

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**FLORIDA STATE MEDICAID
FRAUD CONTROL UNIT:
2015 ONSITE REVIEW**



**Suzanne Murrin
Deputy Inspector General
for Evaluation and Inspections**

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**EXECUTIVE SUMMARY: FLORIDA STATE MEDICAID FRAUD CONTROL
UNIT: 2015 ONSITE REVIEW
OEI-07-15-00340**

WHY WE DID THIS STUDY

The Office of Inspector General (OIG) administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies the Units, and oversees the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. These reviews assess the Units' adherence to the 12 MFCU performance standards and compliance with applicable Federal statutes and regulations.

HOW WE DID THIS STUDY

We conducted an onsite review of the Florida Unit in September 2015. We based our review on an analysis of data from seven sources: (1) policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) financial documentation for fiscal years (FYs) 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) a sample of files for cases that were open in FYs 2012 through 2014; and (7) observation of Unit operations.

WHAT WE FOUND

For FYs 2012 through 2014, the Florida Unit reported 193 convictions, 91 civil judgments and settlements, and combined criminal and civil recoveries of nearly \$382 million. The Unit also maintained proper fiscal control of its resources. Unit management and OIG reported that colocation of staff promoted joint investigative work. However, we identified a few areas where the Unit should improve its operations. Specifically, 42 percent of the case files did not contain all periodic supervisory reviews of cases, as required by Unit policy. The Unit did not report all convictions and adverse actions to Federal partners within required timeframes, and it investigated one sampled case that was not eligible for Federal funding.

WHAT WE RECOMMEND

We recommend that the Florida Unit: (1) ensure that it conducts and documents supervisory reviews of Unit case files according to the Unit's policies and procedures; (2) implement processes to ensure it reports convictions and adverse actions to Federal partners within required timeframes; and (3) repay Federal matching funds spent on a case that was not eligible for Federal funding. The Unit concurred with all three recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse or neglect under State law.¹ The SSA requires each State to operate a MFCU, unless the Secretary of Health and Human Services (HHS) determines that operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in a particular State and that 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 MFCUs.³

Each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.⁴ Unit staff review referrals of potential fraud and patient abuse or neglect to determine their potential for criminal prosecution and/or civil action. In fiscal year (FY) 2015, the 50 Units collectively reported 1,553 convictions, 795 civil settlements or judgments, and approximately \$745 million in recoveries.^{5, 6}

Units must meet a number of requirements established by the SSA and Federal regulations. For example, each Unit must:

- be a single, identifiable entity of State government, distinct from the single State Medicaid agency;⁷
- develop a formal agreement, such as a memorandum of understanding (MOU), which describes the Unit's relationship with the State Medicaid agency;⁸ and

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

² SSA § 1902(a)(61).

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 SSA § 1903(q)(6); 42 CFR § 1007.13.

⁵ Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on February 17, 2016.

⁶ All FY references in this report are based on the Federal FY (October 1 through September 30).

⁷ SSA § 1903(q)(2); 42 CFR § 1007.5 and 1007.9(a).

⁸ 42 CFR § 1007.9(d).

- have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.⁹

MFCU Funding

Each MFCU is funded jointly by its State and the Federal government. Federal funding for the MFCUs is provided as part of the Federal Medicaid appropriation, but it is administered by OIG.¹⁰ Each Unit receives Federal financial participation equivalent to 75 percent of its total expenditures, with State funds contributing the remaining 25 percent.¹¹ In FY 2015, combined Federal and State expenditures for the Units totaled \$251 million, \$188 million of which represented Federal funds.¹²

Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority to administer the MFCU grant program.¹³ To receive Federal reimbursement, each Unit must submit an initial application to OIG for approval and be recertified each year thereafter.

In annually recertifying the Units, OIG evaluates Unit compliance with Federal requirements and adherence to performance standards. The Federal requirements for Units are contained in the SSA, regulations, and policy guidance.¹⁴ In addition, OIG has published 12 performance standards that it uses to assess whether a Unit is effectively performing its responsibilities.¹⁵ The standards address topics such as staffing, maintaining adequate referrals, and cooperation with Federal authorities. Appendix A contains the performance standards.

OIG also performs periodic onsite reviews of the Units, such as this review of the Florida MFCU. During these onsite reviews, OIG evaluates Units' compliance with laws, regulations, and policies, as well as adherence to the 12 performance standards. OIG also makes observations about best

⁹ SSA § 1903(q)(1).

¹⁰ SSA § 1903(a)(6)(B).

¹¹ Ibid.

¹² OIG, *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on February 17, 2016.

¹³ The SSA authorizes the Secretary of HHS to award grants to the Units; the Secretary delegated this authority to the OIG.

¹⁴ On occasion, OIG issues policy transmittals to provide guidance and instructions to MFCUs.

