

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



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**EXECUTIVE SUMMARY – UTAH STATE MEDICAID FRAUD CONTROL UNIT:
2013 ONSITE REVIEW
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WHY WE DID THIS STUDY

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

HOW WE DID THIS STUDY

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

WHAT WE FOUND

From fiscal years 2010 through 2012, the Unit reported recoveries of \$61 million, 26 convictions, and 51 civil judgments and settlements. Unit case files lacked documentation of supervisory approval to open and close cases and documentation of periodic supervisory reviews. In addition, the Unit did not refer three sentenced individuals to OIG for program exclusion. The Unit's policies and procedures manual did not reflect current Unit operations. Finally, the Unit did not report adverse actions to the National Provider Data Bank (NPDB) as required by Federal regulations.

WHAT WE RECOMMEND

We recommend that the Utah Unit (1) ensure that supervisory approval and periodic reviews are documented in Unit case files, (2) ensure that it refers individuals for exclusion to OIG, (3) revise its policies and procedures manual, and (4) ensure that adverse actions are reported to the NPDB. The Unit concurred with all four of our recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.^{1,2} Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State; and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect. Currently, 49 States and the District of Columbia (States) have created such Units.³ In fiscal year (FY) 2012, combined Federal and State grant expenditures for the Units totaled \$217.3 million, of which Federal funds represented \$162.9 million.^{4,5} That year, the 50 Units employed 1,901 individuals.⁶

To carry out its duties in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.⁷ The staff reviews complaints referred by the State Medicaid agency and other sources and determines their potential for criminal prosecution and/or civil action. Collectively, in FY 2012, the 50 Units reported 1,337 convictions and 823 civil judgments and

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

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

³ North Dakota and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units. *Medicaid Fraud Control Units*, Office of Inspector General (OIG) web site. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp> on May 21, 2013.

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

⁵ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on May 8, 2013.

⁶ Ibid.

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

settlements. That year, the Units reported recoveries of approximately \$2.9 billion.⁸

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

Oversight of the MFCU Program

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

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁶ OIG

⁸ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on May 8, 2013. Pursuant to 42 CFR § 1007.17, Units report the total amount of recovered funds in their annual reports to OIG. “Recoveries” are defined as the amount of money that defendants are required to pay as a result of a judgment or settlement in criminal and civil cases, and may not reflect actual collections. Recoveries may involve cases that include participation by other Federal and State agencies.

⁹ SSA § 1903(q)(1).

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

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

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

¹³ SSA § 1903(a)(6)(B).

¹⁴ 42 CFR § 1007.15(a).

¹⁵ 42 CFR § 1007.15(b) and (c).

¹⁶ SSA § 1902(a)(61).

developed and issued 12 performance standards to define the criteria that OIG applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements.¹⁷ Examples of standards include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all three of the professional disciplines (i.e., for auditors, investigators, and attorneys), and establishing policy and procedures manuals to reflect the Unit's operations. See Appendix A for a complete list of the performance standards.¹⁸

Utah Unit

The Unit is an autonomous entity within the Utah Attorney General's Criminal Justice Division and has the authority to prosecute cases of Medicaid fraud and cases of patient abuse and neglect. At the time of our review, all of the Unit's 13 employees were located in Murray, Utah. The Unit Director serves as the Chief Attorney and directly supervises all Unit attorneys, the Chief Investigator, Unit auditors, and Unit support staff. The Chief Investigator directly supervises the five other Unit investigators.

The Unit receives referrals of provider fraud from the Utah Office of Inspector General of Medicaid Services and from Federal agencies, such as OIG. The Unit receives referrals of patient abuse and neglect¹⁹ from the Utah Division of Aging and Adult Services (DAAS). In addition, the Unit receives both types of referrals from other State and local agencies. For additional information on Unit referrals, see Appendix C.

Upon receiving a referral, the Chief Investigator and Unit Director screen it to decide whether to open the referral as a case and proceed with an investigation or refer it to another agency.²⁰ After a referral is accepted for investigation, the Unit paralegal opens it as a case in the Unit's electronic case tracking system. Unit supervisors assign the case to an investigator, an attorney, and, as appropriate, an auditor. The assigned Unit employees then meet to plan the case strategy.

¹⁷ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf> on May 8, 2013.

