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Kansas Medicaid Fraud Control Unit: 2018 Onsite Inspection

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What OIG Found

The Kansas Medicaid Fraud Control Unit (MFCU or Unit) reported 28 indictments; 32 convictions; 33 civil settlements and judgments; and over $16 million in recoveries for fiscal years (FYs) 2015-2017. From the data and information we reviewed, we found that the Unit operated in accordance with applicable laws, regulations, and policy transmittals. However, we identified one finding involving the Unit's adherence to MFCU performance standards:

- Unit investigators and other staff carried large caseloads.

In addition to the finding, we made observations regarding Unit operations and practices, the most significant of which were as follows:

- The Unit conducted outreach to encourage referrals.
- The Unit's increased use of its electronic case management system allowed more efficient access to case information.
- The Unit investigated many cases jointly with OIG and actively participated in cases with the United States Attorney's Office.

We also identified the following beneficial practice that may be useful as a model to other Units:

- The Unit's nurse investigator encouraged referrals to the Unit by working closely with other State agencies.

What OIG Recommends

We recommend that the Unit review its caseload management practices and develop an action plan to lower staff members' caseloads. The Unit concurred with the recommendation.

Unit Case Outcomes

FYs 2015-2017

- 28 indictments
- 32 convictions
- 33 civil settlements and judgments
- Over $16 million in recoveries with $10 million from "global"* civil cases, $4.8 million from nonglobal civil cases, and $1.5 million from criminal cases

Unit Snapshot

At the time of OIG's May 2018 onsite inspection, the Unit had 16 staff, located in its single office location in Topeka, Kansas.

The Unit is a division of the Kansas Attorney General's Office.

The Unit operates in a State where the Medicaid program is 88 percent managed care.

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

Full report can be found at oig.hhs.gov/oei/reports/oei-12-18-00210.asp

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BACKGROUND

Objective
To examine the performance and operations of the Kansas State Medicaid Fraud Control Unit.

Medicaid Fraud Control Units

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

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

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

[3] SSA § 1903(q).

[4] SSA § 1902(a)(61).

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

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

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

OIG Grant Administration and Oversight of the MFCUs

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

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

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

Kansas MFCU

The Kansas MFCU, known as the Medicaid Fraud and Abuse Division, is part of the Kansas Attorney General's Office. The Unit is located in Topeka, Kansas.

At the time of OIG's May 2018 onsite inspection, the Kansas Unit employed 16 staff. Unit staff included a director and deputy director; a special agent in charge (SAC); five special agents; a nurse investigator; a chief auditor; four auditors; two attorneys (in addition to the director and deputy); and a legal assistant. The Unit director has been employed by the MFCU since 2016. During the review period of FYs 2015-2017, Unit expenditures were approximately $4 million, with a State share of $994,000.

Referrals. The primary sources of fraud referrals to the Unit are private citizens, managed care organizations (MCOs), and the State Medicaid

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

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

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

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

agency.[12] The Unit also receives a large number of referrals of patient abuse or neglect from the State survey and certification agency—the Kansas Department for Aging and Disability Services (KDADS)—and from private citizens. Appendix B lists Unit referrals by source for FYs 2015 through 2017.

Investigations. Once the Unit opens an investigation, Unit supervisors assign a team to the case. Teams generally include an attorney and investigator, and, as appropriate for the case, a nurse investigator and/or an auditor. For cases of patient abuse or neglect, teams consist of an attorney, an investigator, and a nurse investigator.

The Unit's policies and procedures require the SAC to conduct quarterly case file reviews on all open investigations with the special agent assigned to each case. The quarterly reviews of case files cover case statuses and the next steps in the investigations. The policy requires Unit staff to document these reviews in its electronic case management system.

Prosecutions. The Kansas MFCU has Statewide authority to investigate and prosecute cases of suspected Medicaid fraud. Additionally, the Unit may prosecute violations of State laws related to the abuse, neglect, or exploitation of dependent adults and the elderly.