¹⁵ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf> on May 22, 2015. On June 1, 2012, OIG published a revision of the performance standards at 77 Fed. Reg. 32645. Because our review covered FYs 2012 through 2014, we applied the standards published on June 1, 2012.

practices, provides recommendations to the Units, and monitors the implementation of the recommendations. These evaluations differ from other OIG evaluations as they support OIG's direct administration of the MFCU grant program. These evaluations are subject to the same internal quality controls as other OIG evaluations, including internal peer review.

Additional oversight includes the collection and dissemination of data about MFCU operations and the provision of training and technical assistance.

Florida Unit

The Unit, a division of the Florida Office of the Attorney General, investigates and prosecutes cases of Medicaid fraud and patient abuse and neglect. To investigate and prosecute such cases, the Unit employs staff in positions including law enforcement investigator, attorney, auditor, and fraud analyst. The Unit also employs administrative and paralegal staff.

At the time of our review, the Unit's 160 employees were located in eight offices. For most operational purposes, the Unit is divided into three regions: North, Central, and South. The North region has offices in Jacksonville, Tallahassee, and Pensacola. The Central region has offices in Orlando and Tampa. The South region has offices in Miami, Ft. Lauderdale, and West Palm Beach. The Unit's Complex Civil Enforcement Bureau, located in Tallahassee, handles the Unit's participation in qui tam cases, major forfeitures, and complex civil cases. The Florida Unit expended \$16,910,095 in combined State and Federal funds in FY 2015.¹⁶

Referrals. The Unit receives referrals from a variety of sources, including but not limited to the State Medicaid agency, local law enforcement, Adult Protective Services, and private citizens. The Unit's intake team receives referrals and may conduct preliminary work such as obtaining billing records. Referrals are then sent to the field offices. Appendix B depicts Unit referrals by referral source for FYs 2012 through 2014.

Investigations and Prosecutions. The law enforcement captain or designated lieutenant within the field office assigns the referral to an investigator, who assesses the merits of the referral to determine if the facts are sufficient to open a case. Captains approve the opening of cases, and Chief Attorneys assign staff attorneys to opened cases. Within 14 days of case assignment, the Lieutenant coordinates a meeting with the investigative team to develop an investigative plan. Lieutenants conduct monthly case review meetings, attended by all investigative team members, to discuss current case status,

¹⁶ OIG, *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.pdf on February 17, 2016.

case direction, and assigned tasks. Upon approval of the Chief Attorney, the attorney prepares a referral letter to submit the case to the appropriate prosecuting authority. Prosecutions may be handled by the local State Attorney's Office or the Office of Statewide Prosecution. Alternatively, Unit attorneys may be cross-designated by the State Attorney's Office or U.S. Attorney's Office to prosecute the Unit's cases. See Appendix C for details on investigations opened and closed by provider category.

Previous Review

A 2009 OIG onsite review of the Unit identified one concern related to 1 of the 12 performance standards. OIG found that Unit investigators did not prepare interim investigative memorandums noting the progress of investigations as part of official case files. OIG suggested that the Unit include interim investigative memorandums in official case files. The Unit responded that it would research the use of investigative memorandums and hold management discussions on this topic, and likely implement an interim investigative memorandum policy in the future. Our 2015 onsite review found no further evidence that the Unit did not document the progression of its investigations.

METHODOLOGY

We conducted the onsite review in September 2015. We based our review on an analysis of data from seven sources: (1) policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) financial documentation for FYs 2012 through 2014; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with Unit management and selected staff; (6) a sample of files for cases that were open in FYs 2012 through 2014; and (7) observation of Unit operations. Appendix D provides details of our methodology.

Standards

These reviews are conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Our review of the Florida Unit found that it was generally in compliance with applicable laws, regulations, and policy transmittals. The Unit reported combined criminal and civil recoveries of \$382 million, 193 convictions, and 91 civil judgments and settlements for the review period. However, the Unit should ensure that it adheres to the performance standards and other Federal requirements by including documentation of periodic supervisory reviews in its case files and reporting all convictions and adverse actions to the OIG and the National Practitioner Data Bank (NPDB) within required timeframes.

For FYs 2012 through 2014, the Florida Unit reported 193 criminal convictions, 91 civil judgments and settlements, and combined criminal and civil recoveries of nearly \$382 million

For FYs 2012 through 2014, the Unit reported 193 criminal convictions and 91 civil judgments and settlements. See Table 1 for the Unit’s yearly criminal convictions and civil judgments and settlements. Of the Unit’s 193 convictions over the 3-year period, 134 involved provider fraud, 47 involved patient abuse and neglect, and 12 involved misappropriation of patient funds.

Table 1: Florida MFCU Criminal Convictions and Civil Judgments and Settlements, FYs 2012–2014

Outcomes	FY 2012	FY 2013	FY 2014	3-Year Total
Criminal Convictions	66	66	61	193
Civil Judgments and Settlements	17	39	35	91

Source: OIG analysis of Unit-submitted documentation, 2015.