¹⁸ The performance standards referred to in this report were published in 1994 and were in effect during most of our review period (FYs 2010 through 2012). In June 2012, OIG published a revision of the performance standards (77 Fed. Reg. 32645, June 1, 2012). Our onsite data collection took place in September 2013. When referring to the performance standards, we refer to the 1994 standards, unless otherwise noted. See Appendix B for a complete list of the revised performance standards.

¹⁹ For the purposes of this report, misappropriation of patients' private funds in residential health care facilities is included in the category of patient abuse and neglect.

²⁰ For fraud referrals, the Chief Investigator and Unit Director also consult with the Chief Auditor to determine whether to open the referral as a case and proceed with an investigation.

The Unit may open a case and pursue it through a variety of actions, including criminal prosecution, civil action, or a combination of the two. The Unit may close a case for a variety of reasons, including, but not limited to, resolving it through criminal and/or civil action or referring it to another agency. For additional information on the Unit's opened and closed investigations, including a breakdown by case type and provider category, see Appendix D.

Previous Review

In 2007, OIG conducted an onsite review of the Utah Unit and found it to be "in general compliance with the Federal rules and regulations that govern the [MFCU] grant." However, the review identified two areas of concern related to the Unit's case flow. The review recommended that the Unit develop a case file index for locating documents within case files and that the Unit open case files only for referrals accepted for formal investigation. According to the report on the 2007 review, the Unit Director's response to the review findings satisfied OIG "that the MFCU [was] properly reporting its statistical information."

METHODOLOGY

We analyzed data from seven sources: (1) a review of Unit documentation, including policies and procedures related to the Unit's operations, staffing, and caseload for FYs 2010 through 2012; (2) a review of financial documentation for FYs 2010 through 2012; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management and selected staff; (6) an onsite review of case files that were open at any point during FYs 2010 through 2012; and (7) an onsite review of Unit operations.

We analyzed data from all seven sources to describe the caseload and assess the performance of the Unit. We also analyzed the data to identify any opportunities for improvement and any instances in which the Unit did not meet the performance standards or was not operating in accordance with laws, regulations, and/or policy transmittals.²¹

In addition, we noted practices that appeared to benefit the Unit. We based these observations on statements from Unit staff and an analysis of collected data. We did not independently verify the effectiveness of these practices, but included the information because it may be useful to other Units in their operations.

We conducted the onsite review in September 2013.

²¹ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov>.

Data Collection and Analysis

Review of Unit Documentation. We collected and reviewed Unit documentation, including policies and procedures related to the Unit's operations, staffing, and cases. This documentation included the Unit's annual reports, quarterly statistical reports, and responses to recertification questionnaires. We reviewed the documentation to determine how the Unit investigates and prosecutes Medicaid cases. The documentation also included data such as the number of referrals received by the Unit and the number of investigations opened and closed. Additionally, we confirmed with the Unit Director that the information we had was current at the time of our review and requested any additional data or clarification, as needed.

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

Interviews With Key Stakeholders. We conducted structured interviews with seven individual stakeholders among five agencies who were familiar with Unit operations. Specifically, we interviewed the Program Integrity Manager for the Utah Office of Inspector General of Medicaid Services; a regional director of DAAS; an Assistant U.S. Attorney based in Utah; the Utah Attorney General's Criminal Justice Division Chief;²² two OIG Special Agents based in Salt Lake City; and the Utah Inspector General of Medicaid Services. These interviews focused on the Unit's interaction with external agencies, Unit operations, opportunities for improvement, and any practices that appeared to benefit the Unit and that may be useful to other Units in their operations.

Survey of Unit Staff. We conducted an online survey of Unit staff.²³ We requested responses from 10 staff members and received responses from 9 of them, a 90-percent response rate. Our questions focused on Unit operations, opportunities for improvement, and practices that appeared to benefit the Unit and that may be useful to other Units in their operations.

²² The Unit Director is supervised by the Chief of the Attorney General's Criminal Justice Division.

²³ We did not survey the Unit Director, Chief Investigator, or Chief Auditor because we interviewed these staff members onsite.

The survey also sought information about the Unit's compliance with applicable laws, regulations, and policy transmittals.

