

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**IDAHO STATE MEDICAID FRAUD
CONTROL UNIT:
2012 ONSITE REVIEW**



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WHY WE DID THIS STUDY

The Office of Inspector General (OIG) oversees all State Medicaid Fraud Control Units (MFCU or Unit) with respect to Federal grant compliance. As part of this oversight, OIG annually reviews and certifies all Units. In addition, OIG conducts onsite reviews of selected States. These reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor Unit compliance with Federal grant requirements, laws, and regulations.

HOW WE DID THIS STUDY

We analyzed data from seven sources: (1) a review of documentation, policies, and procedures related to 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 and selected staff; (6) an onsite review of case files; and (7) an onsite review of Unit operations.

WHAT WE FOUND

Our analysis of collected data from fiscal years (FY) 2009 through 2011 shows that the Unit reported recoveries of \$5 million, Unit convictions and civil judgments and settlements increased, and the Unit opened 326 cases. Unit case files consistently contained documentation of supervisory approval to open and close cases, documentation of at least one supervisory review, and documentation of additional, periodic supervisory reviews. The Unit lacked adequate safeguards to secure case files, however. In addition, the Unit had not fully updated its policies and procedures manual to reflect its current operations and had not updated its memorandum of understanding (MOU) with Idaho's State Medicaid agency—the Department of Health and Welfare (DHW)—to reflect current law and practice. Except for case file security and an MOU stipulation that the Unit may be charged for data requests, we found no evidence of noncompliance with applicable laws, regulations, and policy transmittals.

WHAT WE RECOMMEND

We recommend that the Idaho Unit: (1) ensure that case files are secured against unauthorized access and/or removal and create adequate policies or procedures for securing case files and other documentation containing personally identifiable information, (2) revise its policies and procedures manual to reflect current Unit operations, and (3) revise its MOU with DHW to reflect current law and practice. The Unit concurred with all three of our recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.¹ Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services (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.² Currently, 49 States and the District of Columbia (States) have created such Units.³ In fiscal year (FY) 2011,⁴ combined Federal and State grant expenditures for the Units totaled \$208.6 million, of which Federal funds represented \$156.7 million.⁵ That year, the 50 Units employed 1,833 individuals.⁶

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.⁷ The staff reviews complaints provided by the State Medicaid agency and other sources and determines their potential for criminal prosecution and/or civil action. Collectively, in FY 2011, the 50 Units reported 1,230 convictions and 906 civil settlements or judgments. That year, the Units reported recoveries of approximately \$1.7 billion.⁸

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

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

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

⁴ The Office of Inspector General (OIG) had not yet published final FY 2012 figures at the time of this report.

⁵ All FY references in this report are based on the Federal FY (October 1 through September 30).

⁶ OIG, *State Medicaid Fraud Control Units Fiscal Year 2011 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on April 16, 2012.

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

⁸ OIG, *State Medicaid Fraud Control Units Fiscal Year 2011 Grant Expenditures and Statistics*. Pursuant to 42 CFR § 1007.17, Units report the total amount of recovered funds in their annual reports to OIG.

Units are required to have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an office with such authority.⁹ In Idaho and 43 other States, the Units are located with offices of State Attorneys General that have this authority. In the remaining six States, the Units are located in other State agencies;¹⁰ generally, such Units must refer cases to offices with prosecutorial authority. Additionally, each Unit must be a single, identifiable entity of State government, distinct from the State Medicaid agency, and each Unit must develop a formal agreement—e.g., a memorandum of understanding (MOU)—that describes the Unit’s relationship with that agency.¹¹

Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority to both annually certify the Units and administer grant awards to reimburse States for a percentage of their costs of operating them.¹² All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹³ To receive Federal reimbursement, each Unit must submit an initial application to OIG.¹⁴ OIG reviews the application and notifies the Unit if it is approved and the Unit is certified. Approval and certification are valid for a 1-year period; the Unit must be recertified each year thereafter.¹⁵

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁶ OIG developed and issued 12 performance standards to define the criteria that OIG applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements.¹⁷ Examples include maintaining an adequate caseload through referrals from several sources,

⁹ SSA § 1903(q)(1).

