

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



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**EXECUTIVE SUMMARY: INDIANA STATE MEDICAID FRAUD CONTROL
UNIT: 2013 ONSITE REVIEW
OEI-07-13-00250**

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 conducted an onsite review in May 2013. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation on the Unit's operations, staffing, and caseload for fiscal years (FYs) 2010 through 2012; (2) a review of financial documentation for that timeframe; (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 a sample of case files that were open in FYs 2010 through 2012; and (7) an onsite observation of Unit operations.

WHAT WE FOUND

From FYs 2010 through 2012, the Unit reported combined civil and criminal recoveries exceeding \$110 million and 105 convictions. The Unit did not exercise proper fiscal controls over claimed expenditures and program income, and it did not maintain adequate internal controls of the equipment in its possession. Documented supervisory approval to open cases was missing in an estimated 77 percent of the case files, and documented supervisory approval to close cases was missing in an estimated 18 percent of the closed-case files. In addition, the Unit did not maintain a training plan that included an annual minimum number of training hours for each professional discipline and the Unit's MOU with Indiana's State Medicaid agency did not reflect current law and practice. Finally, the Unit did not timely refer 25 convictions to OIG for the purpose of program exclusion.

WHAT WE RECOMMEND

We recommend that the Unit work with OIG's MFCU oversight division to ensure compliance with the 12 performance standards. The Indiana Unit concurred with all five of our recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of the State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.¹ Under the Medicaid statute, each State must maintain a certified Unit, unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State, and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.² Currently, 49 States and the District of Columbia (States) have created such Units.³ In fiscal year (FY) 2013, combined Federal and State grant expenditures for the Units totaled \$230 million, of which Federal funds represented \$172.5 million.⁴ That year, the 50 Units employed 1,912 individuals.

To carry out its duties and responsibilities 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 the potential for criminal prosecution. In FY 2013, the 50 Units collectively reported 1,341 convictions and 879 civil settlements or judgments.⁶ That year, the Units reported recoveries of approximately \$2.5 billion.⁷

Units are required to have either Statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an office with such authority.⁸ Units must be located in the State Attorney General's office

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

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

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

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

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

⁶ OIG, *State Medicaid Fraud Control Units Fiscal Year 2013 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on July 16, 2014.

⁷ Ibid.

⁸ SSA § 1903(q)(1).

or another State government office with Statewide prosecutorial authority, or operate under a formal arrangement with the State Attorney General's office.⁹

In Indiana and 43 other States, the Units are located within offices of State Attorneys General that have prosecutorial authority. In the remaining six States, the Units are located in other State agencies.¹⁰ Generally, Units within other State agencies must refer cases to other offices with prosecutorial authority, such as an Attorney General or State's Attorney.¹¹

Each Unit must be a single, identifiable entity of the State government, distinct from the State Medicaid agency, and each Unit must develop a formal agreement—i.e., a Memorandum of Understanding (MOU)—that describes the Unit's relationship with that agency.¹²

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to the Office of Inspector General (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.¹³ All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹⁴ To receive Federal reimbursement, each Unit must submit an application to OIG.¹⁵ OIG reviews the application and notifies the Unit of its approval and certification. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.¹⁶

Under the Medicaid statute, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁷ OIG developed and issued 12 performance standards to define the criteria it applies in assessing whether a Unit is effectively carrying out statutory functions and meeting

⁹ SSA § 1903(q)(1). 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf> on May 15, 2013.

¹⁰ The Units share responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States also employ a Medicaid Inspector General who conducts and coordinates the State agency's activities to combat fraud, waste, and abuse in this area.

¹¹ SSA § 1903(q).

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

¹³ The portion of funds reimbursed to States by the Federal government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called Federal Financial Participation (FFP).

¹⁴ SSA § 1903(a)(6)(B).

¹⁵ 42 CFR § 1007.15(a).

¹⁶ 42 CFR § 1007.15(b) and (c).

¹⁷ SSA § 1902(a)(61).

program requirements.¹⁸ Examples of criteria include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all professional disciplines (i.e., for attorneys, investigators, and auditors), and establishing policy and procedure manuals to reflect the Unit's operations. (See Appendixes A and B for complete listings of the performance standards from 1994 and of the revised standards from 2012, respectively.)

Indiana State MFCU

The Indiana Medicaid Fraud Control Unit is a component of the Office of the Indiana Attorney General. At the time of our review, the Unit's 49 employees worked from the Unit's central office in Indianapolis, as well as 9 regional offices located throughout the State.^{19,20} The Unit director, deputy director, and three of the Unit's five supervisors work in the central office, while two supervisors work from regional offices.

The Unit staff is divided into two sections: Litigation and Investigations. The Unit director directly supervises the Unit attorneys, who are assigned to the Litigation section.²¹ The Unit deputy director, who reports to the Unit director, is also the chief investigator and is responsible for managing the four supervisors within the Investigations section. Each supervisor manages the day-to-day activities of an assigned team of investigators, auditors, and support staff. Two supervisors work from Indianapolis and manage staff in that office. Another supervisor works from Hobart, and a fourth supervisor works from New Albany. The Hobart supervisor manages the staff in the northern regional offices, and the New Albany supervisor manages the staff in the southern regional offices.