If a case is not within the Unit's prosecutorial authority, the Unit will refer the case for administrative action to the State Medicaid agency's Program Integrity Division and/or to the appropriate licensing entity. When the Unit determines that Federal health care programs other than Medicaid are the primary victims, the Unit will refer the case to the United States Attorney's Office or to OIG. Two Unit attorneys are cross-designated as Special Assistant United States Attorneys. These attorneys work directly with the United States Attorney's Office on Medicaid fraud cases litigated in the United States District Court.

Kansas Medicaid Program

KanCare. The Kansas Medicaid program, known as KanCare, provides care to more than 415,000 beneficiaries. Kansas contracts with three MCOs to coordinate health care services for all Medicaid beneficiaries. In FY 2018, 88-percent of State Medicaid payments were for care provided by MCOs. The fiscal agent of the Kansas Medicaid program receives, processes, and pays Medicaid claims. In FY 2018, total KanCare expenditures were $3.6 billion.[13]

[12] Referrals from the State Medicaid agency include referrals from the State Medicaid Agency for Surveillance and Utilization Review Subsystem (SURS) or Program Integrity (PI) Unit as well as other offices within the State Medicaid agency.

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

MCO Contract. The Kansas Medicaid Managed Care Model Contract (adopted for all 3 MCOs in Kansas) requires MCOs to refer "abusive or fraudulent" Medicaid claims to the State Medicaid agency. The Unit's Memorandum of Understanding (MOU) with the State Medicaid agency requires the State Medicaid agency to inform the Unit "at the earliest practical time regarding any matter that raises a suspicion of Medicaid provider fraud or abuse."

Prior OIG Report

OIG conducted a previous onsite review of the Kansas Unit in 2012. In that review, OIG found that (1) for FYs 2009 and 2010, the Unit had several internal control weaknesses and inadequate policies and procedures related to certain expenditures; (2) the Unit did not report the identities of all convicted providers to OIG within 30 days of sentencing for the purpose of program exclusion; (3) the Unit did not establish annual training plans for its professional disciplines; and (4) the Unit's case files had inconsistent documentation of supervisory approval for key stages of investigations, although cases generally proceeded timely.[14]

OIG recommended that the Unit (1) develop policies and procedures to address internal control weaknesses; (2) develop a protocol to ensure that identities of convicted providers are reported to OIG; (3) establish annual training plans for professional disciplines; and (4) ensure that all case files contain opening and closing investigative memoranda, documented supervisory approval, and documented periodic supervisory reviews.

In response to OIG recommendations, the Unit (1) developed policies and procedures to ensure that claimed expenditures are reconciled to the Unit's accounting records; (2) modified its case management system to include a section for indicating that exclusion paperwork has been submitted to OIG and began generating monthly reports for the Unit Director to verify that each conviction was reported to OIG timely; (3) developed a training plan for all professional staff; and (4) developed policies and procedures to ensure that all Unit case files contain forms to document opening, closing, and periodic supervisory reviews. Based on information we received from the Unit, OIG considered these recommendations implemented.

Methodology

We conducted the onsite inspection of the Kansas MFCU in May 2018. Our inspection covered the 3-year period of FYs 2015-2017. We analyzed data from seven sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's managers and selected staff; (5) a review of a simple random sample of 50 case files that were open at any point during the review period; (6) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (7) observations of Unit

[14] *Kansas State Medicaid Fraud Control Unit: 2012 Onsite Review*, OEI-07-12-00200, September 2012, available at https://oig.hhs.gov/oei/reports/oei-07-12-00200.asp.

operations. (See Appendix C for a detailed methodology.) In examining the Unit's operations and performance, we applied the published performance standards in Appendix A but did not consider every performance indicator for every standard.