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

Onsite Review of Case Files. We selected a simple random sample of 100 case files from the 258 cases²⁴ that were open at any point from FY 2010 through FY 2012. The design of this sample allowed us to estimate the percentage of all 258 cases with various characteristics at the 95-percent confidence level. We were able to gather information on 98 of the 100 case files selected in the sample, a 98-percent response rate.²⁵ We reviewed these 98 sampled case files and the Unit's processes for monitoring the status and outcomes of cases. From the 100 case files in the initial sample, we selected another simple random sample of 50 files for a more in-depth review of potential issues. This second-phase sample allowed us to conduct a more comprehensive review of case files to identify any potential issues from a qualitative perspective. We consulted Unit staff to address any apparent issues with individual case files, such as missing documentation. For population and sample size counts, as well as confidence interval estimates, see Appendix E.

Onsite Review of Unit Operations. While onsite, we reviewed the Unit's operations. Specifically, we observed the intake of referrals, data analysis operations, security of data and case files, and the general functioning of the Unit. We also checked to ensure that the Unit referred sentenced

²⁴ This figure includes cases opened before FY 2010 that remained open at some point during FYs 2010–2012. This figure does not include 72 multi-State (“global”) civil false-claims cases, which consist of both those worked directly by the Unit and those worked by staff from the Federal government or other Units. For the purposes of our case file review, the Unit's global cases were not included as part of the Unit's case file population. Including global cases, the total number of Unit cases open during the review period was 330.

²⁵ Two of the case files selected for our sample were sealed by court order and therefore unavailable for review.

individuals to OIG for program exclusion and that the Unit reported adverse actions to the National Practitioner Data Bank (NPDB).^{26, 27}

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.²⁸

²⁶ The NPDB was established by the Department of Health and Human Services as “a national health care fraud and abuse data collection program ... for the reporting of certain final adverse actions ... against health care providers, suppliers, or practitioners.” SSA § 1128E(a) and 45 CFR § 61.1(2012). This portion of the NDPB used to be a separate databank called the Healthcare Integrity and Protection Databank (HIPDB). The HIPDB and the NPDB were merged into one databank in May 2013. 78 Fed. Reg. 20473 (April 5, 2013).

²⁷ Examples of adverse actions include criminal convictions; civil judgments (but not civil settlements); exclusions; and other negative actions or findings, including “any action or finding that under the State’s law is publicly available information, and rendered by a licensing or certification authority, including but not limited to, limitations on the scope of practice, liquidations, injunctions and forfeitures.” SSA § 1128E(g)(1) and 45 CFR § 61.3 (2012). We reviewed the reporting of adverse actions under HIPDB requirements because the HIPDB and the NPDB had not yet been merged during the period of our review (FYs 2010 through 2012). Current Unit requirements for reporting to the merged NPDB are in 45 CFR pt. 60.

²⁸ Full text of these standards is available online at <http://www.ignet.gov/pande/standards/oeists11.pdf>.

FINDINGS

From FY 2010 through FY 2012, the Unit reported recoveries of \$61 million, 26 convictions, and 51 civil judgments and settlements

From FY 2010 through FY 2012, the Unit reported total criminal and civil recoveries of \$61 million, an annual average of \$20 million (see Table 1). Of the \$61 million in total recoveries, the Unit attributed \$47,887 to criminal recoveries. Non-“global”²⁹ civil judgments and settlements accounted for 77 percent (\$46 million) of the total civil recoveries, and global cases accounted for 72 of the Unit’s 330 total cases over the 3-year period. The Unit’s annual average expenditures for FYs 2010 through 2012 were \$1.6 million.³⁰

Table 1: Funds Reported Recovered by the Utah Unit, FYs 2010 Through 2012

	FY 2010	FY 2011	FY 2012	3-Year Total	Annual Average*
Criminal Recoveries	\$8,242	\$35,405	\$4,240	\$47,887	\$15,962
Global Civil Recoveries	\$4,611,892	\$6,514,376	\$3,180,029	\$14,306,297	\$4,768,766
Nonglobal Civil Recoveries	\$25,114,128	\$7,166,357	\$14,195,791	\$46,476,276	\$15,492,092
Total Civil Recoveries	\$29,726,020	\$13,680,733	\$17,375,820	\$60,782,573	\$20,260,858
Total Civil and Criminal Recoveries	\$29,734,262	\$13,716,138	\$17,380,060	\$60,830,460	\$20,276,820
Total Expenditures	\$1,446,999	\$1,608,289	\$1,669,284	\$4,724,572	\$1,574,857

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

*Averages in this table are rounded.