For FY 2012, the Indiana Unit expended all but \$600 of its \$3.4 million in authorized Federal funds and an additional \$1.1 million in State matching funds.²² Total combined Federal and State Medicaid expenditures in the

¹⁸ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf> on May 15, 2013. OIG published revised performance standards on June 1, 2012, at 77 Fed. Reg. 32645 (online at <http://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf>).

¹⁹ The Unit's central office is located in the State capital of Indianapolis. Regional offices are located in Angola, Danville, Evansville, Hobart, Mishawaka, Muncie, New Albany, Warsaw, and Westville.

²⁰ OIG analysis of the *2012 Indiana Recertification Questionnaire to MFCU Director. Review Period April 1, 2011, through March 31, 2012.*

²¹ One Litigation section attorney supervises the section's interns and legal support staff.

²² OIG analysis of State form SF-425 for FY 2012.

State of Indiana increased from \$6.2 billion in FY 2010 to \$7.9 billion in FY 2012.²³

For FYs 2010 through 2012, the Unit received an average of 1,912 referrals per year. The Indiana State Department of Health (ISDH) is the State agency responsible for licensing and surveying long-term care facilities and is the most significant source of referrals received by the Unit. ISDH forwards to the Unit every complaint that it receives. The Office of Medicaid Policy and Planning (OMPP) is the State Medicaid agency that houses the Medicaid Program Integrity Unit, which referred 66 prescreened cases to the Unit during FYs 2010 through 2012. Additional referral sources include calls to the Unit hotline; a complaint form located on the Web site of the Office of the Indiana Attorney General; OIG; other State agencies; and providers.

Unit staff enter every referral into the Unit's case management and tracking system. Duplicate referrals are combined into a single complaint to preserve information. An Investigations section supervisor determines whether the Unit has jurisdiction and whether an investigation is warranted. Depending on the available facts and circumstances, the supervisor may elect to close a case without an investigation, initiate a preliminary investigation to obtain more information, or authorize a full investigation. Once an investigation is complete, the case is reviewed by a supervisor who determines whether to close the matter or refer the case to a prosecutor.

The Office of the Indiana Attorney General does not have authority to initiate prosecution for health care crimes. Therefore, the Unit refers cases for prosecution to one of the two United States (U.S.) Attorney's Offices in Indiana or to the appropriate county prosecutor. County prosecutors may elect to prosecute a case, decline it, or refer it back to the MFCU to pursue in the local jurisdiction.

The Litigation section is responsible for prosecuting cases jointly with county prosecutors and for tracking and prosecuting "global"²⁴ and State-only²⁵ *qui tam* (whistleblower) cases. Unit attorneys may also be asked to provide legal advice regarding cases under investigation.

²³ 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/expenditures_statistics/fy2012-statistical-chart.htm on May 15, 2013.

²⁴ "Global" cases are civil false-claims actions involving the U.S. Department of Justice and other State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the coordination of global cases.

²⁵ Indiana False Claims and Whistleblower Protection Act, Indiana Code § 5-11-5.5-4 (c).

METHODOLOGY

We conducted the onsite review in May 2013. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation on the Unit's operations, staffing, and caseload for FYs 2010 through 2012; (2) a review of financial documentation for that timeframe; (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 a sample of case files that were open in FYs 2010 through 2012; and (7) an onsite observation of Unit operations. (Appendix C contains the details of our 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 combined civil and criminal recoveries exceeding \$110 million and 105 convictions

The Unit reported total combined criminal and civil recoveries of nearly \$110 million for FYs 2010 through 2012. Recoveries decreased from \$33 million in FY 2010 to \$29 million in FY 2011, then increased to \$47 million in FY 2012. Settlements for global cases accounted for \$91 million of the total \$110 million in Unit recoveries over the 3-year period. (See Table 1 for details regarding criminal and civil recoveries.)

During our review period, the Unit opened 4,089 cases and closed 3,975 cases. The Unit specified that 2,371 referrals lacked sufficient indication of a crime to warrant a full investigation and that 130 referrals were duplicate complaints that were combined into another matter. (See Appendix D for more information on investigations opened and closed by provider category.) The Unit reported 133 referrals for prosecution, with 105 convictions of 94 individuals and entities for health care fraud, patient abuse and neglect, or financial exploitation.

The Unit reported 1,187 abuse and neglect referrals from ISDH in 2010, 1,074 in 2011, and 500 in 2012. With regard to the much-lower number for 2012, the Unit director stated that because of a lack of resources, the Unit had not recorded all referrals received from ISDH that year. The Unit director also stated that subsequent to 2012, the Unit had recorded and reported correctly to OIG the number of referrals received from ISDH. (For additional information on Unit referrals, see Appendix E.)

Table 1: Indiana MFCU Criminal and Civil Recoveries, FYs 2010–2012

Type of Recovery	FY 2010	FY 2011	FY 2012	Total Recoveries
Criminal Recoveries	\$2,302,000	\$3,238,390	\$5,595,123	\$11,135,513
Global Recoveries	\$28,443,364	\$24,946,873	\$37,416,777	\$90,807,014
Nonglobal Civil Recoveries	\$2,359,058	\$1,702,126	\$4,142,286	\$8,203,470
Total Recoveries	\$33,104,422	\$29,887,389	\$47,154,186	\$110,145,997

Source: OIG review of Unit self-reported data and Quarterly Statistical Reports, FYs 2010–2012.

