. Accessed at <http://oig.hhs.gov/> on March 1, 2012.

<sup>21</sup> The MMAC Unit is responsible for administering and managing Medicaid audit and compliance initiatives as well as for detecting, investigating, and preventing fraud, waste, and abuse of the Medicaid program.

<sup>22</sup> Revised Statutes of Missouri § 198.093.2.

documents within the case file, (2) staff reported some equipment was outdated and additional equipment would be useful, and (3) the Unit charged the MFCU Federal grant for certain non-Medicaid-related activities.<sup>23</sup> The Unit responded that it planned to incorporate system features from a neighboring Unit's case filing system into its system, that equipment would be purchased and upgraded as needed, and that the Unit would seek approval for "de minimus" non-Medicaid-related activities. The current review found no indication that any of these prior issues persist.

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## METHODOLOGY

Our review covered the 3-year period of FYs 2008 through 2010. 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 for FYs 2008 through 2010; (2) a review of financial documentation for FYs 2008 through 2010; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) an onsite review of case files that were open in FYs 2008 through 2010; and (7) an onsite review of Unit operations. Although interview and survey respondents may have provided information that fell outside of our 3-year review period, we used this information to explain further the results of our analyses covering FYs 2008 through 2010.

We analyzed data from all seven sources to describe the caseload and assess the performance of the Unit. We also analyzed the data to identify any opportunities for improvement and any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, and policy transmittals.<sup>24</sup>

### **Data Collection and Analysis**

*Review of Unit Documentation.* We requested and reviewed policies, procedures, documentation of the Unit's operations, staffing, and cases, including its annual reports, quarterly statistical reports, and responses to recertification questionnaires. We also requested and reviewed the Unit's data describing how it detects, investigates, and prosecutes Medicaid cases. Data collected included information such as the number of referrals received by the Unit and the number of investigations opened and closed.

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<sup>23</sup> A programmer analyst assisted in the development of a computerized case-tracking system and monthly time log database for use by all staff in the Office of Attorney General. An auditor spent 4 days completing an assignment involving gasoline price gouging.

<sup>24</sup> All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov>.

*Review of Financial Documentation.* We reviewed Unit policies and procedures related to budgeting, accounting systems, cash management, procurement, property, and personnel to evaluate internal controls and design our tests for financial documentation. We obtained from the Unit its claimed grant expenditures for FYs 2008 through 2010 to: (1) review final Federal 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 reviewed records in the Payment Management System and revenue accounts to identify any unreported program income.

*Interviews With Key Stakeholders.* We conducted structured interviews with key stakeholders who were familiar with the operations of the Unit. Specifically, we interviewed the director of the MMAC Unit, the director of DHSS's Division of Regulation & Licensure, and the director of DHSS's Senior & Disability Services. Additionally, we interviewed the Special Agent in Charge and Assistant Special Agents in Charge for OIG's Kansas City region. These interviews focused on the Unit's interaction with external agencies.

*Survey of Unit Staff.* We administered an electronic survey of all nonmanagerial Unit staff. We requested and received responses from each of the 16 nonmanagerial staff members, for a 100-percent response rate. Our questions focused on operations of the Unit, opportunities for improvement, and noteworthy practices of the Unit. The survey also sought information about the Unit's compliance with applicable laws and regulations.

*Interviews With Unit Management and Staff.* We conducted structured interviews with the Unit's director, deputy director (chief attorney), chief investigator, and chief auditor. We met with the computer programmer who demonstrated how the Unit retrieves and analyzes Medicaid claims data. We asked these managers and staff members to provide us with additional information to better illustrate the Unit's operations, identify opportunities for improvement and noteworthy practices, and clarify information obtained from other data sources.