From FY 2010 through FY 2012, the Unit Reported 26 Convictions and 51 Civil Judgments and Settlements. From FY 2010 through FY 2012, the Unit’s convictions decreased, but civil judgments and settlements remained at a consistent level. During this period, the Unit reported

²⁹ Unit-reported recoveries include funds recovered from multi-State, or “global,” civil false claims cases, which consist of both those worked directly by the Unit and those worked by staff from other Units.

³⁰ The figures presented in this paragraph are rounded.

26 convictions and 51 civil judgments and settlements, an annual average of 8.7 convictions and 17 civil judgments and settlements (see Table 2).

Table 2: Unit Convictions and Civil Judgments and Settlements, FYs 2010 Through 2012³¹

	FY 2010	FY 2011	FY 2012	3-Year Total	Annual Average
Convictions	12	10	4	26	8.7
Civil Judgments and Settlements	18	18	15	51	17

Source: OIG review of Unit self-reported QSRs and other data, FYs 2010–2012.

From FYs 2010 through 2012, the Unit opened an average of 69 cases annually, with an average of 41 cases of provider fraud and 27 cases of patient abuse and neglect. From FYs 2010 through 2012, the Unit closed an average of 73 cases annually, averaging 34 cases of provider fraud and 39 cases of patient abuse and neglect.³² From FYs 2010 through 2012, the Unit received an average of 69 referrals annually, with an average of 41 referrals of provider fraud and 27 referrals of patient abuse and neglect. Although the number of patient abuse and neglect referrals to the Unit declined each year of the review period, Unit management and stakeholders did not identify any specific cause for the decline.³³

Unit case files did not consistently contain documentation of supervisory approval to open and close cases, and 60 percent of case files lacked documentation of periodic supervisory reviews

According to Performance Standard 6(b), Unit supervisors should approve the opening and closing of cases to ensure a continuous case flow and the timely completion of cases. Supervisory approval to open and close cases suggests that Unit supervisors are monitoring the intake and resolutions of cases, thereby facilitating progress in the cases. According to Unit management, the Unit Director approves the opening and closing of all cases. However, 26 percent of the Unit’s case files lacked documentation of supervisory approval to open cases, and 13 percent of the Unit’s closed case files lacked documentation of supervisory approval to close cases.

³¹ Civil judgments and settlements include those received from global cases.

³² Closures include multiple cases opened before FY 2010. The averages in this paragraph are rounded.

³³ As noted in Table C-1 in Appendix C, total patient abuse and neglect referrals to the Unit declined from 41 in FY 2010 to 28 in FY 2011 and 13 in FY 2012.

According to Performance Standard 6(c), supervisory reviews should be “conducted periodically and noted in the case file” to ensure timely case completion.³⁴ According to Unit management, all open cases are reviewed by supervisors on a weekly basis, and Unit supervisors regularly document supervisory reviews in the case files or electronic case file tracking system. However, 60 percent of the Unit’s cases lacked documentation of periodic supervisory reviews either in the case files or in the electronic case file tracking system.

The Unit did not refer three sentenced individuals to OIG for program exclusion

According to Performance Standard 8(d), when a convicted individual is sentenced, the Unit should send a referral letter to OIG “within 30 days or other reasonable time period” for the purpose of program exclusion.^{35, 36} The Unit reported 26 total convictions within the review period, but did not refer 3 of those sentenced individuals to OIG for program exclusion within an appropriate timeframe. Each of these individuals had been sentenced at least 2 years prior to our onsite review, but none had been referred to OIG for program exclusion. Unit management acknowledged this oversight and provided documentation that all three individuals were referred to OIG for program exclusion immediately following our onsite review.

The Unit’s policies and procedures manual did not reflect current Unit operations

According to Performance Standard 3, the Unit should establish policies and procedures for its operations, which should be included in a manual. The Unit’s policies and procedures manual had last been updated in 2013, prior to our onsite review. However, the manual did not address Unit operations specific to its case file review process or its procedures for documenting supervisory approval to open and close cases and periodic

³⁴ For the purposes of this report, supervisory approval to open and close a case does not constitute a periodic supervisory review. “Periodic supervisory reviews” indicate that a supervisor reviewed a case more than once between the case’s opening and closing and documented those reviews in the case file.