¹⁰ In States with a Unit, the Unit shares responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States also employ a Medicaid Inspector General who conducts and coordinates fraud, waste, and abuse activities for the State agency.

¹¹ SSA § 1903(q)(2) and 42 CFR § 1007.9(d).

¹² The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is referred to as Federal Financial Participation.

¹³ SSA § 1903(a)(6)(B).

¹⁴ 42 CFR § 1007.15(a).

¹⁵ 42 CFR § 1007.15(b) and (c).

¹⁶ SSA § 1902(a)(61).

¹⁷ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov> on November 22, 2011. Since the time of our onsite data collection (May 2012), OIG has published a revision of the performance standards, 77 Fed. Reg. 32645 (June 1, 2012). The performance standards referred to in this report are from 1994 and were in effect at the time of our review.

maintaining an annual training plan for all three of the professional disciplines (i.e., for auditors, investigators, and attorneys), and establishing policy and procedures manuals to reflect the Unit's operations. See Appendix A for a complete list of the performance standards.

Idaho Unit

The Unit was founded in 2007; this is its first onsite review.

The Unit is an autonomous entity within the Criminal Law Division of the Idaho Office of the Attorney General and has the authority to prosecute Medicaid fraud and patient abuse and neglect cases. At the time of our review, the Unit's nine employees were located in the State capital of Boise. The Unit Director directly supervises all Unit employees and acts as the Chief Attorney.

The Unit receives provider fraud referrals from the State Medicaid agency—the Idaho Department of Health and Welfare (DHW)—and from Federal agencies, such as OIG. The Unit receives patient abuse and neglect referrals from DHW's Bureau of Facility Standards and Bureau of Long-Term Care. Idaho State statute¹⁸ requires the Unit to refer all patient abuse and neglect allegations it receives to Adult Protective Services of the Idaho Commission on Aging.¹⁹ The Unit receives patient abuse and neglect and provider fraud referrals from other State and local agencies and through a Medicaid Fraud Report Form available on the Idaho Attorney General Web site.²⁰ During the review period, the Unit automatically opened all referrals as cases upon receipt. However, beginning in September 2011, the Unit changed its policy to open cases only after management accepts them for further investigation. For additional information on Unit referrals, see Appendix B.

The Unit's Chief Investigator screens all referrals the Unit receives,²¹ researches the referred complaints, and provides recommendations to the Unit Director on whether to pursue the cases further. The Unit Director decides whether to proceed with the investigations or refer the cases to another agency and notifies the Criminal Law Division Chief of his/her decision.²² For additional information on the Unit's opened and closed

¹⁸ Idaho Statute Title 39, Chapter 53, "Adult Abuse, Neglect, and Exploitation Act."

¹⁹ However, the Unit may still investigate these allegations on its own, without waiting for action from Adult Protective Services or local law enforcement.

²⁰ Complainants use this form to refer both provider fraud and patient abuse and neglect cases to the Unit online. The Unit received 35 Medicaid Fraud Report Form referrals in FYs 2009–2011.

²¹ The Unit occasionally will open cases that were not formally referred by an outside source. For example, a case may be brought to the Unit's attention by the media.

²² The Criminal Law Division Chief within the Idaho Office of the Attorney General supervises the Unit Director.

investigations, including a breakdown by case type and provider category, see Appendix C.

The Unit may open a case and pursue it through a variety of actions, including criminal prosecution, civil action, or a combination of the two. The Unit may close a case for a variety of reasons, including, but not limited to, resolving it through criminal and/or civil action or referring it to another agency.

METHODOLOGY

We analyzed data from seven sources: (1) a review of documentation, policies, and procedures related to the Unit's operations, staffing, and caseload for FYs 2009 through 2011; (2) a review of financial documentation for FYs 2009 through 2011; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management and selected staff; (6) an onsite review of case files that were open in FYs 2009 through 2011; and (7) an onsite review of Unit operations.

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 meet the performance standards or was not operating in accordance with laws, regulations, and policy transmittals.²³ In addition, we noted any practices that appeared to benefit the Unit. We based these observations on statements from Unit staff, data analysis, and our own judgment. We did not independently verify the effectiveness of these practices, but included the information because it may be useful to other Units in their operations.