Standards

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

PERFORMANCE ASSESSMENT

Below are the results of OIG's assessment of the performance and operations of the Kansas Unit. OIG identified the Unit's case outcomes; found that the Unit complied with legal and policy requirements; and offered either a finding or observation(s) for each of the performance standards. OIG found that the caseloads of Unit investigators and other staff were large and, among other observations, OIG identified a beneficial practice designed to encourage referrals to the Unit. Finally, OIG recommended that the Unit develop an action plan to address the large caseloads.

CASE OUTCOMES

Observations

From FYs 2015 through 2017, the Unit reported 28 indictments; 32 convictions; and 33 civil settlements and judgments. Of the 32 convictions, 29 involved provider fraud and 3 involved patient abuse or neglect.

The Unit reported total recoveries of over $16 million for FYs 2015–2017. See Exhibit 1 for a breakdown of the Unit's recoveries.

Exhibit 1: The Unit reported combined civil and criminal recoveries of over $16 million (FYs 2015–2017).

Source: OIG analysis of Unit statistical data FYs 2015-2017.
Note: "Global" recoveries derive from civil settlements or judgments involving the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

STANDARD 1	A Unit conforms with all applicable statutes, regulations, and policy directives.
Observation	**From the data and information we reviewed, the Kansas Unit complied with applicable laws, regulations, and policy transmittals.** From the statistical data and other information we reviewed, we did not identify compliance-related concerns.
STANDARD 2	**A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.**

Finding

Unit investigators and other staff carried large caseloads. According to Performance Standard 2(b), the Unit should employ 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.

In examining the Unit staff's caseloads, we observed that the Unit's staff levels were similar to those of Units in States with similar Medicaid expenditures. Kansas Medicaid expenditures in FY 2017 were approximately $3.4 billion, and the Unit employed 15 staff, similar to the Unit staff sizes in States with similarly sized Medicaid programs. However, as Unit managers and staff reported, and as OIG's judgment, experience, and observations confirmed, the caseloads for all professional groups were too large.[15]

Unit managers and staff with whom we spoke expressed concerns about caseloads. One Unit manager stated that the timeliness of cases suffers as a result of the large caseloads, and another staff member explained that the large caseloads interfered with the ability to receive training. Another Unit manager stated that investigators were overworked and were especially challenged when forced to shift focus between complex cases and a large number of allegations requiring immediate response, such as those involving patient abuse or neglect.

In OIG's judgment and experience, Unit investigators' caseloads were double or triple the amount that a Federal investigator would typically handle, and the caseloads of attorneys and auditors were also too large. See Exhibit 2 for the caseloads for Unit investigators, attorneys, and auditors at the time of the onsite inspection.

[15] OIG was ultimately unable to determine why the caseloads were so large.

Exhibit 2: Unit staff caseloads were large

Source: Unit case assignment list, May 2018.

In OIG's judgment, depending on the complexity of the particular cases, carrying caseloads of this magnitude can lead to overworked staff. Further, in OIG's judgment, staff with such caseloads may not adequately document their cases. Moreover, when cases go to trial, there are likely to be delays to the many other cases handled by the attorney, investigator, or auditor.

In addition to having supervisory responsibilities, the Unit's SAC also carried a large caseload. At the time of OIG's inspection, the SAC carried a caseload of 31 cases. In OIG's experience, it is unusual for an investigative supervisor to carry a large caseload while also having management duties. In addition to his supervisory responsibilities, the SAC was also responsible for completing an initial assessment of each referral, determining whether to open a full investigation, and preparing an electronic case file for each referral.

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

Observation

The Unit revised its written policies and procedures in calendar year 2016. The Unit's policies and procedures manual, the Kansas MFCU Standard Operating Guidelines (Operating Guidelines), is available to staff in hard copy format and in electronic format on the Unit's computer network.

Unit management revised the Operating Guidelines in calendar year (CY) 2016 after a change in key leadership positions. One notable revision required more frequent periodic supervisory reviews (see pages 9-10).