³⁵ Pursuant to section 1128(a) of the SSA, OIG excludes from participation in Federal health care programs any person or entity convicted of a criminal offense related to the delivery of an item or service under the Medicaid program or to the neglect or abuse of patients in residential health care facilities. No payment may be made by Medicaid, Medicare, or other Federal health care programs for an item or service provided, ordered, or prescribed by an excluded individual or entity. 42 CFR § 1001.1901.

³⁶ According to 2012 Performance Standard 8(f), all referrals for exclusion should be transmitted to OIG “within 30 days.” That 2012 standard does not allow the option of transmitting referrals for exclusion within an “other reasonable time period.”

supervisory reviews in the Unit's case files and/or electronic case file tracking system.

The Unit did not report adverse actions to the NPDB

Pursuant to Federal regulations, all State and Federal government agencies must report any adverse actions, generated as a result of investigations or prosecutions of healthcare providers, to the NPDB.³⁷ In addition, according to 2012 Performance Standard 8(g), the Unit should report "qualifying cases" to the NPDB. However, the Unit was not registered with the NPDB and did not report adverse actions to the NPDB during the review period. During our onsite review, Unit management acknowledged this oversight and provided documentation that the Unit is now registered with the NPDB.

Other Observations:

During our onsite review, we noted two practices that may have been beneficial to Unit operations: (1) efforts to ensure that appropriate Unit personnel become Certified Fraud Examiners (CFEs), and (2) the tracking of investigators' workloads. In addition, Unit management reported concerns about the lack of referrals from managed care organizations (MCOs).

Certified Fraud Examiner training

According to Performance Standard 12(e), training undertaken by Unit staff should "aid in the mission of the Unit." During our onsite review, Unit management reported that all Unit auditors and investigators were either trained as CFEs or in training to become CFEs. Unit management and staff reported that CFE training benefitted the Unit's performance by improving the efficiency and effectiveness of Unit provider fraud investigations.

Investigator workload tracking

According to Performance Standard 6, a Unit should have a continuous case flow and cases should be completed in a reasonable time. According to Unit management, the tracking of Unit investigators' workloads helps ensure the timely completion of investigations. The Chief Investigator maintains a spreadsheet documenting the number of cases assigned to each

³⁷ Under requirements established in 2012, Units must report adverse actions to the NPDB within 30 calendar days from the date the final adverse action was taken. 45 CFR § 61.5(a).

investigator, as well as the number of hours spent on each case. This spreadsheet also monitors the complexity of each case, which is taken into account when assigning new cases to investigators. The Chief Investigator reported using this spreadsheet to help ensure that each Unit investigator spends a similar amount of time working on investigations and to help ensure that cases are progressing in a timely manner.

Managed care referrals

According to 2012 Performance Standard 4(a), the Unit should take steps to ensure that MCOs “refer to the Unit all suspected provider fraud cases.” As of 2011, 98 percent of Utah Medicaid enrollees received their health care services through MCOs.³⁸ However, the Unit received no referrals from MCOs during the review period. Unit management reported that it is concerned about the lack of referrals and has taken steps to ensure fraud referrals from MCOs. These steps included discussions among the Unit, the State Medicaid agency (Utah Department of Health), and MCOs. The purpose of these discussions was to develop provisions in MCO contracts to ensure that MCOs send fraud referrals to the Unit.

³⁸ CMS, *2011 Medicaid Managed Care Enrollment Report*, accessed at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf> on October 24, 2013.

CONCLUSION AND RECOMMENDATIONS

From FY 2010 through FY 2012, the Unit reported recoveries of \$61 million, 26 convictions, and 51 civil judgments and settlements. Unit management and staff reported that CFE training improved the efficiency and effectiveness of Unit provider fraud investigations. Finally, Unit management reported that the tracking of investigators' workloads helps ensure the timely completion of investigations.

Opportunities for Unit improvement exist. Specifically, Unit case files did not consistently contain documentation of supervisory approval to open and close cases or periodic supervisory reviews. In addition, the Unit did not refer three sentenced individuals to OIG for program exclusion. The Unit's policies and procedures manual did not reflect the Unit's periodic case file review process. Finally, the Unit did not report adverse actions to the NPDB. Other than the failures to report three providers to OIG for program exclusion and to report adverse actions to the NPDB, we found no evidence of noncompliance with applicable laws, regulations, or policy transmittals.