*Onsite Review of Case Files.* We selected a statistically valid, simple random sample of 98 case files from the 508 cases that were open at some point during FYs 2008 through 2010, which were the most recent complete FYs at the beginning of our review. We reviewed these 98 case files for documentation of supervisory approval for the opening and closing of cases, documented periodic supervisory reviews, timeliness of case development, and the Unit's processes for monitoring the status and

outcomes of cases. See Appendix B for sample sizes and 95-percent confidence intervals associated with point estimates.

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

### **Standards**

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

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## FINDINGS

### **For FYs 2008 through 2010, the Missouri Unit reported recoveries of \$135 million, with 13 convictions and 36 civil settlements**

Unit recoveries included \$134 million in civil cases (i.e., actions involving monetary settlements and court orders) and \$695,437 in criminal cases.

The Unit placed a heavy emphasis on negotiating cases under the Missouri civil false claims act. As part of these civil actions, the Unit pursued agreements with providers to immediately surrender their legal rights to participate in the Medicaid program without being subject to mandatory exclusion by OIG.<sup>25</sup> Of the 508 cases open at some point during FYs 2008 through 2010, 91 percent (463 cases) were charged as civil cases and 9 percent (45 cases) as criminal cases. Charging decisions were made after an investigation was at or very near completion. The Unit also reported filing felony charges against 20 defendants and separately obtaining 13 convictions and 36 civil settlements during our 3-year review period. There were no acquittals and only one dismissal. See Appendix C for details on investigations opened and closed by provider category for FYs 2009 through 2011.

### **The Unit exercised proper fiscal controls over its resources**

According to Performance Standard 11, the Unit should exercise proper fiscal control over its resources. For FYs 2008 through 2010, the Unit claimed expenditures that represented allowable, allocable, and reasonable costs in accordance with applicable Federal regulations. In addition, the Unit maintained adequate internal controls relating to accounting, budgeting, personnel, procurement, property, and equipment.

### **The Unit expanded its definition of referrals and changed its process for closing older cases during FYs 2008 through 2010**

According to Performance Standard 4, the Unit should maintain an adequate workload through referrals from the single State agency and other sources. The Unit should also have a continuous case flow. As noted in the background of this report, the Unit receives referrals from the

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<sup>25</sup> Exclusions would prevent providers from committing future fraud in their current State and other States by restricting their participation in the Medicaid and other Federal health care programs.

State Medicaid Agency, the Unit hotline, and a variety of other sources such as other law enforcement agencies and other State agencies. For FYs 2008 through 2010, the number of referrals increased by 240 percent (from 123 to 418, see Table 1). To explain this dramatic increase, the Unit manager explained that beginning in October 2008, Unit management began counting and tracking all Medicaid Program agencies’ referrals, MFCU hotline calls, and all case leads as “referrals,” based on a recommendation from the State Auditor. Previously, the Unit would consider a complaint as a referral only if a case was opened. Additionally, Unit management stated that prior to January 2011, allegations received from private attorneys alleging abuse were opened directly into cases, skipping the referral stage. Leads which were deemed as unsubstantiated and warranted no further investigation were not counted as referrals. Finally, managers attributed part of the increase in fraud referrals to enhanced outreach efforts and improved communication with key stakeholders (i.e., the State Medicaid Agency and the MMAC Unit).

**Table 1: Unit Referrals for FYs 2008 Through 2010, by Type**

Type	FY 2008	FY 2009	FY 2010
Fraud	58	131	182
Patient Abuse and Neglect (Includes Patient Funds Cases)	65	221	236
<b>Total</b>	<b>123</b>	<b>352</b>	<b>418</b>

Source: OIG analysis of Missouri MFCU Quarterly Statistical Report data, 2012.

When a referral is received, a preliminary investigation is conducted to determine if opening a case is merited. Multiple referrals may result in one opened case, a referral may lead to multiple open cases, or the Unit may decide not to open cases based on the quality of the referrals. The Unit may also forward a referral to another agency.