The Unit did not exercise proper fiscal controls over claimed expenditures and receipt of settlement amounts

According to the 1994 and 2012 Performance Standard 11, the Unit should exercise proper fiscal control over Unit resources. However, we found that during the review period of FYs 2010 through 2012, the Unit lacked adequate fiscal internal controls related to claimed expenditures and settlement amounts. We also found evidence that the Unit lacked adequate fiscal internal controls in FY 2013, a period subsequent to our review timeframe.

We found several examples of inadequate fiscal internal controls related to expenditures. First, we were unable to reconcile \$4,900 of the Unit's \$13.2 million in claimed costs reported on the Unit's Financial Status Reports (FSRs) for the review period. Second, the Unit's financial reconciliation process did not appear to be subject to a second level of review. Third, during the course of our review the Unit had difficulty locating requested financial information and providing it to OIG; the Unit attributed this to the retirement of the Unit's controller in August 2013. Also, for FY 2013, subsequent to our review period, the Unit's FSR reported expenditures of nearly \$78,000 more in Federal funds than authorized on the Unit's notice of award. To cover funds that the Unit had overspent, OIG provided the Unit with a supplement, which the Unit was required to match with \$25,896 of its own funds.

Finally, for FY 2010, we found instances of inadequate fiscal internal controls related to settlement amounts. We identified civil settlement funds that the Unit received directly and retained. Per OIG's *State Fraud Policy Transmittal Number 10-01, Program Income*—which reiterated the Centers for Medicare & Medicaid Services (CMS) policy²⁶ regarding the reporting of program income and settlements—the Unit should have instead sent these funds, along with other civil settlement amounts, to the State Medicaid agency to calculate the Federal share and return the appropriate portion to the Federal government.

The Unit did not maintain adequate internal controls of the equipment in its possession

According to 1994 and 2012 Performance Standard 11(b), the Unit should maintain an equipment inventory that is updated regularly to reflect all property in the Unit's possession. Federal regulations require a physical inventory of property (i.e., equipment) to be conducted at least once every

²⁶ CMS State Health Official Letter #08-004.

2 years.²⁷ State guidelines also require a documented physical inventory to be conducted annually.²⁸

We found that the Unit did not conduct physical inventories of its property during our review period and lacked policies and procedures to ensure that annual physical inventories were conducted and maintained for auditing purposes. Consequently, the Unit was unable to locate a lateral file valued at \$947, purchased in FY 2010. Additionally, the Unit had five computers with State of Indiana property tag numbers that did not correspond to numbers on its equipment inventory. The lack of physical inventories could result in the inability to identify additional property and equipment purchased with Federal funds.

Unit case files lacked documented supervisory approvals and reviews

According to 1994 Performance Standard 6(b) and 2012 Performance Standard 5(b), Unit supervisors should approve the opening and closing of cases to ensure a continuous case flow and timely completion of cases. Supervisory approval to open and close cases demonstrates that Unit supervisors are monitoring the intake of cases and the timeliness of case resolutions, thereby promoting the efficiency and effectiveness of Unit staff. During our onsite review, Unit management and supervisory staff specified that authorization to open and close cases is documented by email and uploaded to the Unit's electronic case management system. From our case file review, we estimate that 77 percent of the case files lacked documented supervisory approval to open cases and an estimated 18 percent of closed-case files lacked documented supervisory approval to close cases. Global cases and cases "closed without investigation" composed an estimated 52 percent of the case population and were not included in our review, as the Unit did not have a formal process of supervisory approval for the opening or closing of these types of cases.

According to 1994 Performance Standard 6(c) and 2012 Performance Standard 7(a), supervisory reviews should be "conducted periodically and noted in the case file" to ensure timely case completion.²⁹ An estimated 69 percent of case files lacked documentation indicating one or more supervisory reviews. (See Appendix F for all estimates and 95-percent confidence intervals for projections.)

²⁷ 45 CFR § 92.32(d)(2).

²⁸ Section 6 of the State of Indiana's Capital Asset Policy (July 1, 2009, Revision).

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

The Unit's deputy director reported that each supervisor decides how often to conduct periodic reviews of case files—one supervisor conducts reviews on a regular basis, while the other three supervisors conduct their reviews on an informal basis. One supervisor conducts his case file reviews every 6 months via email; during our onsite review, he shared copies of those documents with the review team. The review team noted that investigators assigned to this supervisor selected the cases for supervisory review during each review period. A second supervisor reported that his team conducts quarterly case file reviews as a group, where the team provides feedback on each investigator's cases. A third supervisor reported daily reviews of the latest entries recorded in the case management and tracking system. The remaining supervisor reported that his case file reviews are less formal because he “works cases with [investigators] every day” and is familiar with each investigation. The Unit director also acknowledged that the supervisors “have not been making [supervisory review] entries” into the case management and tracking system.

Although we found no evidence to suggest that supervisors lacked awareness of the cases assigned to their teams, the lack of a formalized supervisory case review process may be problematic. For example, we noted one case in our sample that lacked evidence of investigative progress for an extended period of time. Entries into the case management and tracking system reflect that the complaint was received in early 2006 and was later combined with a duplicate case in mid-2007. No activity was recorded until 2009, when a series of case notes was entered into the system. No further activity occurred until 2012, when the case was referred to State Medicaid agency. The lack of progress on the case was attributed to the investigator's working on another important case with an external agency. In another example, a case was declined for prosecution in 2011 but was never closed. The lack of case closings in these examples was identified only after the review team provided the list of sampled case files selected for review. One case was closed just prior to our onsite review, and the case supervisor closed the second case while the review team was onsite.