We recommend that the Utah Unit:

Ensure that supervisory approval to open and close cases and periodic supervisory reviews are documented in Unit case files

The Unit should ensure that supervisors are approving the opening and closing of cases and consistently reviewing case files; approval to open and close cases and periodic supervisory reviews should be documented in the case files.

Ensure that letters referring providers for exclusion are submitted to OIG within an appropriate timeframe

The Unit should ensure that letters referring individuals and entities for exclusion are sent within 30 days of defendant sentencing, consistent with 2012 Performance Standard 8(f).

Revise its policies and procedures manual to reflect current Unit operations

The Unit should revise its policies and procedures manual to include its periodic case file review process.

Ensure that adverse actions are reported to the NPDB

The Unit should ensure that it reports all adverse actions, generated as a result of investigations or prosecutions of healthcare providers, to the NPDB, as specified in Federal regulations.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with the four report recommendations.

Regarding the first recommendation, the Unit reported that it has instructed staff to include case-referral approval forms signed by Unit management in the case files. The Unit also reported that it has instructed supervisors to note periodic supervisory reviews in the Unit's electronic case-management system.

Regarding the second recommendation, the Unit explained that it did not report the three cases to OIG for exclusion because it misunderstood OIG's exclusion policy. The Unit reported that it now understands this policy and has since referred the three cases in question to OIG for exclusion.

Regarding the third recommendation, the Unit agreed to update its policies and procedures manual to reflect current Unit operations. The Unit reported that it anticipates that the update will be completed by June 2014.

Regarding the fourth recommendation, the Unit reported that it is now registered with the NPDB and will report all adverse actions as required.

APPENDIX A

Performance Standards for MFCUs (Units)³⁹

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

³⁹ 59 Fed. Reg. 49080 (Sept. 26, 1994). These performance standards were in effect during most of our review period and precede the performance standards published in June 2012.

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

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

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

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

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

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

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

7. A Unit should have a process for monitoring the outcome of cases. In meeting this standard, the following performance indicators will be considered:

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX B

Revised 2012 Performance Standards for MFCUs (Units)⁴⁰

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

⁴⁰ 77 Fed. Reg. 32645 (June 1, 2012).

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.
- b. The Unit provides periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.
- c. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).

- d. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.
- e. The Unit provides timely information, when requested, to those agencies identified in (D) above regarding the status of referrals.
- f. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.

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

- a. Each stage of an investigation and prosecution is completed in an appropriate timeframe.
- b. Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.
- c. Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.

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

- a. The Unit seeks to have a mix of cases from all significant provider types in the State.
- b. For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.
- c. The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.
- d. As part of its case mix, the Unit maintains a balance of fraud and patient abuse and neglect cases for those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases.

- e. As part of its case mix, the Unit seeks to maintain, consistent with its legal authorities, a balance of criminal and civil fraud cases.

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

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

recoveries and the types of relief obtained through civil judgments or prefilings settlements.

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

- a. The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.
- b. The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, cases involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.
- c. The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.
- d. For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.
- e. For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.
- f. The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.
- g. The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.

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

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

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

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

- a. The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.
- b. The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR 455.23, "Suspension of payments in cases of fraud."
- c. The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).
- d. Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.
- e. The MOU incorporates by reference the CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit.

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

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

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

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

APPENDIX C

Referrals of Provider Fraud and Patient Abuse and Neglect to the Utah MFCU by Source, FYs 2010 Through 2012

Table C-1: Total MFCU Referrals of Fraud and Abuse and Annual Average

Case Type	FY 2010	FY 2011	FY 2012	3-Year Total	Annual Average*
Patient Abuse and Neglect	41	28	13	82	27
Provider Fraud	52	34	38	124	41
Total	93	62	51	206	69

Source: Unit response to OIG data request.

*Averages in this column are rounded.