For FYs 2008 through 2010, the number of cases opened by the Unit decreased by 16 percent. In FY 2008, the Unit opened 125 cases, compared to 105 in FY 2010.<sup>26</sup> (See Table 2.) Unit management attributed the decrease to the Unit’s streamlining of its case opening, referral intake, and investigative processes. Unit management attributed further reductions to conducting more investigative work at the referral stage to avoid opening nonmeritorious cases.

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<sup>26</sup> Outside of our review period, the Unit reported opening 176 cases in FY 2011.

**Table 2: Cases Opened for FYs 2008 Through 2010, by Type\***

Type of Investigation	FY 2008	FY 2009	FY 2010
Fraud	59	42	69
Patient Abuse and Neglect (Includes Patient Funds Cases)	66	51	36
<b>Total</b>	<b>125</b>	<b>93</b>	<b>105</b>

\*Includes only new cases opened during the FY.  
Source: OIG analysis of Missouri MFCU data, 2012.

The Unit may close a case through civil action, criminal prosecution, a determination of insufficient evidence, referral, or other administrative action. For FYs 2008 through 2010, the number of cases closed by the Unit decreased by 48 percent. In FY 2008, the Unit closed 185 cases, compared to 97 in FY 2010. (See Table 3.)

Managers explained the decline in case closings as follows. In early 2008, Unit management determined that Unit productivity would be enhanced by reducing the number of older, open cases and focusing unit resources on newer cases and investigations. This process resulted in administrative closures of more than 100 older files in approximately 2 months. These cases had an average age of over 3 years. Their closure caused the average age of cases closed by the MFCU to fall to just over 1 year. See Appendix C for information about the Unit’s cases by provider category.

**Table 3: Cases Closed for FYs 2008 Through 2010, by Type**

Type of Investigation	FY 2008	FY 2009	FY 2010
Fraud	113	48	58
Patient Abuse and Neglect (Includes Patient Funds Cases)	72	59	39
<b>Total</b>	<b>185</b>	<b>107</b>	<b>97</b>

Source: OIG analysis of Missouri MFCU data, 2012.

### **The Unit did not establish annual training plans for the professional disciplines**

According to Performance Standard 12, the Unit should establish annual training plans for each professional discipline. The training provided should aid in the mission of the Unit. At the time of our onsite review, managers reported that they had not established annual training plans for

any of the three professional disciplines (i.e., auditor, investigator, and attorney).<sup>27</sup> Rather, staff are sent to training as opportunities arise.

All new hires in the Missouri Unit are required to attend in-house training conducted by the chief investigator and the Unit attorneys, and separate training conducted by the National Association of Medicaid Fraud Control Units (NAMFCU) on Health Care Fraud/Patient Abuse and Neglect. All MFCU attorneys are required to complete 15 hours of Continuing Legal Education per year. Investigators receive ongoing in-house training and are sent to the Medicaid Fraud 101 and 102 courses, sponsored by NAMFCU, as openings allow. Sixty-two percent of staff stated that they have adequate training to perform their jobs.

Several managers reported that few training opportunities have been available for staff in recent years. The managers acknowledged the challenge of identifying and accessing training opportunities to fit the unique needs of their staff. Managers also requested reinstatement of the multidisciplinary biennial conferences formerly provided by OIG.

After the onsite review, the Unit began work on an annual training plan for new and established employees in the investigative, audit, and legal disciplines. The Unit shared a preliminary draft of the training plan during the writing of this report.

### **One-third of case files lacked documentation of supervisory approval for key stages of the investigation and nearly all lacked documentation of periodic supervisory reviews**

According to Performance Standard 6, the Unit should complete cases within a reasonable timeframe. As a part of this effort, managers should approve the opening and closing of cases and document any supervisory case reviews in the case file. Thirty-three percent of all case files were missing documented supervisory approval for the opening of investigations and 1 percent of the closed case files did not include documented supervisory approval detailing the case closure. Unit management explained that prior to October 2008, referrals from State agencies were considered “preliminarily verified and therefore skipped the referral stage, and were directly opened into complaints. Thus no separate documentation indicated supervisory openings of such matters as none