The first case example cited above did not adhere to 1994 Performance Standard 6(a) and 2012 Performance Standard 5(a), which state that each stage of an investigation and prosecution is to be completed in an appropriate timeframe. In both instances, the cases were not closed appropriately and did not adhere to 2012 Performance Standard 5(b), which states: “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.”

The Unit did not maintain a training plan that included an annual minimum number of training hours for each professional discipline

According to 1994 Performance Standard 12(b) and 2012 Performance Standard 12(a), the Unit should maintain an annual training plan for each professional discipline that includes an annual minimum number of training hours. The Unit did not have an annual training plan. However, the Unit's policies and procedures manual specifies that all new staff members are required to attend basic Medicaid training and all new investigators must also complete a weeklong training course at the Indiana Law Enforcement Academy. Further, all employees are encouraged to attend one out-of-State training annually, to obtain training that is unavailable locally. Each employee's performance plan includes an annual development component for identifying needs related to professional development, continuing education, and other types of training. All staff who answered the training-related questions on the staff survey reported that the Unit provided training opportunities and that the training they received aided the mission of the Unit.³⁰

The Unit's MOU with the State Medicaid agency did not reflect current law and practice

According to 2012 Performance Standard 10, the Unit is to ensure that its MOU "reflects current practice, policy, and legal requirements." The Unit's MOU did not include a provision describing the referral process between the Unit and the State Medicaid agency for providers who are subject to a payment suspension on the basis of a credible allegation of fraud.³¹ Therefore, the Unit did not meet 2012 Performance Standard 10(b). Subsequent to our onsite review, the Unit incorporated payment-suspension provisions into a revised MOU.

³⁰ Although we reviewed Unit training, 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/or law enforcement training, and that the lack of an annual training plan does not suggest that professional staff are unqualified.

³¹ The Affordable Care Act, § 6402(h)(2), requires State Medicaid programs—as a condition of receiving FFP—to suspend payments to providers for whom there is a credible allegation of fraud, unless good cause exists to not suspend payments. One way to establish good cause is for the MFCU to inform the Medicaid agency that the suspension would compromise or jeopardize its investigation of the provider. CMS and OIG implemented this provision in revisions to 42 CFR §§ 455.23 and 1007.9(e) effective March 25, 2011 (76 Fed. Reg. 5862).

The Unit did not timely refer 25 convictions to OIG for the purpose of program exclusion

According to 1994 Performance Standard 8(d), the Unit has the responsibility to transmit to OIG “reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period.”³² The 2012 revised Performance Standard 8(f) states that it is the Unit’s responsibility to transmit “all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders,” and does not add “or other reasonable time period” to the 30-day timeframe. Of the 105 convictions, 25 were not referred timely to OIG for exclusion. The Unit never referred 11 convictions to OIG, and it referred 14 convictions after the 30-day timeframe. One referral that OIG received in 2012 had been forwarded 468 days after sentencing.

Other observations: Data systems

In its *2012 Annual Report* to OIG, the Unit reported an issue of concern regarding electronic medical records and other potential digital evidence seized during the course of an investigation. The Unit described a situation in which investigators seized more than one million computer files and required the resources of a U.S. Attorney’s Office’s data management system to search, sort, and organize the data. The Unit also noted that it is impractical to rely on the Offices of the U.S. Attorneys for data management capabilities in all such cases and that it would need additional funding from the State to obtain an in-house system capable of storing and effectively managing large volumes of electronic records and evidence. This issue remains unresolved.

³² Under 42 U.S.C. § 1320a-7(a), OIG is required to exclude from participation in Federal health care programs any person or entity convicted of a criminal offense related to the delivery of an item or service under the Medicaid program or to the neglect or abuse of patients in residential health care facilities. See also 42 CFR § 1001.1901.

CONCLUSION AND RECOMMENDATIONS

For FYs 2010 through 2012, the Unit reported combined civil and criminal recoveries of more than \$110 million, of which \$91 million represented global case recoveries. The Unit referred 133 cases for prosecution, which resulted in 105 convictions against 94 individuals and entities for health care fraud, patient abuse and neglect, or financial exploitation.

The Unit lacked sufficient fiscal internal control policies and procedures to ensure the proper reporting of its income and expenditures. Further, internal controls regarding the inventory of property (i.e., equipment) had weaknesses that resulted in our inability to locate and identify ownership of equipment under the Unit's control.

Seventy-seven percent of case files lacked documentation of supervisory approval to open a case, and 18 percent of closed case files lacked documentation of supervisory approval to close a case. Additionally, 69 percent of case files reviewed lacked documentation of at least one supervisory review. Our review also found that the Unit lacks a formalized supervisory case review process.

The Unit did not maintain a training plan that included an annual minimum number of training hours for each professional discipline. The Unit's MOU with the State Medicaid agency did not include language regarding the suspension of payments in cases of fraud. The Unit did not timely refer the convictions of 25 providers to OIG for the purpose of program exclusion, in accordance with the Performance Standards.

We recommend that the Indiana Unit:

Develop policies and procedures to address fiscal internal control weaknesses

The Unit should implement policies and procedures to correct fiscal internal control weaknesses affecting reconciliation reporting, second level financial management reviews, grant funds expenditures, and the allocation of civil settlement proceeds. Finally, the Unit should work with the Indiana Medicaid program to calculate and return the appropriate, if any, Federal share of civil settlement amounts to the Federal government.