We conducted the onsite review in May 2012.

Data Collection and Analysis

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

Review of Financial Documentation. We reviewed Unit financial practices to determine compliance with applicable laws and regulations

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

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

Interviews With Key Stakeholders. We conducted structured interviews with six individual stakeholders among four agencies who were familiar with Unit operations. Specifically, we interviewed DHW's Medicaid Program Integrity Supervisor; DHW's Bureau of Facility Standards Chief; an Assistant U.S. Attorney based in Boise; the Criminal Law Division Chief; an OIG Special Agent based in Boise; and an Assistant Special Agent in Charge for OIG's Region IX, which includes the State of Idaho. These interviews focused on the Unit's interaction with external agencies, Unit operations, opportunities for improvement, and any practices that appeared to benefit the Unit and that may be useful to other Units in their operations.

Survey of Unit Staff. We conducted an electronic survey of all applicable Unit staff.²⁴ We requested and received responses from six nonmanagerial staff members, for a 100-percent response rate.²⁵ Our questions focused on operations of the Unit, opportunities for improvement, and practices that appeared to benefit the Unit and that may be useful to other Units in their operations. The survey also sought information about the Unit's compliance with applicable laws, regulations, and policy transmittals.

Interviews With Unit Management and Selected Staff. We conducted structured interviews with the Unit's Director (Chief Attorney), Chief Investigator, and an auditor. We asked them to provide us with additional information necessary to better understand the Unit's operations, identify opportunities for improvement, identify practices that appeared to benefit the Unit and that may be useful to other Units in their operations, and clarify information obtained from other data sources.

Onsite Review of Case Files. We selected a simple random sample of 100 case files from the 329 cases²⁶ that were open at any point from FY 2009 through FY 2011. The design of this sample allowed us to

²⁴ We did not survey one of the Unit's nonmanagerial auditors because we interviewed that auditor onsite.

²⁵ This report uses the terms "management" and "supervisors" interchangeably. "Nonmanagement" employees are Unit staff members who have no supervisory authority.

²⁶ This figure includes cases opened before FY 2009 that remained open at some point during FYs 2009–2011.

estimate the percentage of all 329 cases with various characteristics at the 95-percent confidence level. We reviewed these 100 sampled case files and the Unit's processes for monitoring the status and outcomes of cases. From these 100 case files, we selected another simple random sample of 50 for a more in-depth review of potential issues. This second-phase sample allowed us to conduct a more comprehensive review of case files to identify other potential issues from a qualitative perspective. For population and sample size counts, as well as confidence interval estimates, see Appendix D.

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.²⁷

²⁷ Full text of these standards is available online at <http://www.ignet.gov/pande/standards/oeistds11.pdf>.

FINDINGS

From FY 2009 through FY 2011, the Unit reported recoveries of \$5 million, Unit convictions and civil judgments and settlements increased, and the Unit opened 326 cases

From FY 2009 through FY 2011, the Unit reported total criminal and civil recoveries²⁸ of \$5 million—an annual average of \$1.7 million (see Table 1). Of the \$5 million in recoveries, the Unit attributed \$4.8 million to civil recoveries and \$225,000 to criminal recoveries. The Unit’s annual average expenditures for FYs 2009 through 2011 were \$647,000.²⁹

Table 1: Idaho MFCU Reported Recovered Funds, FYs 2009 Through 2011

	FY 2009	FY 2010	FY 2011	3-Year Total	Annual Average
Reported Criminal Recoveries	\$20,185	\$28,764	\$176,152	\$225,101	\$75,034
Reported Civil Recoveries	\$985,219	\$2,597,964	\$1,190,879	\$4,774,062	\$1,591,354
Total Reported Recoveries	\$1,005,404	\$2,626,728	\$1,367,031	\$4,999,163	\$1,666,388
Total Expenditures	\$596,666	\$646,119	\$699,273	\$1,942,058	\$647,353

Source: OIG analysis of Unit Quarterly Statistical Reports, FYs 2009 through 2011.