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<sup>27</sup> Although we reviewed training records, we did not evaluate the staff’s professional qualifications. Rather, we applied the performance standards to evaluate whether the Unit maintained a formal training plan for each professional discipline and assessed training opportunities specific to Unit operations. We recognize that attorneys, investigators, and auditors receive professional and law enforcement training, and that the lack of an annual training plan does not suggest that professional staff are unqualified.

was needed—such openings were a matter of policy, not individual supervisory authorization.” Unit management further informed us that prior to January 2011, all allegations of resident abuse were handled similarly without documentation reflecting supervisory approval for opening cases.<sup>28</sup>

Performance Standard 6 also states that supervisory reviews should be conducted periodically and noted in the case file. Overall, only 3 percent of the case files contained any documentation of periodic supervisory reviews.<sup>29</sup> The Unit director explained that attorney reviews of investigations typically consist of conversations between attorneys and investigators that occur approximately every 2 weeks. These conversations were not documented and were thus not inserted in the case files. The Unit director typically meets with the attorneys once per month and documents the meeting in a case log report, but this is not typically inserted into the case files.

Finally, 11 percent of case files were not opened within 60 days of receipt and another 7 percent of case files had no record of the amount of time from receipt to opening. Delays were outside of the Unit’s control in only a limited number of instances.

### **Unit practices leave case files vulnerable to unauthorized access**

According to Performance Standard 1, a Unit will be in conformance with all applicable statutes, regulations, and policy transmittals, including regulations regarding the security of case files (i.e., 42 CFR § 1007.11(f)). During our onsite review, we observed unit practices that left case files vulnerable to unauthorized access.

After the onsite review, the Unit implemented a plan to prevent unauthorized access to case files.

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<sup>28</sup> All but one of the cases missing supervisory approval for opening fit within the internal practices the Unit established.

<sup>29</sup> For the purposes of this report, supervisory approval to open and close a case does not constitute a case file review. Periodic supervisory review indicates that a supervisor reviewed a case more than once between its opening and closing.

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## CONCLUSION AND RECOMMENDATIONS

For FYs 2008 through 2010, the Unit obtained 13 criminal convictions and 36 civil settlements, and reported recoveries of \$134 million in civil cases and \$695,437 in criminal cases. Providers who settle civilly are not subject to mandatory exclusion by OIG. Exclusions would prevent providers from committing future fraud by restricting their participation in the Medicaid program.

Although the Unit maintained proper fiscal controls over its resources, our review found opportunities for improvement and instances in which the Unit did not fully meet the performance standards. Specifically, the Unit did not establish annual training plans, and its case files lacked documentation of supervisory approval for key stages of the investigation and periodic supervisory reviews. Additionally, the Unit lacked safeguards to secure case files. At the same time, our review found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals.

Based on these findings, we recommend that the Missouri Unit:

### **Establish Annual Training Plans for Professional Disciplines**

The Unit should develop formal training plans that indicate the type and duration of training expected each year for employees in each professional discipline. The Unit may work with NAMFCU or OIG to identify additional relevant training opportunities for staff.

After our onsite review, the Unit began work on an annual training plan for new and established employees in the investigative, audit, and legal disciplines. The Unit shared a preliminary draft of the training plan while this report was being written.

### **Ensure That Case Files Contain Documented Supervisory Approval and Documented Periodic Supervisory Reviews**

The Unit should make use of its newly developed formal investigative checklist tool to ensure that case openings are approved by supervisors. Unit managers should place documentation of all supervisory reviews in the case files. This will assist in evaluating the timeliness of investigation, prosecution, and closure of cases.

### **Ensure That Case Files Are Not Vulnerable to Unauthorized Access**

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## UNIT COMMENTS

With regard to our first recommendation, the Unit is implementing a MFCU Training Policy, including annual plans. Annual training plans will be formulated for individual employees and for disciplines.