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

Observations

The Unit conducted outreach to encourage referrals. The Unit took steps to maintain volume and quality of referrals through outreach efforts. To encourage referrals, the Unit meets monthly with staff from the State Medicaid agency's program integrity unit, MCOs, and the fiscal agent. Topics of discussion at the monthly meetings include identification of fraud trends and improper or suspicious Medicaid billing practices. The Unit also reported on its efforts to educate providers, State agencies, and citizens about the Unit's function and operations. For example, Unit staff provided training to KDADS, the survey and certification agency, about the illegal diversion of controlled substances by providers. Additionally, the Unit reported that it generates referrals by participating in the Attorney General's Senior Consumer Protection Advisory Council and the Federal Elder Abuse Task Force.[16]

Beneficial Practice

The Unit's nurse investigator encouraged referrals to the Unit by working closely with other State and local agencies. The Unit's nurse investigator, hired in 2016, was charged with reviewing various sources to identify complaints of patient abuse or neglect that might warrant further review by the Unit.[17] As part of these duties, the nurse investigator reviewed closed complaints of alleged abuse or neglect of nursing home residents on file with the State Medicaid agency, KDADS, and other State regulatory agencies that oversee health care facilities to determine if any of the complaints should be investigated by the Unit.

The nurse investigator also arranged for the Unit to receive complaints of patient abuse or neglect from KDADS at the same time as local law enforcement. Previously, when KDADS received a complaint of a possible crime, it notified local law enforcement agencies, such as the local police department or county sheriff's office. The nurse investigator requested that KDADS also include the Unit on these email notifications. As a result, the Unit's nurse investigator and SAC now receive these notifications at the same time as local law enforcement.

The nurse investigator, after reviewing the notifications, (1) contacted local law enforcement that also received the notifications to determine whether they planned to take any action; (2) contacted the health care facilities involved with the allegations to obtain additional information; and (3) if the allegations involved matters within the Unit's authority, she sent the additional information to the Unit's SAC to determine whether to open

[16] In our review, we did not determine whether the Unit's efforts resulted in a greater number of referrals from these sources.

[17] The nurse investigator is a registered nurse who conducts investigations of possible Medicaid fraud and patient abuse or neglect.

a formal investigation. The number of referrals of patient abuse or neglect that the Unit received increased from 23 in FY 2016 to 44 in FY 2017. Unit management attributed the increase to the nurse investigator's interaction with KDADS.

STANDARD 5	A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.

Observation

All sampled case files, with one exception, contained supervisory approval of case openings and, as appropriate, case closings. According to Performance Standard 5(b), supervisors should approve the opening and closing of all investigations, 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. Of the 50 sampled case files we reviewed, 49 case files contained documentation supporting case opening. All 31 closed case files in the sample contained documentation supporting case closing.

STANDARD 6	A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

Observation

The Unit's caseload included both cases of fraud and cases of patient abuse or neglect, covering a broad mix of provider types. During the review period, 89 percent of the Unit's cases involved fraud and 11 percent involved patient abuse or neglect. At the end of FY 2017, the Unit's cases covered 37 provider types, including physicians, licensed practitioners, health care facilities, and medical service providers.

STANDARD 7	A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.

Observations

All sampled case files opened in FY 2016 or later contained documentation of periodic supervisory reviews, but five earlier files contained no such documentation.[18] During OIG's 2012 onsite review of the Unit, we recommended that the Unit ensure that all case files contain documentation of periodic supervisory reviews. In response to OIG's recommendation, the Unit implemented a policy requiring that all open case files would include periodic-review forms, approved by the SAC or Director, for every 6-month period that a case was open. The Unit

[18] Of the 50 case files in OIG's sample, the Unit opened 26 cases prior to FY 2016 and 24 in FY 2016 or later.

revised this policy in CY 2016 to require that periodic supervisory reviews of all open cases be conducted quarterly, rather than every 6 months, and be documented in the case file.