Table C-2: MFCU Referrals, by Referral Source

Referral Source	FY 2010		FY 2011		FY 2012		Total	Percentage of All Referrals*
	Fraud	Abuse and Neglect	Fraud	Abuse and Neglect	Fraud	Abuse and Neglect		
Adult Protective Services	0	27	1	24	0	9	61	29.6%
Other	32	1	15	0	9	0	57	27.7%
State Medicaid Agency	10	6	6	4	12	4	42	20.4%
OIG	1	0	2	0	13	0	16	7.8%
Licensing Board	5	4	2	0	0	0	11	5.3%
Providers	3	1	4	0	0	0	8	3.9%
Law Enforcement	0	1	2	0	2	0	5	2.4%
MFCU Hotline	1	0	0	0	0	0	1	0.5%
Private Citizens	0	0	1	0	0	0	1	0.5%
Other State Agencies	0	0	1	0	0	0	1	0.5%
Ombudsman	0	1	0	0	0	0	1	0.5%
Prosecutors	0	0	0	0	1	0	1	0.5%
State Survey and Certification	0	0	0	0	1	0	1	0.5%
Total	52	41	34	28	38	13	206	100%
Annual Total	93		62		51			
Annual Average*							69	

Source: Unit response to OIG data request.

*This average is rounded.

APPENDIX D

Investigations Opened and Closed by the Utah MFCU, by Provider Category and Case Type, FYs 2010 Through 2012

Table D-1: Total Annual Opened and Closed Investigations

Case Type	FY 2010	FY 2011	FY 2012	3-Year Total	Annual Average*
Opened	93	62	51	206	69
Patient Abuse and Neglect	41	28	13	82	27
Provider Fraud	52	34	38	124	41
Closed	105	33	80	218	73
Patient Abuse and Neglect	66	25	26	117	39
Provider Fraud	39	8	54	101	34

Source: Unit response to OIG data request.

*Averages in this column are rounded.

Table D-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Home Health Aides	0	2	0	0	0	0
Nondirect Care	0	1	0	0	1	0
Nurses/Doctor's Assistants	9	13	2	4	1	5
Nursing Facilities	3	5	4	5	0	2
Other Long-Term Care Facilities	1	1	2	1	0	2
Other	28	44	20	15	11	17
Total	41	66	28	25	13	26

Source: Unit response to OIG data request.

Table D-3: Provider Fraud Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Facilities						
Hospitals	0	0	0	0	1	0
Nursing Facilities	1	0	0	1	0	1
Other Long-Term Care Facilities	0	1	0	0	1	0
Other Facilities	3	2	5	0	1	2
Subtotal	4	3	5	1	3	3
Practitioners						
Counselors/ Psychologists	0	0	0	0	1	1
Dentists	0	1	0	0	1	3
Optometrists/Opticians	0	0	0	0	2	1
Physicians	4	0	2	2	2	4
Other Practitioners	1	6	4	0	3	5
Subtotal	5	7	6	2	9	14
Medical Support						
Durable Medical Equipment Suppliers	1	0	1	0	0	2
Home Health Care Agencies	0	3	2	0	0	0
Laboratories	0	1	0	0	0	1
Nurses/Doctor's Assistants	2	1	0	1	3	2
Pharmaceutical Manufacturers	31	15	14	1	6	18
Pharmacies	1	1	3	1	5	2
Radiologists	0	0	0	0	0	1
Transportation Services	0	0	0	0	1	0
Other Medical Support	3	3	1	1	5	4
Subtotal	38	24	21	4	20	30
Program Related						
Other Program Related	5	5	2	1	6	7
Subtotal	5	5	2	1	6	7
Total	52	39	34	8	38	54

Source: Unit response to OIG data request.

APPENDIX E

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

Table E-1 shows population and sample counts and percentages by case type. Note that both samples have percentages of case types similar to the general population, though sample counts for some case types are very small. Because of these small sample sizes, we cannot reliably generalize what we found in our sample review to each case type in the population, and only our overall estimates project to the population of all case files. We estimated the 4 population values for all 258 nonglobal case files from the results of our review of the case files selected in our simple random samples. Table E-2 includes the estimate descriptions, sample sizes, point estimates, and 95-percent confidence intervals for these four estimates.

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

Case Type	Population Count and (%) n=258	Sample Count* and (%) n=98	Sample Count* and (%) n=50
Closed	208 (81%)	80 (82%)	42 (84%)
Open	50 (19%)	18 (18%)	8 (16%)
Civil (Nonglobal)	19 (7%)	8 (8%)	5 (10%)
Criminal	239 (93%)	90 (92%)	45 (90%)
Patient Abuse/Neglect	142 (55%)	47 (48%)	22 (44%)
Provider Fraud (Nonglobal)	116 (45%)	51 (52%)	28 (56%)

Source: The Utah MFCU provided a list of all case files open during FYs 2010 through 2012.

*OIG generated this random sample.