With regard to our second recommendation, the Unit's case management system will require automated documentation of supervisory reviews of each case for insertion into each case file. All case openings will be approved in writing.

With regard to our third recommendation, the Unit has addressed potential access issues by ensuring all case files will be maintained in locked file cabinets; lockable desk drawers; and a secure, locked key-coded evidence room.

The full text of the Unit's comments is provided in Appendix D. We did not make any changes to the report based on the Unit's comments.

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## APPENDIX A

### Performance Standards

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?

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## APPENDIX B

### Point Estimates and Confidence Intervals Based on Case File Reviews

We calculated confidence intervals for key data points for the case file reviews. The sample sizes, point estimates, and 95-percent confidence intervals are given for each of the following:

**Table B-1: Confidence Intervals for Case File Review Data**

<b>Data Element Description</b>	<b>Sample Size</b>	<b>Point Estimate (percentage)</b>	<b>95-Percent Confidence Interval</b>
Case files did not include documented supervisory approval for the opening of investigations.	98	32.7	24.8–41.6
Case files did not include documented supervisory approval for the closing of investigations.	87	1.1	0.2–6.6
Cases were not opened within 60 days of receipt.	98	11.2	6.7–18.3
The amount of time from receipt of referral to case opening could not be determined.	98	7.1	3.7–13.5
Case files included documented periodic supervisory reviews.	98	3.1	1.1–8.3

Source: Office of Inspector General analysis of Medicaid Fraud Control Unit case files, 2012.

## APPENDIX C

### Investigations Opened and Closed by Provider Category for FYs 2008 Through 2010

**Table C-1: Fraud Investigations**

<b>Provider Category</b>	<b>FY 2008</b>		<b>FY 2009</b>		<b>FY 2010</b>	
<b><u>Facilities</u></b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>
Hospitals	5	1	2	3	2	3
Nursing Facilities	0	2	1	0	1	2
Other Long-Term Care Facilities	0	0	0	0	0	0
Substance Abuse Treatment Centers	0	0	0	0	0	0
Other	4	8	11	3	5	6
<b><u>Practitioners</u></b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>
Doctors of Medicine or Osteopathy	2	12	3	3	4	2
Dentists	2	2	2	2	7	7
Podiatrists	0	0	1	0	1	0
Optometrists/Opticians	1	1	0	0	0	0
Counselors/Psychologists	8	23	5	6	1	7
Other	2	1	0	4	2	1
<b><u>Medical Support</u></b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>
Pharmacies	4	14	0	0	5	3
Pharmaceutical Manufacturers	7	8	9	4	17	12
Durable Medical Equipment and/or Supplies	1	0	0	2	2	2
Labs	0	0	1	1	1	0
Transportation Services	0	2	1	0	0	1
Home Health Care Agencies	16	13	0	13	11	6
Home Health Care Aides	4	11	1	1	1	1
Nurses, Physician Assistants, Nurse Practitioners, Certified Nurse Aides	1	1	0	1	0	0
Radiologists	0	0	0	0	0	0
Medical Support—Other	2	0	5	5	4	3
<b><u>Program Related</u></b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>	<b>Opened</b>	<b>Closed</b>
Managed Care	0	12	0	0	0	0
Medicaid Program Administration	0	0	0	0	0	0
Billing Company	0	1	0	0	0	1
Other	0	1	0	0	5	1
<b>Total of All Provider Categories</b>	<b>59</b>	<b>113</b>	<b>42</b>	<b>48</b>	<b>69</b>	<b>58</b>

Source: Missouri Medicaid Fraud Control Unit (Unit).