For the same period, the Unit reported combined criminal and civil recoveries of nearly \$382 million. See Table 2 for the Unit’s yearly recoveries and expenditures. Slightly more than half of the recoveries were obtained from “global” cases, which accounted for 58 percent of all recoveries during the 3-year review period.¹⁷

¹⁷ “Global” cases are civil false claims actions involving the U.S. Department of Justice and other State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases.

Table 2: Florida MFCU Recoveries and Expenditures, FYs 2012–2014*

Type of Recovery	FY 2012	FY 2013	FY 2014	3-Year Total
Global Civil	\$147,077,424	\$18,372,264	\$54,177,449	\$219,627,136
Nonglobal Civil	\$96,908,691	\$13,470,829	\$34,189,784	\$144,569,305
Criminal	\$4,687,000	\$9,035,625	\$3,989,871	\$17,712,496
Total Recoveries**	\$248,673,115	\$40,878,718	\$92,357,105	\$381,908,938
Total Expenditures	\$13,520,572	\$14,179,446	\$15,506,674	\$43,206,691

* Due to rounding, dollar figures for each category of recoveries do not always sum to the total recoveries.

**Recovery amounts vary from year to year due to particular settlements. For example, \$85.6 million of the Unit's global civil recoveries in FY 2012 came from the settlements of three pharmaceutical cases.

Source: OIG analysis of Unit-submitted documentation, 2015.

Forty-two percent of the case files did not contain documentation of all periodic supervisory reviews of cases, as required by Unit policy; however, almost all of the case files included documentation of supervisory approval to open and close cases

Forty-two percent of the Unit's case files lacked documentation of all periodic supervisory reviews, as required by Unit policy.¹⁸ This occurred even though the case management system generated automated reminders alerting supervisors to overdue reviews.

Performance Standards 5(b) and 7(a) state that supervisors should periodically review the progress of cases, consistent with Unit policies and procedures, ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe, and note in the case file that the reviews take place. The Unit's policy for supervisory reviews of fraud and patient abuse and neglect cases states that lieutenants shall conduct monthly case review meetings.^{19, 20} The Unit's policy further states that lieutenants should electronically document action items discussed in the meetings in the case management system. We note that the Unit's policy requires that supervisory reviews be held monthly, which is more frequently than the quarterly supervisory reviews other Units typically require.

¹⁸ Appendix E contains the point estimates and 95-percent confidence intervals for all statistics in this report.

¹⁹ Cases with a fugitive status require supervisory review every 6 months.

²⁰ The Unit's policy for supervisory reviews of complex civil cases, as written in the protocols for such cases, states that cases will be periodically reviewed every April and October (i.e., every 6 months).

Although 42 percent of the case files did not contain documentation of all periodic supervisory reviews, we also found that, consistent with Unit policy, nearly all files contained documentation of supervisory approval to open and close cases. Performance Standard 5(b) states that Unit supervisors should approve the opening and closing of cases. Specifically, we found that 99 percent of the Unit’s case files included documentation of supervisory approval to open the cases and all of the Unit’s closed case files in our sample included documentation of supervisory approval to close the cases.²¹ Supervisory approval to open cases indicates that Unit supervisors are monitoring the intake of cases, thereby facilitating progress in the investigation. Supervisory approval of the closing of cases helps ensure the timely completion and resolution of cases.

The Unit did not report all convictions and adverse actions to Federal partners within required timeframes

The Unit did not report all convictions to OIG or all adverse actions to the NPDB within the required timeframes. Performance Standard 8(f) states that the Unit should transmit to OIG reports of all convictions for the purpose of exclusion from Federal health care programs, within 30 days of sentencing. Additionally, Federal regulations require that Units report any adverse actions, generated as a result of prosecutions of healthcare providers, to the NPDB within 30 calendar days from the date the adverse action was taken.^{22, 23} The Unit’s policies and procedures did not address the reporting of convictions to OIG or the reporting of adverse actions to the NPDB. The Unit reported that staff error contributed to the failure to report convictions and adverse actions within the required timeframes.

²¹ All closed case files in our sample included documentation of supervisory approval to close the cases. However, we cannot be certain—because of sampling error—that all of the Unit’s closed case files in the review period included this documentation. As a statistical matter, we are 95-percent confident that at least 94.4 percent of the closed cases in the population had documentation of supervisory approval to close the case.

²² SSA § 1128E(g)(1); 45 CFR § 60.3. Examples of adverse actions include criminal convictions; civil judgments (but not civil settlements); exclusions; and other negative actions or findings.

²³ 45 CFR § 60.5. In addition to Federal regulations, the Performance Standards also require the Unit to report to NPDB. Performance Standard 8(g) states that the Unit should report “qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases.” We reviewed the reporting of adverse actions under NPDB requirements because the HIPDB and the NPDB were merged during our review period (FYs 2012 through 2014). 78 Fed. Reg. 20473 (April 5, 2013).