From FY 2009 through FY 2011, Unit convictions and civil judgments and settlements increased

From FY 2009 through FY 2011, the Unit obtained 15 convictions and 23 civil judgments and settlements—an annual average of 5 convictions and 7.7 civil judgments and settlements (see Table 2).

²⁸ Unit-reported recoveries include only the State share of funds recovered from multi-State, or “global,” civil false claims cases, both those worked directly by the Unit and those worked by staff from other Units. The Unit-reported civil recoveries do not include the Federal share of recoveries allotted to the Idaho Unit from global cases involving the U.S. Department of Justice and other State MFCUs.

²⁹ The Unit provided data on reported expenditures in response to an OIG data request on February 3, 2012. The figures presented in this paragraph are rounded.

Table 2: Unit Convictions and Civil Judgments and/or Settlements, FYs 2009 Through 2011

	FY 2009	FY 2010	FY 2011	3-Year Total	Annual Average
Convictions	2	5	8	15	5
Civil Judgments and/or Settlements	3	9	11	23	7.7

Source: OIG analysis of Unit Quarterly Statistical Reports, FYs 2009 through 2011.

The Unit’s convictions increased during the review period—from two in FY 2009 to eight in FY 2011. The Unit’s civil judgments and settlements also increased during the review period—from 3 in FY 2009 to 11 in FY 2011.

From FY 2009 through FY 2011, the Unit opened 326 cases

From FYs 2009 through 2011, the Unit opened an average of 109 cases annually—an average of 93 provider fraud and 16 patient abuse and neglect cases. From FYs 2009 through 2011, the Unit closed an average of 97 cases annually—an average of 82 provider fraud and 15 patient abuse and neglect cases.³⁰ From FYs 2009 through 2011, the Unit received an average of 106 referrals annually—an average of 95 provider fraud and 11 patient abuse and neglect referrals.

Ninety-eight percent of case files contained documentation of supervisory approval to open and close cases

According to Performance Standard 6(b), Unit supervisors should approve the opening and closing of cases to ensure a continuous case flow and the timely completion of cases. Supervisory approval to open and close cases 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. Based on our review of 100 case files, the Unit documented supervisory approval to both open and close cases in 98 percent of the case files.

³⁰ Closures include multiple cases opened before FY 2009.

Ninety-one percent of case files contained documentation of at least one supervisory review and 89 percent contained documentation of additional, periodic supervisory reviews

According to Performance Standard 6(c), supervisory reviews should be “conducted periodically and noted in the case file” to ensure timely case completion.³¹ Based on our review of 100 case files, 91 percent of Unit case files contained documentation indicating at least one supervisory review and 89 percent contained documentation indicating additional, periodic supervisory reviews.

The Unit lacked adequate safeguards to secure case files

According to Performance Standard 1, a Unit will conform to “all applicable statutes, regulations and policy transmittals.” Pursuant to Federal regulations, a Unit must “prevent the misuse of information under the Unit’s control” by safeguarding the privacy rights of witnesses, victims, and informants.³² A Unit must also safeguard the identities of suspects when the allegations are unsubstantiated, unless such identities are already in the public record or the individuals clearly consented to the release of their private information. Unit case files containing personally identifiable information were not secured from access by non-MFCU personnel. Although individuals must use a coded access card to enter the Unit’s general office space, several Attorney General Criminal Law Division entities share this office space, and non-MFCU personnel can gain access to areas where case files are stored on open, accessible shelves. These vulnerabilities have created the possibility that personally identifiable information could be removed from the premises undetected. Since our onsite review, the Unit has provided documentation demonstrating that the case files have been properly secured.

The Unit’s policies, procedures, and MOU with DHW were outdated

Although the Unit updated its policies and procedures manual in February 2012, the Unit Director stated that the investigative checklist had not been incorporated into the written manual. In addition, the Unit did not have adequate policies or procedures for securing case files and other

³¹ 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.