**Table C-2: Patient Abuse, Neglect, and Funds Investigations**

Provider Category	FY 2008		FY 2009		FY 2010	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing Facility	53	51	40	48	32	30
Nondirect Care	1	5	1	1	0	0
Other Long-Term Care	2	2	2	3	1	3
Registered/Licensed Nurses/Physician's Assistants/Nurse Practitioners	0	0	0	0	0	0
Certified Nurse Aides	0	0	0	0	0	0
Home Health Aides	0	9	1	1	1	0
Other	10	5	7	6	2	6
<b>Total</b>	<b>66</b>	<b>72</b>	<b>51</b>	<b>59</b>	<b>36</b>	<b>39</b>

Source: Missouri Unit.

**APPENDIX D**  
**Agency Comments**



**ATTORNEY GENERAL OF MISSOURI**

CHRIS KOSTER  
ATTORNEY GENERAL

JEFFERSON CITY  
65102

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June 29, 2012

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

Re: Missouri Medicaid Fraud Control Unit "MFCU" (OEI-07-11-00750)

Dear Mr. Wright:

Missouri MFCU appreciates the opportunity to respond to the HHS-OIG Onsite Review of the Missouri State Medicaid Fraud Control Unit for the Review Period FFY 2008-10. As we have had new leadership in the Missouri Attorney General's Office (January 2009) and the MFCU (April 2010) during the review period, we have taken this review and interaction with HHS-OIG staff as an opportunity for continued operational improvement, expanding our best practices and targeting areas needing attention. Your staff's recognition of the challenges facing MFCUs in best implementing the Performance Standards – in the context of our respective authorities, resources and the nuances in the operation of each state's Medicaid Program – renders the review process constructive and effective.

We particularly appreciate the diligence shown by the HHS-OIG Review team and the constructive communication which facilitated our analysis and response to the Onsite Review.

As your report indicates, Missouri MFCU has achieved a strong record of financial recoveries, continues to resolve a growing number of fraud and abuse cases and case referrals (through the review period and beyond) and continues to build strong productive relationships with our Single State Agency as well as our and federal and state law enforcement partners.

HHS-OIG has requested that we respond with comments to the Onsite Review, including whether we concur with the recommendations and statements of specific actions or alternative actions, with timelines. HHS-OIG has also requested the reasons for any disagreement with the recommendations. As you noted, we had begun implementation of a number of actions to address your recommendations prior to receiving them. Each of our responses to the recommendations has been implemented.

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In the response below, we have set forth each summary recommendation from the Onsite Review and our response, in which we set forth the circumstances leading to the recommendation.

**Establish Annual Training Plans for Professional Disciplines**

~~The Unit should develop formal training plans that indicate the type and duration of training expected each year for employees in each professional discipline. The Unit may work with NAMFCU or OIG to identify additional relevant training opportunities for staff.~~

**Response:** We concur with the recommendation. We have implemented the new procedure – as previously forwarded to you – for adopting annual training plans for each MFCU professional discipline.

**Analysis:** During the review period, the Unit maintained a written training policy which emphasized: 1) initial in-house orientation and mentoring new staff, 2) access to NAMFCU trainings as availability allowed, 3) access to more specific training on an individual-nccd basis and in view of the cost-effectiveness of the trainings available, and 4) satisfaction of all professional MFCU disciplines' requirements for continuing education. However, as noted, we maintained no "annual training plan" for each professional discipline. Since our investigators are not commissioned officers under state law, the attorneys are the only professional discipline for which MFCU employees are subject to mandatory training (See Mo Supreme Court Rule 15). During the review period and since, all MFCU attorneys have more than satisfied the numerous legal educational hours required. Since FFY 2008, MFCU employees (38) have received over 1,852 hours of formal training. This training has been designed to satisfy all professional requirements. In addition, we designed and conducted in-house training courses (often shared with our SSA), and we continue to take advantage of cost-effective NAMFCU, OIG and private course offerings.

As noted in the review, any deficiency in advance/individualized "planning" of such training efforts has not affected staff qualifications and productivity. A more than sufficient amount of training has taken place notwithstanding the lack of formal training plans.