The Unit did not report half of its convictions to OIG in a timely manner and did not report 10 convictions

The Unit obtained 193 convictions in the review period, half of which it did not report within the required timeframe and 10 that it did not report prior to the onsite review.²⁴ Of the convictions reported to OIG, the Unit did not report half (92 of 183) within 30 days after sentencing. Of the convictions that the Unit did not report on time, the Unit reported 40 convictions within 31 to 60 days of sentencing, 17 convictions within 61 to 90 days of sentencing, and 35 convictions more than 90 days after sentencing. Late reporting of convictions to OIG could delay the initiation of the program exclusion process, resulting in improper payments to providers by Medicare or other Federal health care programs or possible harm to beneficiaries.

The Unit did not report nearly two-thirds of its adverse actions to the NPDB in a timely manner

The Unit reported all 192 adverse actions to the NPDB; however, it did not report 65 percent (124 of 192) within 30 days of the action.²⁵ Of the adverse actions that the Unit did not report within the required timeframe, the Unit reported 57 within 31 to 60 days of the action, 36 within 61 to 90 days of the action, and 31 more than 90 days after the adverse action. The NPDB is designed to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions.

The Unit investigated one sampled case that was not eligible for Federal funding

The Unit investigated one sampled case that was not eligible for Federal matching funds. According to Federal statute and regulations, the scope of a Unit's grant authority includes the investigation of fraud allegations relating to Medicaid providers and patient abuse and neglect allegations in Medicaid-funded and board-and-care facilities.²⁶ However, the scope of a Unit's grant authority does not extend to activities related to the investigation and prosecution of patient abuse and neglect allegations that do not occur in Medicaid-funded or board-and-care facilities. A Unit may

²⁴ Following the onsite review, OIG received reports of all convictions by the end of January 2016.

²⁵ The number of adverse actions is 192 rather than 193 because 1 conviction was not a health-care related conviction.

²⁶ 42 CFR §§ 1007.11(a) and (b)(1); SSA § 1903(q).

not receive Federal matching funds for activities that fall outside the scope of its grant authority.²⁷

In one sampled case, the Unit investigated an allegation of abuse of a Medicaid recipient. However, the incident did not occur in a Medicaid-funded or board-and-care facility. The case remained open for 5 months.

We note that the President's FY 2017 Budget for HHS includes an OIG proposal to expand Units' authority with regard to cases of patient abuse and neglect.²⁸ As Medicaid has been increasingly relying on home and community-based services, the proposal would permit the investigation and prosecution of patient abuse and neglect arising when Medicaid services are provided in either of those settings.

The proposal would give Units the same authority in the areas of patient abuse and neglect cases that they already have for fraud cases.

The Unit maintained proper fiscal control of its resources

The Unit maintained proper fiscal control of its resources during the review period. Performance Standard 11 states that the Unit should exercise proper fiscal control over the Unit's resources. The Unit's financial documentation indicated that the Unit's requests for reimbursement for FYs 2012 through 2014 represented allowable, allocable, and reasonable costs. In addition, the Unit maintained adequate internal controls related to accounting, budgeting, personnel, procurement, property, and equipment.

Other observation: Unit management and OIG reported that collocation of staff promoted joint investigative work

The Unit participates in the U.S. Department of Justice's Medicare Strike Force in Miami. Seven Unit staff (one lieutenant and six investigators) are colocated with OIG agents in OIG office space. According to OIG staff, the arrangement has facilitated communication and promoted efficiency in the team's joint investigations. Under this arrangement, OIG staff concentrate on investigating allegations of fraud in the Medicare program, while Unit staff concentrate on investigating the same allegations in the Medicaid program. OIG reported that it spends no additional funds to

²⁷ 42 CFR § 1007.19(d).

²⁸ HHS, *Fiscal Year 2017 Budget in Brief, Strengthening Health and Opportunity for all Americans*, pp. 88-89. Accessed at <http://www.hhs.gov/sites/default/files/fy2017-budget-in-brief.pdf> on March 8, 2016.

maintain these workstations. Unit management commented that the positive working relationship with OIG improved its rapport with other Federal partners such as the U.S. Attorney's Office and the Federal Bureau of Investigation.

CONCLUSION AND RECOMMENDATIONS

Our review of the Florida Unit found that it was generally in compliance with applicable laws, regulations and policy transmittals. For FYs 2012 through 2014, the Florida Unit reported 193 criminal convictions and 91 civil judgments and settlements, and combined criminal and civil recoveries of \$382 million. The Unit colocated some of its staff with OIG agents, thereby promoting joint investigative work. Additionally, the Unit maintained proper fiscal control of its resources.

We identified two areas where the Unit should improve its operations. Specifically, the Unit should ensure that all case files contain documentation of periodic supervisory reviews and report all convictions and adverse actions to Federal partners within required timeframes. Finally, we identified one case that the Unit investigated that was not eligible for Federal funding.

We recommend that the Florida Unit:

Ensure it conducts and documents supervisory reviews of Unit case files according to the Unit's policies and procedures

The Unit should take steps to ensure that employees adhere to the Unit's written policy for conducting and documenting supervisory reviews of cases.