According to Performance Standard 7(a), reviews by supervisors should be conducted periodically, consistent with the Unit's policies and procedures, and should be noted in the case file. We found that five case files for cases opened and closed prior to FY 2016 did not contain documentation of periodic supervisory reviews consistent with the Unit's policy at that time. One of these case files was open for approximately 3 years but contained documentation of only one periodic supervisory review. Four of these case files contained no documentation of periodic supervisory reviews. However, we found that all files for sampled cases opened in FY 2016 or later contained documentation of supervisory reviews consistent with the Unit's revised policy.

The Unit's increased use of its electronic case management system allowed more efficient access to case information. While conducting case file reviews, OIG found that it was difficult to locate documentation for some of the Unit's older case files, i.e., those opened prior to 2016. OIG observed that Unit staff had not entered documentation for some of the Unit's older cases into the Unit's electronic case management system. For other cases, OIG observed that Unit staff had entered documentation into the electronic case management system but had scanned all documents from paper case files into a single attachment rather than attaching and labeling each case document separately. This made it difficult to locate specific documents in the electronic case management system.

However, OIG observed a noticeable change with cases opened during or after CY 2016, when staff began to enter case information directly into the Unit's electronic case management system during the course of investigations. OIG observed that the Unit's increased use of this system made it easier to find, review, and track case information in case files opened during or after 2016. A Unit manager also observed that the Unit saved significant time by entering case information directly into the electronic system.

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

Observation

The Unit investigated many cases jointly with OIG and actively participated in cases with the United States Attorney's Office. During the review period, the Unit jointly investigated with OIG a total of 40 cases, involving 60 different suspects. Additionally, the Unit actively participated in cases with prosecutors from the Criminal and Civil Divisions of the Kansas United States Attorney's Office. The Unit's Director and Deputy Director are themselves both cross-designated as Special Assistant United States

Attorneys and prosecute many of their own cases in United States District Court. One Assistant United States Attorney described the MFCU as "very effective" and stated her belief that the MFCU Director "is able to bring the relevant parties together very quickly to discuss potential issues and the scope of investigations."

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

Observation

The Unit made written recommendations regarding program deficiencies to the State Medicaid agency. The Unit informed the State Medicaid agency of potential program deficiencies identified through MFCU investigations. For example, during our review period, the Unit recommended that the State Medicaid agency (1) work with the MCOs to strengthen the documentation requirements related to transportation services and (2) implement safeguards to the system used to report and monitor services that personal care attendants provide to Medicaid beneficiaries. The Unit director stated that he remains in contact with the appropriate State Medicaid agency staff to monitor the recommendations and any actions taken in response to them.

STANDARD 10	A Unit periodically reviews its Memorandum of Understanding (MOU) with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.

Observation

The Unit's MOU with the State Medicaid agency reflected current practice, policy, and legal requirements. The Unit's MOU with the State Medicaid agency was executed on November 1, 2012. OIG confirmed that the MOU reflected current practice, policy, and legal requirements.

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

Observation

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

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

Observation

The Unit maintained a training plan that included an annual minimum number of training hours for each professional discipline. The Unit had an annual training plan that required Unit attorneys, investigators, and auditors to complete an annual minimum number of training hours. The plan required new Unit employees to complete in-house basic training and required all Unit employees to complete training programs on Medicaid fraud and discipline-specific training programs.

CONCLUSION AND RECOMMENDATION

For FYs 2015 through 2017, the Kansas Unit reported 28 indictments; 32 convictions; 33 civil settlements and judgments; and combined criminal and civil recoveries of over $16 million.

From the data and information we reviewed, we determined that the Kansas Unit generally adhered to applicable legal requirements and the performance standards. We also made observations regarding Unit operations and practices, including a beneficial practice that the Unit employed that may serve as a model for other Units: the Unit's nurse investigator identified and encouraged referrals to the Unit by working closely with other State agencies.