Establish policies and procedures to ensure annual physical inventories of Unit property

Ensure that all case files contain opening and closing supervisory approvals and documented supervisory reviews

The Unit should take action to ensure that all case files include documented supervisory approvals for the opening and closing of cases. Additionally, the

Unit should incorporate a periodic supervisory review policy into the policies and procedures manual.

Establish a training plan that includes an annual minimum number of training hours for each professional discipline

Refer individuals for program exclusion to OIG within 30 days of sentencing

The Unit should make certain that all individuals and entities convicted of fraud, abuse, or neglect are reported within 30 days of their sentencing, in accordance with Performance Standard 8(f) of the 2012 Performance Standards.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with the five report recommendations.

Regarding the first recommendation, the Unit partially concurred with the finding, and concurred with the recommendation. The Unit reported that claimed expenditures will be subjected to a second-level review to ensure accounting accuracy. The Unit explained that the retirement of the Unit's controller during the review was a contributing factor in the difficulty in providing requested information, which should not be a concern in the future. Also, the Unit acknowledged that any future requests for supplemental funding will be submitted prior to the end of the grant period. Finally, the Unit reported that it will work with the State Medicaid agency to return any Federal civil share of settlement amounts that may be due to the Federal Government.

Regarding the second recommendation, the Unit concurred and noted that following our onsite review, staff located a file cabinet that exactly matched the description of the item that was not found during the onsite review. However, the equipment was missing an inventory tag.

Regarding the third recommendation, the Unit concurred and reported having implemented a new standardized procedure for the documentation of supervisory approvals and reviews.

Regarding the fourth recommendation, the Unit concurred and has reported having developed a written training plan that includes a minimum number of training hours for each professional discipline.

Regarding the fifth recommendation, the Unit concurred. The Unit explained that it does not possess independent prosecution authority, and as such must rely on county prosecutors to report when a plea is negotiated and entered. The Unit stated that nevertheless, it will strive to report all convictions as required.

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

1994 Performance Standards³³

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:

³³ 59 Fed. Reg. 49080, Sept. 26, 1994. These performance standards were in effect for a portion of our review period, and were superseded by the performance standards published in June 2012.

- a. Does the Unit have policy and procedure manuals?
- b. Is an adequate, computerized case management and tracking system in place?

4. A Unit should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit work with the single State Medicaid agency to ensure adequate fraud referrals?
- b. Does the Unit work with other agencies to encourage fraud referrals?
- c. Does the Unit generate any of its own fraud cases?
- d. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?

5. A Unit's case mix, when possible, should cover all significant provider types. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit seek to have a mix of cases among all types of providers in the State?
- b. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?
- c. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?
- d. Are there any special Unit initiatives targeting specific provider types that affect case mix?
- e. Does the Unit consider civil and administrative remedies when appropriate?

6. A Unit should have a continuous case flow, and cases should be completed in a reasonable time. In meeting this standard, the following performance indicators will be considered:

- a. Is each stage of an investigation and prosecution completed in an appropriate time frame?
- b. Are supervisors approving the opening and closing of investigations?
- c. Are supervisory reviews conducted periodically and noted in the case file?

- 7. A Unit should have a process for monitoring the outcome of cases.** In meeting this standard, the following performance indicators will be considered:
- a. The number, age, and type of cases in inventory.
 - b. The number of referrals to other agencies for prosecution.
 - c. The number of arrests and indictments.
 - d. The number of convictions.
 - e. The amount of overpayments identified.
 - f. The amount of fines and restitution ordered.
 - g. The amount of civil recoveries.
 - h. The numbers of administrative sanctions imposed.
- 8. A Unit will cooperate with the OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit communicate effectively with the OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?
 - b. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?
 - c. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?
 - d. Does the Unit transmit to the OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?
- 9. A Unit should make statutory or programmatic recommendations, when necessary, to the State government.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?
 - b. Does the Unit provide program recommendations to single State agency when appropriate?
 - c. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?

- 10. A Unit should periodically review its memorandum of understanding (MOU) with the single State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice.** In meeting this standard, the following performance indicators will be considered:
- a. Is the MOU more than 5 years old?
 - b. Does the MOU meet Federal legal requirements?
 - c. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?
 - d. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?
- 11. The Unit director should exercise proper fiscal control over the Unit resources.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?
 - b. Does the Unit maintain an equipment inventory?
 - c. Does the Unit apply generally accepted accounting principles in its control of Unit funding?
- 12. A Unit should maintain an annual training plan for all professional disciplines.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit have a training plan in place and funds available to fully implement the plan?
 - b. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?
 - c. Are continuing education standards met for professional staff?
 - d. Does the training undertaken by staff aid to the mission of the Unit?

APPENDIX B

2012 Revised Performance Standards³⁴

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.

³⁴ 77 Fed. Reg. 32645 (June 1, 2012).

- 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 C

Detailed Methodology

Data collected from the seven sources below was used to describe the caseload and assess the performance of the Unit.