Implement processes to ensure it reports convictions and adverse actions to Federal partners within required timeframes

The Unit should implement processes to ensure it reports convictions to OIG within 30 days of sentencing and adverse actions to NPDB within 30 days of the action. The Unit may want to determine whether an automated reminder in its case management system might facilitate timely reporting.

Repay Federal matching funds spent on the case that was not eligible for Federal funding

The Unit should work with OIG to identify the staff hours and expenditures associated with the ineligible case and repay the Federal matching funds.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Florida Unit concurred with all three of our recommendations.

Regarding the first recommendation, the Unit stated it is evaluating whether it should change its policy of requiring monthly case reviews to requiring quarterly case reviews. The Unit stated that such a policy revision would still allow supervisors to review case progress and improve compliance with the Unit's policies and procedures.

Regarding the second recommendation, the Unit stated it has revised its electronic case file system to capture reporting dates and permit staff to easily review convictions and verify reporting dates. The Unit also stated it currently is reviewing system programming to enable the generation of electronic reminders of due dates for reporting convictions to OIG and adverse actions to NPDB. Finally, the Unit stated it is reviewing its policies and procedures for potential revisions to address this recommendation. Although the Unit stated that it will make every effort to meet the required reporting timeframes, it noted that the courts do not always make sentencing documents available within these timeframes.

Regarding the third recommendation, the Unit has worked with OIG to identify Unit costs associated with the ineligible case and will repay grant funds.

The Unit's comments are provided in Appendix F.

APPENDIX A

2012 Performance Standards²⁹

1. A UNIT CONFORMS WITH ALL APPLICABLE STATUTES, REGULATIONS, AND POLICY DIRECTIVES, INCLUDING:
A. Section 1903(q) of the Social Security Act, containing the basic requirements for operation of a MFCU;
B. Regulations for operation of a MFCU contained in 42 CFR part 1007;
C. Grant administration requirements at 45 CFR part 92 and Federal cost principles at 2 CFR part 225;
D. OIG policy transmittals as maintained on the OIG Web site; and
E. Terms and conditions of the notice of the grant award.
2. A UNIT MAINTAINS REASONABLE STAFF LEVELS AND OFFICE LOCATIONS IN RELATION TO THE STATE'S MEDICAID PROGRAM EXPENDITURES AND IN ACCORDANCE WITH STAFFING ALLOCATIONS APPROVED IN ITS BUDGET.
A. The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
B. The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
C. The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
D. The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
E. To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.
3. A UNIT ESTABLISHES WRITTEN POLICIES AND PROCEDURES FOR ITS OPERATIONS AND ENSURES THAT STAFF ARE FAMILIAR WITH, AND ADHERE TO, POLICIES AND PROCEDURES.
A. The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.
B. The Unit adheres to current policies and procedures in its operations.
C. Procedures include a process for referring cases, when appropriate, to Federal and State agencies. Referrals to State agencies, including the State Medicaid agency, should identify whether further investigation or other administrative action is warranted, such as the collection of overpayments or suspension of payments.
D. Written guidelines and manuals are readily available to all Unit staff, either online or in hard copy.
E. Policies and procedures address training standards for Unit employees.
4. A UNIT TAKES STEPS TO MAINTAIN AN ADEQUATE VOLUME AND QUALITY OF REFERRALS FROM THE STATE MEDICAID AGENCY AND OTHER SOURCES.
A. The Unit takes steps, such as the development of operational protocols, to ensure that the State Medicaid agency, managed care organizations, and other agencies refer to the Unit all suspected provider fraud cases. Consistent with 42 CFR 1007.9(g), the Unit provides timely written notice to the State Medicaid agency when referred cases are accepted or declined for investigation.

²⁹ 77 Fed. Reg. 32645 (June 1, 2012).

B. The Unit provides periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.
C. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).
D. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.
E. The Unit provides timely information, when requested, to those agencies identified in (D) above regarding the status of referrals.
F. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.
5. A UNIT TAKES STEPS TO MAINTAIN A CONTINUOUS CASE FLOW AND TO COMPLETE CASES IN AN APPROPRIATE TIMEFRAME BASED ON THE COMPLEXITY OF THE CASES.
A. Each stage of an investigation and prosecution is completed in an appropriate timeframe.
B. Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.
C. Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.
6. A UNIT'S CASE MIX, AS PRACTICABLE, COVERS ALL SIGNIFICANT PROVIDER TYPES AND INCLUDES A BALANCE OF FRAUD AND, WHERE APPROPRIATE, PATIENT ABUSE AND NEGLECT CASES.
A. The Unit seeks to have a mix of cases from all significant provider types in the State.
B. For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.
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.
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.
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 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.
6. The number of criminal convictions and the number of civil judgments.
7. The dollar amount of overpayments identified.
8. The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of recoveries and the types of relief obtained through civil judgments or pre-filing settlements.
8. A UNIT COOPERATES WITH OIG AND OTHER FEDERAL AGENCIES IN THE INVESTIGATION AND PROSECUTION OF MEDICAID AND OTHER HEALTH CARE FRAUD.
A. The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.
B. The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, cases involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.
C. The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.
D. For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.
E. For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.
F. The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.
G. The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.
9. A UNIT MAKES STATUTORY OR PROGRAMMATIC RECOMMENDATIONS, WHEN WARRANTED, TO THE STATE GOVERNMENT.
A. The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.
B. The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.
10. A UNIT PERIODICALLY REVIEWS ITS MEMORANDUM OF UNDERSTANDING (MOU) WITH THE STATE MEDICAID AGENCY TO ENSURE THAT IT REFLECTS CURRENT PRACTICE, POLICY, AND LEGAL REQUIREMENTS.
A. The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.
B. The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR 455.23, "Suspension of payments in cases of fraud."
C. The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).
D. Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.