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

documentation containing personally identifiable information. Moreover, the Unit's MOU with DHW had not been updated to reflect recent legal changes that allow the Unit to refer any provider under investigation of a credible fraud allegation to DHW for payment suspension. In addition, the Unit's MOU with DHW³³ stipulates that the Unit may be charged for data requests to the DHW Medicaid Program Integrity Unit, contrary to Federal regulations.³⁴

The Unit had not updated its policies and procedures manual to reflect current Unit operations

According to Performance Standard 3, a Unit should establish policies and procedures for its operations, which should be included in a policies and procedures manual. According to Unit management, the manual needs to be revised to incorporate the use of the investigative checklist. In addition, the manual does not incorporate adequate policies and procedures for securing case files and other documentation containing personally identifiable information from unauthorized access and/or removal.

The Unit had not updated its MOU with DHW to reflect current law and practice

According to Performance Standard 10, Units should periodically review their MOUs with the State Medicaid agency to ensure that they reflect current law and practice. As required by Federal regulations,³⁵ the Unit had an MOU with DHW. However, the MOU did not reflect recent legal changes that allow the Unit to refer any provider under investigation for a credible fraud allegation to DHW for payment suspension.³⁶ In addition, Federal regulations require that the State Medicaid agency promptly fulfill any data request from a Unit without charge,³⁷ and that State Medicaid agency obligations to the Unit must be included in the MOU between the Unit and DHW.³⁸ However, the MOU between the Unit and DHW stipulates that "if a charge is incurred by DHW [as a result of fulfilling a data request for the Unit], then such charges will be reimbursed by the [Unit]."³⁹ In addition, the MOU stipulates that Unit requests for information will be assigned equal priority to similar requests from

³³ *Memorandum of Understanding between the Idaho Office of Attorney General and the Idaho Department of Health and Welfare*, § III(A&B).

³⁴ 42 CFR § 455.21(a)(2)(i).

³⁵ 42 CFR § 1007.9(d).

³⁶ 42 CFR §§ 455.23 and 1007.9(e).

³⁷ 42 CFR § 455.21(a)(2)(i).

³⁸ 42 CFR § 1007.9(d).

³⁹ *Memorandum of Understanding between the Idaho Office of Attorney General and the Idaho Department of Health and Welfare*, § III(A&B).

DHW staff, “provided the data does not have to be specially retrieved.”⁴⁰ Neither MOU stipulation complies with Federal regulations, which state that Unit data requests must be fulfilled promptly, regardless of retrieval difficulty, and without charge. The Unit Director indicated that the Unit has never been charged by DHW for data, and that Unit data requests were completed promptly by DHW.

Other Observation: Investigative Checklist and Case Plan

According to Performance Standard 6, a Unit should have a continuous case flow and complete its cases in a reasonable time. According to Unit management and staff, the implementation of an investigative checklist in February 2010 benefitted the Unit’s case flow. The investigator assigned to each case uses the checklist as an investigation guide, and Unit supervisors use the checklist to ensure that personnel follow appropriate investigation policies and procedures and that all investigation steps are completed. In addition, Unit attorneys discuss the “investigative case plan” of each case with the investigator assigned to the case prior to the Unit’s monthly staff meetings. Each investigative case plan is then reviewed by the Unit Director. The investigative case plan contains the overall investigation and prosecution strategy for each case, describes how far the case has progressed, and lists which documents should be included in the case files.

⁴⁰ Ibid., § III(C).

CONCLUSION AND RECOMMENDATIONS

From FY 2009 through FY 2011, the Unit obtained 15 convictions and 23 civil judgments or settlements, reported recoveries of \$5 million, and opened 326 cases. Unit convictions and civil judgments and settlements increased during the review period. Unit supervisors consistently approved the opening and closing of cases, and case files consistently contained documentation of periodic supervisory reviews. The Unit took steps to ensure timely case completion by implementing an investigative checklist and investigative case plan. Finally, the Unit exercised proper fiscal control over its resources.

Other opportunities for improvement exist. Specifically, Unit case files were not secured against potential unauthorized access or removal. The Unit's policies and procedures manual had not been updated to reflect all current Unit operations. Finally, the Unit's MOU with DHW was not updated to reflect recent legal changes that allow the Unit to refer any provider under investigation of a credible fraud allegation to DHW for payment suspension, and the MOU allowed for the Unit to be charged by DHW for data requests, contrary to Federal regulations. With the exceptions of case file security and the MOU stipulation that the Unit may be charged for data requests, our review of compliance issues found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals.