However, we identified one finding: Unit staff maintained caseloads that were too high. Although the Unit's staff levels were similar to those of other Units with similarly sized Medicaid programs, Unit staff reported—and OIG's review confirmed—that large caseloads left staff overworked and may have affected their efficiency.

We recommend that to address this finding, the Kansas Unit:

Review its caseload management practices and develop an action plan to lower staff members' caseloads

The Unit should review its caseload management practices and determine why the caseloads assigned to Unit professional staff were so large. The Unit should use the results of its review to develop an action plan to lower staff caseloads. The plan should include the Unit's strategy for expanding staff capacity, such as by using different case management or prioritization techniques, or through hiring additional staff.

UNIT COMMENTS AND OIG RESPONSE

The Kansas Unit concurred with our recommendation to review its caseload management practices and develop an action plan to lower staff members' caseloads. The Unit stated that it has already undertaken or plans to take the following actions:

1. The Unit hired an additional investigator;
2. The Unit reviewed its process for reviewing incoming cases to streamline and prioritize cases that should be worked or referred to another office for review or action;
3. The Unit revised its case management system to simplify the case closing process;
4. Unit management assigned a Unit investigator and attorney to concentrate on personal care services cases to ensure that these cases are processed more efficiently; and
5. For purposes of requesting legislative approval for FY 2020 funding, the Attorney General reviewed the need for additional Unit staff. The Unit anticipates that the Attorney General will request legislative approval to increase Unit funding for an increase in Unit staff size.

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

APPENDIX A: MFCU Performance Standards[19]

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; [20]
   D) OIG policy transmittals as maintained on the OIG website; and
   E) Terms and conditions of the notice of the grant award.

2) **A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.**
   A) The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
   B) The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
   C) The Unite employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
   D) The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
   E) To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.

3) **A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.**
   A) The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.
   B) The Unit adheres to current policies and procedures in its operations.

[19] 77 Fed. Reg. 32645 (June 1, 2012).
[20] For FYs 2016 and later, grant administration requirements and cost principles are found at 45 CFR part 75.

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 providers types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

A) The Unit seeks to have a mix of cases from all significant provider types in the State.

B) For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.
C) The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.
D) As part of its case mix, the Unit maintains a balance of fraud and patient abuse and neglect cases for those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases.
E) As part of its case mix, the Unit seeks to maintain, consistent with its legal authorities, a balance of criminal and civil fraud cases.

7) A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.

A) Reviews by supervisors are conducted periodically, consistent with MFCU policies and procedures, and are noted in the case file.
B) Case files include all relevant facts and information and justify the opening and closing of the cases.
C) Significant documents, such as charging documents and settlement agreements, are included in the file.
D) Interview summaries are written promptly, as defined by the Unit's policies and procedures.
E) The Unit has an information management system that manages and tracks case information from initiation to resolution.
F) The Unit has an information management system that allows for the monitoring and reporting of case information, including the following:
    1) The number of cases opened and closed and the reason that cases are closed.
    2) The length of time taken to determine whether to open a case referred by the State Medicaid agency or other referring source.
    3) The number, age, and types of cases in the Unit's inventory/docket.
    4) The number of referrals received by the Unit and the number of referrals by the Unit to other agencies.
    5) The dollar amount of overpayments identified.
    6) The number of cases criminally prosecuted by the Unit or referred to others for prosecution, the number of individuals or entities charged, and the number of pending prosecutions.
    7) The number of criminal convictions and the number of civil judgments.
    8) The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of recoveries and the types of relief obtained through civil judgments or prefiling settlements.

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

A) The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.

B) The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, case involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.

C) The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.

D) For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.

E) For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.

F) The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.

G) The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.

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

A) The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.

B) The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.

10) A Unit periodically reviews its Memorandum of Understanding (MOU) with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.

A) The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.

B) The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR 455.23, "Suspension of payments in cases of fraud."

C) The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).

D) Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.

E) The MOU incorporates by reference the *CMS Performance Standard for Referrals of Suspected Fraud From a State Agency to a Medicaid Fraud Control Unit*.

11) A Unit exercises proper fiscal control over Unit resources.

A) The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.
B) The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.
C) The Unit maintains an effective time and attendance system and personnel activity records.
D) The Unit applies generally accepted accounting principles in its control of Unit funding.
E) The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.

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

A) The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.
B) The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.
C) Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.
D) The Unit participates in MFCU-related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.
E) The Unit participates in cross-training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

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

	FY 2015		FY 2016		FY 2017		Grand Totals	
Referral Source	Fraud	Abuse & Neglect[1]	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect
Adult Protective Services	7	0	4	2	4	4	15	6
Anonymous	7	3	11	4	3	2	21	9
Office of Inspector General	5	2	7	1	3	0	15	3
Licensing Board	1	0	3	0	1	0	5	0
Local Prosecutor	1	0	1	0	0	0	2	0
Long-Term Care Ombudsman	0	0	0	0	0	0	0	0
Managed Care Organizations	13	1	12	0	28	0	53	1
State Medicaid Agency Other	0	1	2	0	38	2	40	3
State Medicaid Agency SURS or PI Unit[2]	1	0	0	0	1	0	2	0
Other	15	2	12	0	10	2	37	4
Law Enforcement	8	5	4	5	7	6	19	16
Private Citizen	29	20	20	11	18	11	67	42
Private Health Insurer	0	0	1	0	0	0	1	0
Provider	18	1	15	0	4	0	37	1
Provider Association	0	0	1	0	0	0	1	0
Other State Agency	15	0	9	0	4	0	28	0
State Survey and Certification	0	0	9	0	3	17	12	17
Total	120	35	111	23	124	44	355	102
Annual Total	155		134		168		457	

Source: OIG analysis of Unit Annual Statistical Reports, FYs 2015-2017.
[1] The category of referrals of patient abuse and neglect includes referrals regarding misappropriation of patients' private funds.
[2] The abbreviation "PI" stands for program integrity; the abbreviation "SURS" stands for Surveillance and Utilization Review Subsystem.

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APPENDIX C: Detailed Methodology

Data Collection and Analysis

We collected and analyzed data from the seven sources below to identify any opportunities for improvement and instances in which the Unit did not adhere to the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.[21] We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards.

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

(2) Review of Unit Fiscal Controls. We conducted a limited review of the Unit's control over its fiscal resources. Prior to the onsite review, we analyzed the Unit's response to an internal controls questionnaire and we conducted a desk review of the Unit's financial status reports. We followed up with Unit officials to clarify issues identified in the internal controls questionnaire. We also selected a purposive sample of 30 items from the current inventory list of 436 items maintained in the Unit's office and verified those items onsite.

(3) Interviews with Key Stakeholders. In April and May 2018, we interviewed key stakeholders, including officials in the Kansas State Medicaid Program Integrity Unit; the Kansas Department for Aging and Disability Services; Kansas Adult Protective Services; and the United States Attorneys' Offices. We also interviewed the supervisor from OIG's Region VII Office of Investigations, which works regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

(4) Onsite Interviews with Unit Management and Staff. We conducted structured onsite interviews with the Unit's management in May 2018.

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

We interviewed the Unit Director, Deputy Director, and Special Agent in Charge. While onsite, we also spoke with other members of Unit staff. We asked these individuals to provide information related to (1) Unit operations; (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; (3) opportunities for the Unit to improve its operations and/or performance; and (4) clarification regarding information obtained from other data sources.

(5) Onsite Review of Case Files. To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2015 through 2017, as well as the following information for each case: its current status; its opening and closing dates, if applicable; whether the case was criminal, civil, or global; the provider type involved in the case; and whether the case was worked jointly with OIG. The total number of cases was 663.