E. The MOU incorporates by reference the <i>CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit</i> .
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

Table B-1: Unit Referrals by Referral Source for FYs 2012 Through 2014

Referral Source	FY 2012			FY 2013			FY 2014		
	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Funds
State Medicaid agency – PIU ³⁰	33	0	0	25	1	2	25	0	0
Medicaid agency – other	18	19	2	12	37	1	6	7	3
Managed care organizations	5	0	0	2	0	0	7	0	0
State survey and certification agency	0	0	0	1	0	0	0	0	0
Other State agencies	20	3	2	14	3	1	16	1	0
Licensing board	0	0	0	0	0	0	0	0	0
Law enforcement	7	1	1	8	5	3	13	1	0
Office of Inspector General	19	9	0	10	11	0	23	9	1
Prosecutors	1	0	0	0	0	0	0	0	0
Providers	26	3	3	44	0	3	31	1	2
Provider associations	0	0	0	1	0	0	0	0	0
Private health insurer	1	0	0	1	0	1	2	0	0
Long-term-care ombudsman	0	2	1	0	0	1	0	1	1
Adult protective services	5	446	28	4	453	35	5	777	77
Private citizens	444	45	22	580	68	26	498	30	17
MFCU hotline	0	0	0	0	0	0	0	0	0
Other	129	20	3	155	20	2	173	9	0
Total	708	548	62	857	598	75	799	836	101
Annual Total	1,318			1,530			1,736		

Source: OIG analysis of Unit-submitted documentation, FYs 2012–2014, 2015.

³⁰ The abbreviation “PIU” stands for Program Integrity Unit.

APPENDIX C

Investigations Opened and Closed by Provider Category for FYs 2012 Through 2014

Table C-1: Fraud Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
Facilities	Opened	Closed	Opened	Closed	Opened	Closed
Hospitals	5	3	14	5	8	6
Nursing facilities	4	4	1	4	6	1
Other long-term-care facilities	9	10	7	12	4	10
Substance abuse treatment centers	0	0	0	0	0	0
Other	5	3	3	5	3	0
Subtotal	23	20	25	26	21	17
Practitioners	Opened	Closed	Opened	Closed	Opened	Closed
Doctors of medicine or osteopathy	38	30	18	43	32	38
Dentists	8	7	4	7	10	10
Podiatrists	0	2	0	2	0	1
Optometrists/opticians	0	0	1	0	1	0
Counselors/psychologists	6	2	1	2	3	5
Chiropractors	0	0	0	1	0	0
Other	0	0	0	0	0	0
Subtotal	52	41	24	55	46	54
Medical Support	Opened	Closed	Opened	Closed	Opened	Closed
Pharmacies	22	10	22	19	22	19
Pharmaceutical manufacturers	41	28	39	60	26	55
Suppliers of durable medical equipment and/or supplies	15	5	22	18	25	3
Laboratories	3	4	11	4	11	2
Transportation services	1	1	2	3	5	3
Home health care agencies	36	50	15	43	16	30
Home health care aides	6	3	0	5	2	4
Nurses, physician assistants, nurse practitioners, certified nurse aides	5	2	1	6	5	2
Radiologists	2	1	0	1	0	2
Medical support—other	15	20	25	34	54	36
Subtotal	146	124	137	193	166	156

Table C-1 (Continued): Fraud Investigations

Program Related	Opened	Closed	Opened	Closed	Opened	Closed
Managed care organizations	4	1	4	7	3	3
Medicaid program administration	0	1	0	0	0	0
Billing company	2	0	0	0	0	1
Other	0	0	2	0	0	0
Subtotal	6	2	6	7	3	4
Total Provider Categories	227	187	192	281	236	231

Source: OIG analysis of Unit-submitted documentation, 2015.

Table C-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing facilities	15	14	6	7	8	9
Other long-term-care facilities	16	27	15	19	10	15
Nurses, physician assistants, nurse practitioners, certified nurse aides	13	7	12	8	16	14
Home health aides	0	0	0	0	0	0
Other	10	7	12	3	20	18
Total	54	55	45	37	54	56

Source: OIG analysis of Unit-submitted documentation, 2015.