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

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Case Files With No Documented Supervisory Approval for Opening	98	25.5%	18.6–33.3%
Case Files With No Documented Supervisory Approval for Closing	80	12.5%	7.0–20.5%
Case Files With No Documentation of at Least One Supervisory Review	98	33.7%	26.0–41.9%
Case Files With No Documentation of Periodic Supervisory Review	98	60.2%	51.6–68.2%

APPENDIX F
Unit Comments

STATE OF UTAH
OFFICE OF THE ATTORNEY GENERAL



SEAN D. REYES
ATTORNEY GENERAL

SPENCER E. AUSTIN
Chief Criminal Deputy

PARKER DOUGLAS
General Counsel & Chief of Staff

BRIDGET K. ROMANO
Solicitor General

BRIAN L. TARBET
Chief Civil Deputy

April 1, 2014

Mr. Brian P. Ritchie
Acting Deputy Inspector General
for Evaluation and Inspection
5560 Cohen Building
330 Independence Avenue, S.W.
Washington, DC 20201

Re: Comments on 2013 Onsite Review of the Utah Medicaid Fraud Control Unit,
OEI-09-13-00490

Dear Sir,

I am in receipt of the draft report of the 2013 Utah State Medicaid Fraud Control Unit Onsite Review. I appreciate the professionalism of your staff and their willingness to answer questions and to discuss ways we can improve the Utah Medicaid Fraud Control Unit. I felt that the process was thoroughly explained and the audit was conducted consistent with the written and verbal instructions provided by the onsite review team. I was pleased to learn that our Unit is compliant with federal rules and performance standards in all but a few areas wherein we concur with the recommendations of the oversight review. Below I will address each of those recommendations and our timetable for compliance:

Oversite Review Findings and Implementation Plan:

1. **Ensure supervisory approval and periodic reviews are documented in case files:** Each case opened by the Unit includes a small approval sheet signed by the Chief Investigator and Director. In sixty percent of files reviewed this document was missing from the file. We have instructed staff to assure that the case referral approval form is included in the file. It may be necessary to change the size and format of the approval sheet to assure that it does not get misplaced or to make it easier to attach to the larger letter sized files. With respect to supervisory review, the audit reported on page 11 of the draft report that the Chief Investigator maintains a spreadsheet documenting the number of cases assigned for each investigator and the time spent on each investigation. The spreadsheet also gauges the complexity of the case. The performance standard requires that the periodic case reviews be noted in the

Mr. Brian P. Ritchie
April 1, 2014
Page Two

case file. Though the spreadsheet was the former practice for monitoring and documenting case progression, the Unit agrees to the recommendation and has already implemented the practice of noting in the electronic case management system (Versadex) each supervisory review. Our goal is to conduct a formal case review on at least a quarterly basis.

2. **Ensure that letters referring providers for exclusion are submitted to the OIG within the appropriate timeframe:** There were three cases which the Unit did not refer to the OIG for exclusion. This was a mistake based on a misunderstanding of the exclusion policy and it has been rectified. The three cases have since been referred to the OIG for exclusion review purposes.
3. **Revise policy and procedure manual to reflect current Unit operations:** The Unit's policy and procedure manual will be updated to more directly reflect the case approval process, including the need to maintain documentation, etc. The Unit anticipates that this will be completed in the next 60 days.
4. **Ensure that adverse actions are reported to the NPDB:** There was a delay in registering with the NPDB to facilitate mandatory reporting. The Unit is now registered and we will report all adverse actions as required.

The Utah Medicaid Fraud Control Unit concurs with each of the findings and is appreciative of the feedback and support of the oversight team. If you require additional information, do not hesitate to contact me. I can be reached by calling (801)281-1259 or by email at rsteed@utah.gov.

Sincerely,



Robert E. Steed, Director Utah MFCU

cc: Sean Reyes, Utah Attorney General
Susan Burbach, OIG

ACKNOWLEDGMENTS

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

Matthew DeFraga served as the lead analyst for this study. Other Office of Evaluation and Inspections staff from the San Francisco regional office who provided support include Rosemary Rawlins. Central office staff who provided support include Susan Burbach, Kevin Farber, Christine Moritz, Andrew VanLandingham, and Sherri Weinstein. Office of Investigations staff who provided support include Scott Frye.

Office of Inspector General

<http://oig.hhs.gov>

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