We recommend that the Idaho Unit:

Ensure That Its Case Files Are Secure

The Unit should store its case files and other documentation containing personally identifiable information in a locked room or in locked storage cabinets. Since our onsite review, the Unit has provided documentation demonstrating that the case files have been properly secured.

Revise Its Policies and Procedures Manual To Reflect Current Unit Operations

The Unit should revise its policies and procedures manual to include the investigative checklist and develop policies and procedures for securing case files and other documentation containing personally identifiable information.

Revise Its MOU With DHW To Reflect Current Law and Practice

The Unit should revise its MOU with DHW to specify that the Unit may refer any provider suspected of fraud for payment suspension to DHW and to describe the procedures for this type of referral. In addition, the Unit should revise its MOU with DHW to remove the stipulation that the Unit may be charged for data requests.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with the three report recommendations.

Regarding our first recommendation, the Unit secured its case files by moving the files into a locked room.

Regarding our second recommendation, the Unit revised its policies and procedures to include the investigative checklist and developed policies and procedures for securing case files and other documentation containing personally identifiable information.

Regarding our third recommendation, the Unit is working with DHW to complete a revised MOU by October 5, 2013.

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

APPENDIX A

Performance Standards for Medicaid Fraud Control Units (Unit)⁴¹

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

⁴¹ 59 Fed. Reg. 49080 (Sept. 26, 1994). These performance standards were in effect at the time of our review and precede the performance standards published in June 2012.

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

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

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

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

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

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

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

7. A Unit should have a process for monitoring the outcome of cases.

In meeting this standard, the following performance indicators will be considered:

- a. The number, age, and type of cases in inventory.
- b. The number of referrals to other agencies for prosecution.
- c. The number of arrests and indictments.
- d. The number of convictions.
- e. The amount of overpayments identified.
- f. The amount of fines and restitution ordered.
- g. The amount of civil recoveries.
- h. The numbers of administrative sanctions imposed.

8. A Unit will cooperate with the OIG and other federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit communicate effectively with the OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?
- b. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?
- c. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?
- d. Does the Unit transmit to the OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

9. A Unit should make statutory or programmatic recommendations, when necessary, to the State government. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?

- b. Does the Unit provide program recommendations to single State agency when appropriate?
- c. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?

10. A Unit should periodically review its memorandum of understanding (MOU) with the single State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice. In meeting this standard, the following performance indicators will be considered:

- a. Is the MOU more than 5 years old?
- b. Does the MOU meet Federal legal requirements?
- c. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?
- d. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?

11. The Unit director should exercise proper fiscal control over the Unit resources. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?
- b. Does the Unit maintain an equipment inventory?
- c. Does the Unit apply generally accepted accounting principles in its control of Unit funding?

12. A Unit should maintain an annual training plan for all professional disciplines. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit have a training plan in place and funds available to fully implement the plan?
- b. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?
- c. Are continuing education standards met for professional staff?
- d. Does the training undertaken by staff aid to the mission of the Unit?

APPENDIX B

Referrals of Provider Fraud and Patient Abuse and Neglect to the Idaho Medicaid Fraud Control Unit by Source, Fiscal Years 2009 Through 2011

Table B-1: Total Medicaid Fraud Control Unit Fraud and Abuse Referrals and Annual Average

Case Type	FY 2009	FY 2010	FY 2011	3-Year Total	Annual Average
Patient Abuse and Neglect	13	7	13	33	11
Provider Fraud	105	90	90	285	95
Total	118	97	103	318	106

Source: Office of Inspector General (OIG) analysis of Idaho Fraud Control Unit (Unit) Quarterly Statistical Reports, fiscal years (FY) 2009 through 2011.