Table C-3: Patient Funds Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nondirect care	9	9	8	8	6	3
Nurses, physician assistants, nurse practitioners, certified nurse aides	0	0	1	0	3	1
Home health aides	0	0	0	0	0	0
Other	2	6	4	3	3	3
Total	11	15	13	11	12	7

Source: OIG analysis of Unit-submitted documentation, 2015.

APPENDIX D

Detailed Methodology

We used data collected from the seven sources below to describe the caseload and assess the performance of the Florida Unit.

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information from several sources regarding the Unit's investigation of Medicaid cases, including information about the number of referrals the Unit received, the number of investigations the Unit opened and closed, the outcomes of those investigations, and the Unit's case mix. We also collected and analyzed information about the number of cases that the Unit referred for prosecution and the outcomes of those prosecutions.

We gathered this information from several sources, including the Unit's quarterly status reports; annual reports; recertification questionnaire; policy and procedures manuals; and MOU with the State Medicaid agency. We requested any additional data or clarification from the Unit as necessary.

Review of Unit Financial Documentation. To evaluate internal control of fiscal resources, we reviewed policies and procedures related to the Unit's budgeting, accounting systems, cash management, procurement, property, and staffing. We reviewed records in the Payment Management System (PMS)³¹ and revenue accounts to determine the accuracy of the Federal Financial Reports (FFRs) for FYs 2012 through 2014. We also obtained the Unit's claimed grant expenditures from its FFRs and the supporting schedules. From the supporting schedules, we requested and reviewed supporting documentation for the selected items. We noted any instances of noncompliance with applicable regulations.

We reviewed three purposive samples to assess the Unit's internal control of fiscal resources. The three samples included the following:

1. To assess the Unit's expenditures, we selected a purposive sample of 1,258 accounting records from 41,803 accounting records. The accounting records were selected from 4 of 38 Unit-supplied files. We selected routine and nonroutine accounting records representing a variety of budget categories and payment amounts.

³¹ The PMS is a grant payment system operated and maintained by the Department of Health and Human Services, Program Support Center, Division of Payment Management. The PMS provides disbursement, grant monitoring, reporting, and case management services to awarding agencies and grant recipients, such as MFCUs.

2. To assess inventory, we selected and verified a purposive sample of 32 items from the current inventory of 209 items listed as located in the Unit's Tallahassee offices. To ensure a variety in our inventory sample, we included items that were portable, high value, or unusual in nature (e.g., vehicles, communication equipment).
3. To assess employee time and effort, we selected a purposive sample of 30 of 159 Unit employee names that were paid. We then requested and reviewed documentation (e.g., time card records) to support the time and effort of the employees.

Interviews with Key Stakeholders. In August and September 2015, we interviewed key stakeholders, including officials in the U.S. Attorney's Office (Criminal and Civil Divisions), the State Attorney General's Office, and State agencies that interacted with the Unit (i.e., Adult Protective Services, Agency for Health Care Administration, Agency for Persons with Disabilities, Department of Health, Long-Term Care Ombudsman, Office of Statewide Prosecution, and Office of the State Attorney). We also interviewed a supervisor from OIG's Region M Office of Investigations who works regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities and opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Survey of Unit Staff. In August 2015, we conducted an online survey of Unit staff.³² We requested responses from 131 staff members and received completed surveys from 130, or 99 percent. The survey focused on operations of the Unit, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Structured Interviews with Unit Management and Selected Staff. We conducted structured interviews with the Unit's director, deputy director, four chief attorneys, five law enforcement captains, and chief auditor. We also conducted group interviews of the Unit's 15 law enforcement lieutenants by geographic location. We asked these individuals to provide information related to (1) the Unit's 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

³² We did not survey the MFCU director, deputy director, or other regional supervisors whom we interviewed remotely or onsite. We also did not survey two employees who began employment within 2 weeks of the date we conducted our survey.

and/or performance, and (4) clarification regarding information obtained from other data sources.

Onsite Review of Case Files and Other Documentation. We requested that the Unit provide us with a list of cases that were open at any point during FYs 2012 through 2014. This list of 1,548 cases included, but was not limited to, the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened. From this list of cases, we excluded 155 cases that were categorized as “global.”

We then selected a simple random sample of 100 cases from the remaining 1,393 cases. From the initial sample of 100 case files, we selected a further simple random sample of 50 files for an OIG investigator to conduct an indepth review of selected issues, such as the timeliness of investigations and case development.

Fifteen sampled cases were not reviewed. Fourteen cases were labeled by the Unit as civil fraud cases; however, they were global cases. The fifteenth case was a case file number opened for the purpose of conducting data mining activities; however, this case did not represent a case worked by the Unit. After excluding the ineligible cases, we reviewed 85 total case files.

Because there were 15 ineligible cases in the 100 sampled cases, it is possible that there could be other ineligible cases in the population. Therefore, we estimated (1) the total number of eligible case files, and (2) the number of eligible closed case files, as shown in Table D-1.