**Plan:** We are implementing the MFCU Training Policy (including an annual plan) as previously forwarded to OIG. Annual training plans will be formulated on an individual employee and discipline-specific basis concurrent with our annual AGO employee evaluation cycle occurring each August. The plans will be documented and their implementation monitored and recorded.

**Ensure That Case Files Contain Documented Supervisory**

**Approval and Documented Periodic Supervisory Reviews**

The Unit should make use of its newly developed formal investigative checklist tool to ensure that case openings are approved by supervisors.

Unit managers should place documentation of all supervisory reviews in the case files. This will assist in evaluating the timeliness of investigation, prosecution, and closure of cases.

**Response:** We concur with this recommendation. Our MFCU case management system now facilitates automated documentation of our supervisory reviews of each case for insertion into each case file and that all case openings are approved in writing.

**Analysis:** During the review period, certain types of case referrals were automatically opened on our case tracking system without written documentation reflecting supervisory approval. These matters included referrals from other law enforcement (United States Attorneys Offices, FBI, etc.) or regulatory agencies which by their nature and content have the necessary evidentiary support to merit case opening and at least a minimal investigative inquiry. Thus these referrals were systematically opened and pursued without a distinct administrative “opening” as to each.

Further, our statute - Section 198.093 RSMo – requires the Attorney General’s Office to investigate certain complaints of abuse and, as such, these matters were also opened without individual supervisory approval. These matters accounted for nearly 301 of the cases opened by MFCU during the review period. The Director now reviews all referrals, including those bearing this presumed credibility, to determine the merit of opening same.

With respect to documentation of case reviews of MFCU attorneys’ caseload, as a matter of administrative mechanics, we have consistently documented case-related status information, progress and case management direction. However, accompanying documentation was collectively retained in a separate file – not in the case files. As mentioned, MFCU’s current electronic ‘investigative checklist’ process (and other features of our case management system) will ease the task of generating case-related documentation – including both case opening and case management documentation – in the individual case files.

**Plan:** Since the review period, we have begun and will continue to electronically document referrals and case openings from all sources, “periodic supervisory reviews,” case dispositions (including referrals to other agencies) and case closures. In addition, case (provider) type, investigative hours invested in each case and age of cases will also be recorded and tracked to facilitate ongoing evaluation of Unit productivity and case progress.

**Ensure That Case Files Are Not Vulnerable to Unauthorized Access**

**Response:** We concur with this recommendation. Potential access issues have been addressed by assuring that case files are secured in locked file cabinets or our key-coded evidence room.

**Analysis:** MFCU acknowledges the importance of securing potentially sensitive records and materials including our work product and potential confidential materials obtained in investigations and cases.

**Plan:** Since the review period, lockable file cabinets, lockable desk drawers and a secure, locked key-coded evidence room have provided us the opportunity to secure all case files and ensure confidential material is secure.

MFCU policy makes clear all employees' obligation to protect not only our work product, but also patient and provider confidentiality as required by law. Compliance will be strictly enforced.

**Conclusion**

The Missouri MFCU appreciates the efforts of HHS-OIG and the consultations provided by the Onsite Review. We understand and concur with the recommendations, which will be implemented as our electronic MFCU case management system is completed.

As the statistics you note demonstrate, MFCU has achieved cost effective protection of the Medicaid Program over the course of the review period. We have continued to improve both on our record of recovery and our prosecutorial successes and will implement the recommendations you have made in a manner consistent with our mission.

Respectfully submitted,

*/S/*

Joséph P. Bindbeutel  
Assistant Attorney General  
Director, Medicaid Fraud Control Unit

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## ACKNOWLEDGMENTS

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Brian T. Whitley served as the team leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Michael J. Brown, Susan Burbach, and Teresa Dailey. Office of Audit Services staff who conducted the study include Ann Lowe and Julie Wisner. Office of Investigations staff who conducted the study include Margaret Walker. Central office staff who provided support include Kevin Farber, Ryan Moul, Debra Roush, Richard Stern, and Jason Weinstock.

# Office of Inspector General

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