Data Collection

Review of Unit Documentation. Prior to the onsite review, we analyzed information from several sources regarding the Unit's investigations and referrals for prosecution of Medicaid cases. Specifically, we collected and analyzed information about the number of referrals the Unit received, the number of investigations the Unit opened and closed, the outcomes of those investigations, and the Unit's case mix. We also collected and analyzed information about the number of cases that the Unit referred for prosecution and the outcomes of those prosecutions. We gathered this information from several sources, including the Unit's Quarterly Status Reports, annual reports, recertification questionnaire, policy and procedures manuals, and the MOU with the State Medicaid agency. Additionally, we confirmed with the Unit director that the information we had was current as of May 2013. As necessary, we requested any additional data or clarification.

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 reviewed the Unit's claimed \$13.2 million (\$9.7 million Federal share and \$3.5 million State share) in grant expenditures for FYs 2010 through 2012 to (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 no indirect costs were reported during the period. We reviewed records from the Payment Management System to identify any unusual patterns of drawdowns (withdrawals from the grant funds). Finally, we reviewed revenue accounts to identify program income amounts.

Interviews with Key Stakeholders. In April 2013, we conducted structured interviews with key stakeholders who were familiar with the operations of the Unit. Specifically, we interviewed officials in the U.S. Attorneys' Offices from the Northern and Southern districts of Indiana, and staff from the following agencies under the umbrella of Indiana's Family and Social Services Administration (FSSA): OMPP, and its Program Integrity Unit; the Division of Aging; the Office of General Counsel; the State Long-Term Care Ombudsman; and Adult Protective Services. We also interviewed staff from the Division of Long-Term Care within the Indiana Department of Health. Additionally, we interviewed Special Agents from OIG's Chicago regional

office who work regularly with the Unit. Each of these interviews focused on the Unit's interaction with external agencies. We used the information collected from these interviews to develop subsequent questions for interviews with Unit management.

Survey of Unit Staff. In April 2013, we conducted an online survey of all nonmanagerial Unit staff within each professional discipline (i.e., investigators, auditors, and attorneys) as well as support staff and the support staff supervisor in the Litigation section.³⁵ We requested and received responses from each of the 43 staff members, a 100-percent response rate. Our questions focused on operations of the Unit, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Interviews with Unit Management. During our May 2013 onsite review, we conducted structured interviews with the Unit director, deputy director, and the four supervisors in the Investigations section. We asked these individuals to provide additional information to better illustrate the Unit's operations, identify opportunities for improvement, identify practices that contributed to the effectiveness and efficiency of Unit operations and/or performance, and clarify information obtained from other data sources.

Onsite Review of Case Files. The Unit provided a list of 4,886 cases that were open at any point during FYs 2010 through 2012. We excluded from our analysis 2,469 of these cases that the Unit had categorized as "global" or "closed without investigation." We then selected a simple random sample of 100 cases from the remaining 2,417 cases. From these 100 cases, we selected a simple random sample of 50 cases for a more in-depth review of selected issues, such as the timeliness of investigations and case development. We excluded an additional three ineligible cases in our sample that were not initially identified by the Unit as global cases. In our final case file analysis, we reviewed the remaining 97 cases for documentation of supervisory approval for the opening of cases, documentation of the closing of cases (if applicable), and documentation of supervisory case file reviews. Finally, we projected the results of our case file reviews to an estimated population of 2,344 Unit cases categorized as nonglobal, of which an estimated 1,595 represented closed case files.

Onsite Review of Unit Operations. As part of our May 2013 onsite visit, we reviewed the Unit's workspace and operations. Specifically, we visited the

³⁵ The supervisor within the Litigation section supervises support staff—not investigators, auditors, or attorneys. Therefore, we included this individual in our staff survey.

Unit's central office in Indianapolis. We observed the Unit's offices and meeting spaces, security of data and case files, location of select equipment, and the general functioning of the Unit.

Data Analysis

We analyzed 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.³⁶ In addition, we noted practices that appeared to be beneficial to 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.

³⁶ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu>.

APPENDIX D

Investigations Opened and Closed by Provider Category for Federal Fiscal Years 2010 Through 2012

Table D-1: Fraud Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
Facilities	Opened	Closed	Opened	Closed	Opened	Closed
Hospitals	14	11	12	20	14	14
Nursing Facilities	21	18	19	13	22	21
Other Long-Term Care Facilities	5	4	3	2	8	7
Substance Abuse Treatment Centers	0	0	0	0	0	0
Other	2	5	10	38	7	2
Subtotal	42	38	44	73	51	44
Practitioners	Opened	Closed	Opened	Closed	Opened	Closed
Doctors of Medicine or Osteopathy	23	29	26	22	24	18
Dentists	25	26	15	12	11	9
Podiatrists	2	3	0	1	0	1
Optometrists/Opticians	2	3	1	2	2	1
Counselors/Psychologists	2	3	2	2	2	2
Chiropractors	3	4	1	5	4	1
Other	1	2	2	0	0	1
Subtotal	58	70	47	44	43	33
Medical Support	Opened	Closed	Opened	Closed	Opened	Closed
Pharmacies	7	12	10	13	16	6
Pharmaceutical Manufacturers	74	22	94	29	39	11
Durable Medical Equipment and/or Supplies	14	9	17	12	16	5
Laboratories	11	0	3	4	3	0
Transportation Services	12	29	13	18	13	11
Home Health Care Agencies	10	10	7	6	8	6
Home Health Care Aides	2	1	0	1	2	1
Nurses/Physician Assistants/ Nurse Practitioners/Certified Nurse Aides	10	16	13	15	9	18
Radiologists	1	0	1	0	0	2
Medical Support—Other	29	37	18	16	29	18
Subtotal	170	136	176	114	135	78

Table D-1 (Continued): Fraud Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Managed Care	1	0	0	0	0	0
Medicaid Program Administration	0	0	0	0	1	0
Billing Company	0	0	0	0	0	0
Other Program Related	4	2	3	2	1	0
Other—Global	31	8	27	11	14	4
Subtotal	36	10	30	13	16	4
Total Provider Categories	306	254	297	244	245	159

Source: Unit response to OIG data request.