Table D-1: Estimates of the Population of Eligible Case Files

Estimate Description	Sampled Case Files	Population of Eligible Case Files	95-percent Confidence Interval
Total eligible case files	85	1,184	1,069–1,270
Eligible closed case files	63	878	755–980

Source: OIG analysis of Florida MFCU case files, 2015.

Using the results of our review of the sampled case files, we reported two estimates related to the subpopulation of eligible case files and one estimate related to the subpopulation of eligible closed case files. The point estimates and their 95-percent confidence intervals are in Appendix E.

Onsite Review of Unit Operations. During our September 2015 site visit, we observed the Unit’s offices and meeting spaces; the security of data and case files; location of select equipment; and the general functioning of the Unit. We also determined whether the Unit referred sentenced

individuals to OIG for program exclusion and whether the Unit reported adverse actions to the NPDB.

Data Analysis

We analyzed data to identify any opportunities for improvement and any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.³³

³³ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu>.

APPENDIX E

Table E-1: Point Estimates and 95-Percent Confidence Intervals Based on Reviews of Case Files

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval for Percentages	
			Lower Limit	Upper Limit
Case files that did not contain documentation of periodic supervisory review	85	42.4%	32.0%	53.2%
Case files that contained documentation of supervisory approval for opening	85	98.8%	93.8%	99.9%
Case files that contained documentation of supervisory approval for closing	63	100.0%	94.4%	100.0%

Source: OIG analysis of Florida MFCU case files, 2015.

APPENDIX F

Unit Comments



PAM BONDI
ATTORNEY GENERAL
STATE OF FLORIDA

OFFICE OF THE ATTORNEY GENERAL
Medicaid Fraud Control Unit
James D. Varnado, Director

PL-01 The Capitol
Tallahassee, FL 32399-1050
Phone (850) 414-3910 Fax (850) 921-5194
James.Varnado@myfloridalegal.com
<http://www.myfloridalegal.com>

May 20, 2016

Suzanne Murrin
Deputy Inspector General for
Evaluation and Inspections
Dept. of Health & Human Services
330 Independence Ave., S. W.
Cohen Building, Room 5660
Washington, D. C. 20201

Re: Florida State Medicaid Fraud Control Unit
2015 Onsite Review OEI-07-15-00340

Dear Deputy Inspector General Murrin:

This letter represents the invited comments of the Florida Medicaid Fraud Control Unit to your draft report of April 22, 2016.

Recommendation #1: Ensure the Unit conducts and documents supervisory reviews of Unit case files according to the Unit's policies and procedures.

Unit Comment: The Unit concurs with this recommendation. Unit management is re-evaluating the monthly case review policy to adopt the more common investigative business practice of quarterly case reviews. This policy revision will still allow supervisors to review case progress and improve compliance with the Unit's policies and procedures.

Recommendation #2: Implement processes to ensure it reports convictions and adverse actions to Federal partners within required timeframes.

Unit Comment: The Unit concurs with this recommendation. Unit management recognized the failure to timely report convictions and adverse actions prior to the end of the onsite review period. All individuals not previously reported to OIG within the proper timeframe of the onsite review period have since been reported to OIG. The Unit is now up-to-date with its reporting requirement.

Ms. Suzanne Murrin
May 20, 2016
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To address the issue for future reporting, MFCU has: 1) revised it's electronic case files to capture report dates; 2) added a view to easily review convictions and verify report dates; and 3) is currently reviewing programming to generate an electronic system reminder of OIG report due dates for convictions and adverse actions. MFCU policies and procedures are under review for revision for this recommendation.

Although we concur that convictions and adverse actions should be reported to Federal partners in a timely manner, the timeframe within which those reports are made are often outside the control of the Unit. MFCUs cannot control the courts, and in some cases may not be able to meet this reporting requirement. The Unit will make every effort to meet the specified timeframe.

Recommendation #3: Repay Federal matching funds spent on the case that was not eligible for Federal funding.

Unit Comment: The Unit contacted DHHS/OIG Grant Management and has agreed to repay the Federal funds by offset against the current grant. This repayment will be documented on the SF-425 for the quarter ended 06/30/16.

I would like to express my appreciation to the onsite review team for the professionalism shown during the onsite review process, and thank you for the opportunity to comment on the recommendations of the review team.

Sincerely,



James D. Varnado, Director
Office of the Attorney General
Florida Medicaid Fraud Control Unit

JDV/jh

ACKNOWLEDGEMENTS

This report was prepared under the direction of Brian T. Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Jennifer King, Deputy Regional Inspector General; and in consultation with Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Tricia Fields, of the Kansas City regional office, served as the project leader for this study. Other Office of Evaluation and Inspections staff who conducted the review include Conswelia McCourt and Dennis J. Tharp. Other Medicaid Fraud Policy and Oversight Division staff who participated in the review include Susan Burbach. Office of Investigations staff also participated in the review. Office of Audit Services staff who conducted a financial review include Deana Baggett and Beverly Farley. Central office staff who contributed include Kevin Farber, Lonie Kim, and Joanne Legomsky.

Office of Inspector General

<http://oig.hhs.gov>

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