We excluded all global cases from our review of the Unit's case files because global cases are civil false claims actions that typically involve multiple agencies, such as the United States Department of Justice and a group of State MFCUs.[22] We excluded 58 global cases, leaving 605 case files.

From the 605 remaining case files, we selected a simple random sample of 50 cases for review. We reviewed the 50 case files for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals. During the review of the sampled cases, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

(6) Review of Unit Submissions to OIG and National Provider Data Bank. We also reviewed all convictions submitted to OIG for program exclusion during the review period (28 convictions), and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period (32 adverse actions). We reviewed whether the Unit submitted information on all sentenced individuals to OIG for program exclusion and all adverse actions to the NPDB for FYs 2015 through 2017. We also assessed the timeliness of the submissions to OIG and the NPDB.

(7) Onsite Review of Unit Operations. During our May 2018 onsite inspection, we reviewed the Unit's workspace and operations. To conduct this review, we visited the Unit's office in Topeka, Kansas. While onsite, we observed the Unit's offices and meeting spaces, security of

[22] "Global" cases are civil False Claims Act cases that are litigated in Federal courts by the U.S. Department of Justice and involve a group of MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the States.

data and case files, location of select equipment, and the general functioning of the Unit.

APPENDIX D: Unit Comments

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TO: Suzanne Murin
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For Evaluation and Inspection

FROM: Jackie Williams
Deputy Attorney General and Director, MFCU
Kansas Attorney General's Office

DATE: July 16, 2019

SUBJECT: Response to draft report entitled *Kansas Medicaid Fraud Control Unit: 2018 Onsite Inspection,* OEI-12-18-00210.

This memorandum is in response to the draft report for the 2018 Onsite Inspection, OEI-12-18-00210. Thank you for the opportunity to provide a written response to the draft report. It is the goal of the Kansas Medicaid Fraud Control Unit (MFCU) to effectively manage the resources available to conduct investigations that have impact and support the mission of the Office of the Attorney General with the highest attention to quality in accordance with applicable laws, regulations, and policy transmittals.

Thank you for your observations regarding MFCU operations and practices that included the amount of outreach conducted to encourage referrals, the increased use of the electronic case management system, and the many joint cases with the OIG and the United States Attorney's Office. The beneficial practice that was identified concerning the use of a registered nurse investigator was also appreciated.

We were pleased that your report stated that the MFCU complied with the required performance standards with the exception of the investigators and other staff carrying large caseloads. The recommendation that the MFCU *Review its caseload management practices and develop an action plan to lower staff members' caseloads and maximize effectiveness* is addressed below.

We concur with your recommendation that the MFCU caseloads are too large. This issue had been identified by staff prior to the review and continues to be an area of focus. The following specific actions have already been taken or will be taken in the near future:

1. Attorney General Derek Schmidt has reviewed the need for additional staffing for the MFCU beginning in fiscal year 2020; it is anticipated he will request approval by the Kansas Legislature to approve funding for this proposed increase in staffing.
2. An additional agent has been hired and will soon be joining the MFCU staff.
3. The MFCU has reviewed its process for reviewing incoming cases to streamline and prioritize cases that should be worked or referred to another office for review or action.
4. Changes in the case management system were made to simplify the case closing process to close case more efficiently, but with better tracking of referrals and documentation.
5. An agent and attorney were dedicated to concentrate on direct support worker cases. This has resulted in cases being processed quicker and the overall number of these types of cases being reduced.

Thank you and your staff for professionalism during this process. The MFCU staff members appreciated the exchange of information and ideas with the review team.

Please let me know if you would like additional information or have questions.

ACKNOWLEDGMENTS

Jordan Clementi of the Medicaid Fraud Policy and Oversight Division served as the team leader for this inspection. Two agents from the Office of Investigations also participated in the inspection. Office of Evaluation and Inspections staff who provided support include Ben Gaddis, Kevin Farber, and Christine Moritz.

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

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