Table D-2: Patient Abuse, Neglect, and Funds Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing Facility	1,148	1,184	1,088	1,048	441	492
Other Long-Term Care	92	87	82	84	204	177
Nurses/Physician Assistants/ Nurse Practitioners/Certified Nurse Aides	15	36	8	20	8	30
Home Health Aides	2	0	0	1	1	2
Other	58	63	50	49	44	45
Total	1,315	1,370	1,228	1,202	698	746

Source: Unit response to OIG data request.

APPENDIX E

Medicaid Fraud Control Unit Referrals by Provider Category for Federal Fiscal Years 2010 Through 2012

Referral Source	FY 2010			FY 2011			FY 2012		
	Fraud	Abuse and Neglect	Patient Funds	Fraud	Abuse and Neglect	Patient Funds	Fraud	Abuse and Neglect	Patient Funds
Medicaid Agency – Program Integrity Unit / Surveillance and Utilization Review Unit (Family and Social Services Administration, Office of Medicaid Policy and Planning)	21	1	0	14	5	0	25	0	0
Medicaid Agency – Other	3	7	0	3	2	0	1	0	0
State Survey and Certification (Indiana State Department of Health)	5	1,187	0	7	1,074	3	17	500*	5
Other State Agencies	5	6	0	10	6	0	2	9	0
Licensing Board	6	1	0	2	0	0	1	0	0
Law Enforcement	13	34	0	15	22	1	13	22	2
Office of Inspector General	1	2	0	12	9	0	5	1	0
Prosecutors	2	1	1	0	4	2	1	3	2
Providers	24	129	0	16	226	4	50	140	3
Provider Associations	0	0	0	0	0	0	0	0	0
Private Health Insurer	7	0	0	2	0	0	4	0	0
Long-Term Care Ombudsman	1	6	0	0	7	0	0	7	0
Adult Protective Services	3	20	0	0	23	1	1	18	1
Private Citizens	168	440	1	189	699	4	132	265	7
MFCU Hotline	0	0	0	0	0	0	0	0	0
Other	31	3	0	2	2	1	2	1	0
Total	290	1,837	2	272	2,079	16	254	966	20
Annual Total	2,129			2,367			1,240		

Source: OIG analysis of Indiana's MFCU Revised Quarterly Statistical Reports, FYs 2010–2012.

* The Unit is unable to provide the number of referrals that were not reported to OIG for 2012.

APPENDIX F

Point Estimates and 95-Percent Confidence Intervals Based on Reviews of Case Files

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

Table F-1: Confidence Intervals for Case File Review Data

Data Element Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Case files missing supervisory approval for the opening of investigations	97	77.3%	68.0%–84.6%
Closed-case files missing documented supervisory approval for the closing of investigations	66	18.2%	10.6%–29.3%
Case files missing one or more documented supervisory reviews	97	69.1%	59.3%–77.4%

Source: OIG analysis of Indiana's MFCU case files, 2014.

APPENDIX G

UNIT COMMENTS



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June 12, 2014

Mr. Brian Ritchie
Acting Deputy Inspector General for Evaluation and Inspections
Office of the Inspector General
United States Department of Health and Human Services
Room 5660, Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

*Re: Indiana State Medicaid Fraud Control Unit
Onsite Review, OEI-07-13-00250*

Dear Mr. Ritchie:

I have received and thoroughly examined the report of our latest onsite review and desire that you allow this letter to serve as our response, in which we concur and dissent to certain aspects of your "findings." But first, allow me to express my appreciation of the professionalism of your staff during the audit, and make a special note of their willingness to discuss and explain strategies by which we can continue to improve the delivery of our services within the requirements of the law. As a relatively new Director, I was gratified to learn from this most recent process that Indiana continues to perform at a high level of efficiency and effectiveness. My comments will follow the order of Findings contained in your letter.

Finding: The Unit did not exercise proper fiscal controls over claimed expenditures and receipt of settlement amounts.

Response: The Unit concurs in part, and disagrees in part, with respect to both the "Claimed Expenditures" and "Settlement Amounts" Findings.

Claimed Expenditures: The Unit does not concur with this finding. In 2009 The Indiana Attorney General transitioned accounting systems. This migration of accounting systems over the applicable grant review period and change in personnel responsible for the data collection for the analysis period may have contributed to the inability to reconcile \$4,900.00 of costs within the \$13,200,000.00 in claimed costs. The amount represents 0.037% of claimed costs and is within a 99.9% tolerance and therefore could be considered too *de minimus* to

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reconcile given the amount of man hours needed to perform that reconciliation. However, the Unit accepts the recommendation that accounting practices will be subject to a second level of review to help alleviate this concern in the future.

The Unit concurs with the finding that we did have difficulty finding and supplying some requested financial information. The Unit's controller retired the month of the audit contributing to the difficulty finding and supplying requested financial information, which should not be a concern in the future.