Table B-2: Unit Referrals, by Referral Source

Referral Source	FY 2009		FY 2010		FY 2011		Total	Percentage of All Referrals
	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect		
Private Citizens*	36	4	36	2	36	1	115	36.2
Other**	30	0	27	2	19	3	81	25.5
Single State Medicaid Agency	17	1	11	0	15	0	44	13.8
Unit Hotline***	10	2	11	0	10	2	35	11.0
State Survey and Certification Agency	0	2	0	1	1	5	9	2.8
OIG	2	0	2	1	4	0	9	2.8
Other State Agencies	4	0	0	1	2	1	8	2.5
Law Enforcement	1	2	0	0	2	0	5	1.6
Outside Prosecutors	2	0	1	0	1	1	5	1.6
Adult Protective Services	0	2	1	0	0	0	3	0.9
Licensing Board	3	0	0	0	0	0	3	0.9
Providers	0	0	1	0	0	0	1	0.3
Total	105	13	90	7	90	13	318	100
Annual Total	118		97		103			
Annual Average								106

Source: OIG analysis of Unit Quarterly Statistical Reports, FYs 2009 through 2011.

*Includes phone calls to the Unit's main number, emails to the Unit, and walk-in referrals.

** Includes global National Association of Medicaid Fraud Control Units case referrals and Unit self-referrals.

***Medicaid Fraud Report forms submitted to the Unit through the Idaho Attorney General Web site.

APPENDIX C

Investigations Opened and Closed by Provider Category and Case Type, Fiscal Years 2009 Through 2011

Table C-1: Total Annual Opened and Closed Investigations

Case Type	FY 2009	FY 2010	FY 2011	3-Year Total	Annual Average*
Opened	129	95	102	326	109
Patient Abuse and Neglect	28	7	12	47	16
Provider Fraud	101	88	90	279	93
Closed	113	87	91	291	97
Patient Abuse and Neglect	26	8	11	45	15
Provider Fraud	87	79	80	246	82

Source: Idaho Medicaid Fraud Control Unit (Unit) response to Office of Inspector General (OIG) data request.

*Averages in this table are rounded.

Table C-2: Total Investigations, by Case Type

Case Type	FY 2009		FY 2010		FY 2011	
	Opened	Closed	Opened	Closed	Opened	Closed
Patient Abuse and Neglect	28	26	7	8	12	11
Provider Fraud	101	87	88	79	90	80
Total	129	113	95	87	102	91

Source: Unit response to OIG data request.

Table C-3: Patient Abuse and Neglect Investigations

Provider Category	FY 2009		FY 2010		FY 2011	
	Opened	Closed	Opened	Closed	Opened	Closed
Home Health Aides	2	0	1	3	1	1
Nondirect Care	6	6	0	0	0	0
Nurses/Doctors' Assistants/Nurse Aides	5	4	0	1	3	2
Nursing Facilities	2	2	2	0	3	3
Other Long-Term Care Facilities	0	1	0	0	0	0
Other	13	13	4	4	5	5
Total	28	26	7	8	12	11

Source: Unit response to OIG data request.

Table C-4: Provider Fraud Investigations

Provider Category	FY 2009		FY 2010		FY 2011	
	Opened	Closed	Opened	Closed	Opened	Closed
Facilities						
Hospitals	0	2	4	3	2	3
Nursing Facilities	2	1	2	4	4	4
Other Long-Term Care Facilities	2	4	3	2	3	3
Substance Abuse Facilities	0	1	0	0	0	0
Other	4	5	6	8	4	2
Practitioners	Opened	Closed	Opened	Closed	Opened	Closed
Chiropractors	3	2	1	0	0	1
Counselors/ Psychologists	18	19	11	11	11	12
Dentists	3	1	6	5	2	3
Doctors of Medicine or Osteopathy	5	6	6	7	6	5
Optometrists/ Opticians	1	1	0	0	0	0
Other	1	1	1	1	0	0
Medical Support	Opened	Closed	Opened	Closed	Opened	Closed
Durable Medical Equipment Suppliers	6	5	1	3	6	4
Home Health Care Agencies	4	5	2	1	3	3
Home Health Care Aides	14	9	4	8	24	11
Laboratories	0	0	1	0	1	0
Nurses/Doctors' Assistants/Nurse Aides	2	5	7	5	0	4
Pharmaceutical Manufacturers	17	2	12	9	10	8
Pharmacies	6	4	1	2	4	2
Radiologists	0	0	1	1	0	0
Transportation Services	1	3	5	3	2	3
Other	5	5	12	5	6	10
Program Related	Opened	Closed	Opened	Closed	Opened	Closed
Billing Companies	2	2	0	0	1	1
Managed Care	3	2	0	0	1	0
Medicaid Program Administration	1	1	1	1	0	0
Other	1	1	1	0	0	1
Total	101	87	88	79	90	80

Source: Unit response to OIG data request.

APPENDIX D

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

Table D-1 shows population and sample counts and percentages by case type. Note that both samples have percentages of case types similar to the general population, though sample counts for some case types are very small. Because of these small sample sizes, we cannot reliably generalize what we found in our sample review to each case type in the population, and only our overall estimates project to the population of all case files. We estimated the 4 population values for all 329 case files from the results of our review of the case files selected in our simple random samples. Table D-2 includes the estimate descriptions, sample sizes, point estimates, and 95-percent confidence intervals for these four estimates.

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

Case Type	Population Count and (%) n=329	Sample Count* and (%) n=100	Sample Count* and (%) n=50
Closed	254 (77%)	82 (82%)	41 (82%)
Open	75 (23%)	18 (18%)	9 (18%)
Civil	55 (17%)	16 (16%)	9 (18%)
Criminal	274 (83%)	84 (84%)	41 (82%)
Global	53 (16%)	17 (17%)	10 (20%)
Patient Abuse/Neglect	48 (15%)	15 (15%)	6 (12%)
Provider Fraud	228 (69%)	68 (68%)	34 (68%)

Source: The Idaho Medicaid Fraud Control Unit provided a list of all case files open during fiscal years 2009 through 2011.

*The Office of Inspector General generated this random sample.

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

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Case Files With Documented Supervisory Approval for Opening	100	98.0%	93.6–99.4%
Case Files With Documented Supervisory Approval for Closing	82	97.6%	92.1–99.2%
Case Files With Documentation Indicating at Least One Supervisory Review	100	91.0%	84.5–95.1%
Case Files With Documentation Indicating Periodic Supervisory Review	100	89.0%	82.4–93.6%

APPENDIX E

Unit Comments



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

April 1, 2013

Stuart Wright
Deputy Inspector General
For Evaluation and Inspection
U.S. Department of Health and Human Services
Room 5660, Cohen Building
330 Independence Avenue, SW
Washington D.C. 20201

RE: IDAHO STATE MEDICAID FRAUD CONTROL UNIT: 2012 ONSITE REVIEW, 031-09-12-00110.

Dear Mr. Wright,

I have reviewed the 2012 onsite review of the Idaho Attorney General's Medicaid Fraud Control Unit (MFCU). I concur with the audit's three recommendations. I also wish to thank you for your staff's professionalism. The manner in which they conducted themselves and sought information ahead of time made for a smooth audit.

The first recommendation is for the MFCU to store its case files and other documentation containing personally identifiable information in a locked room or in locked storage cabinets. As noted in the draft report, this was addressed prior to the receipt of the draft report by moving the files to a locked file room. The draft report also acknowledged that access to the area where the files had previously been stored was minimized by the fact that one had to be given access to the Division office space through locked doors.

The second recommendation is for the MFCU to revise its policies and procedures to include the investigative checklist and develop policies and procedures for securing case files

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and other documentation containing personally identifiable information. This has been accomplished since receiving the draft report.

The third recommendation is for the MFCU to revise its Memorandum of Understanding with the Idaho Department of Health and Welfare (DHW) regarding procedures involving referrals of providers suspected of fraud for payment suspicion to DHW and the removal of the stipulation that the Unit may be charged for data requests. The MFCU will work with the DHW to accomplish this by October 5, 2013.

We look forward to working together with you and others in the U.S. Department of Health and Human Services in the future in our role of policing the Idaho Medicaid Program as envisioned by the Idaho Legislature and Congress.

Sincerely

/S/

Kendal McDevitt
Deputy Idaho Attorney General
Director, Medicaid Fraud Control Unit

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This report was prepared under the direction of Timothy S. Brady, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Michael Henry, Deputy Regional Inspector General.

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