The Unit does not concur with the finding that the Unit's seeking supplemental funds was inappropriate. The supplement was requested on the recommendation of the OIG, represented reasonable expenditures, and implicitly approved by the OIG via its offer of additional grant moneys in assistance. The Unit is not required to limit its expenditures to the amount of the grant, and was perfectly willing to cover those additional costs with state funds. The Unit appreciated the OIG's recommendation and believed that represented OIG's approval of the expenditures in light of the considerations that gave rise to the need to expend those funds. The unit appreciates and will follow the recommendation that should such a need arise in the future; the Unit will submit a supplemental request before the end of the grant year.

Settlement Amounts: The Unit does not concur with the finding that the Unit did not exercise proper fiscal controls of receipt of settlement amounts. Any perceived incorrect reporting of program income did not result in the State of Indiana providing less than its share of the Unit's budget. One might infer from the language of this finding that the State of Indiana somehow benefited from erroneous reporting. That is not the case. The State of Indiana did not benefit from any erroneous reporting. The Unit accepts the auditors recommendation and will continue to work with the State's Medicaid program to return the appropriate, if any, Federal share of civil settlements amounts to the Federal government.

Finding: The Unit did not maintain adequate internal controls of the equipment in its possession.

Response: The Unit concurs that we lacked written standards and procedures for the review of physical inventories. For the review period the State maintained all property, equipment and vehicles, in the PeopleSoft Financials system. Subsequent to the review period, the Unit implemented a rolling annual inventory of assets in possession, which will ensure MFCU receives a physical asset inventory audit no greater than once per year and no less than once every two years, in accordance with 45 CSR 92.32(d)(2). The characterization that "the Unit was unable to locate a lateral file valued at \$947" is not complete as the Unit did find a lateral file cabinet, bearing no inventory tag at all, exactly matching the description of the lateral file assigned the missing inventory tag. Thus no property is missing or unaccounted in the possession of the Unit.

Finding: The Unit case files lacked documented supervisory approvals and reviews.

Response: The Unit concurs, and would express appreciation that the finding comments on the Unit's commitment to the underlying purpose of the rule and that Supervisors perform their duties with a keen awareness of the cases assigned to their teams. While we may not have documented the actions relating to the aforementioned standard to an acceptable amount, we did adhere to the spirit of the standard and performed the functions outlined therein. In accordance with the finding, the Unit has created a new standard operating procedure for case review which will standardize the procedure and documentation in accordance with the review findings.

Finding: The Unit did not maintain a training plan that included an annual minimum number of training hours for each professional discipline.

Response: The Unit concurs. The Unit does, in fact, have state guidelines that it does comply with in providing training to its employees and its employees are provided training pursuant to a systematic program, but the unit did not have its own written plan. The Unit has now put its training program in writing, in correction of this finding including an annual minimum number of training hours.

Finding: The Unit's MOU with the State Medicaid agency did not reflect current law and practice.

Response: The Unit concurs in the finding that during the period under review the Memorandum of Understanding (MOU) did not contain a provision describing the referral process between the Unit and Indiana Family Social Services Agency (FSSA). As noted by the findings, the Unit has now added the requested payment-suspension provisions into the newest MOU post review period.

The practice, policy, and legal requirements reflected in the MOU for the review period were current. None were incorrect or outdated. And the performance standard does not require that the MOU contain each and every practice, policy and legal requirement by which the Unit and the State Medicaid agency cooperate. The relationship between the Unit and the State Medicaid agency is dynamic. The agencies meet twice a month to discuss matters of mutual concern. If the MOU had to reflect every modification of a practice or policy, the MOU would have to be updated several times a year, which would require a new MOU being created each time. This would require the MOU being approved through a lengthy process by the Department of Administration, State Budget Agency, Attorney General's Office, and FSSA. Such a burdensome requirement was clearly not intended by this performance standard. Furthermore, the agencies had developed a robust and excellent working agreement for payment suspensions based on credible allegations of fraud, which had been the subject of a lengthy series of meetings and discussions. The agreement not being in the MOU did not mean that the MOU reflected any practice, policy, or legal requirement that was not current.

Finding: The Unit did not timely refer 25 convictions to OIG for the purpose of program exclusion.

Response: The Unit concurs that some referrals were made past the 30 day limit set by Performance Standard 8(f). Performance Standard 8(f) does not reflect the abilities of Units such as Indiana's, which are reliant on county prosecutors to inform the Unit when a plea is negotiated and entered on a particular case. Since the Unit itself has no independent prosecution power, this reliance results sometimes in pleas being negotiated without the knowledge of the Unit. As a result, the lack of prosecution power and reliance on 91 county prosecutors makes the 30-day requirement unreasonable. However, the Unit recognizes that the current 30-day reporting policy is the rule and important for program integrity, therefore, Indiana will strive to report all convictions as required. The 30-day rule is unreasonable and the OIG has acknowledged as much. It is the Unit's understanding that the OIG intends to return to this rule the language recently omitted by Performance Standard 8(f) which recognized that the 30-day timeframe could not reasonably be met by some Units.

The Indiana Medicaid Fraud Control Unit is appreciative of your work in this audit. If you require additional information, please do not hesitate to contact me. I can be reached by calling (317) 915-5300 or matthew.whitmire@atg.in.gov.

Sincerely,

/S/

Matthew Whitmire
Director, Indiana MFCU

Cc: Greg Zoeller, Indiana Attorney General

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