

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



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2015 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). As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. The reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor Unit compliance with Federal grant requirements.

HOW WE DID THIS STUDY

We conducted an onsite review of the California Unit in February 2015. We analyzed data from seven sources: (1) a review of any documentation related to the Unit's policies and procedures, operations, staffing, and Federal fiscal years (FYs) 2012-2014 caseload, (2) a review of financial documentation for FYs 2012-2014; (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 a sample of case files associated with cases that were open at any point during FYs 2012-2014; and (7) an onsite review of Unit operations.

WHAT WE FOUND

During FYs 2012-2014, the Unit expended \$83 million and generated 337 convictions, 67 civil judgments and settlements, and total recoveries of \$795 million, \$531 million of which was attributed to cases investigated directly by the Unit. Our review of the Unit found that it was generally in compliance with applicable laws, regulations, and policy transmittals. However, we identified some aspects of Unit operations that should be improved. Specifically, some Unit case files lacked certain required documentation, the Unit lacked a training plan for its investigators and auditors, and the Unit did not report most adverse actions or convictions in appropriate timeframes. Although the Unit generally exercised proper fiscal control of its resources, it improperly claimed some indirect costs during FYs 2012-2014. We noted three practices, among others, that the Unit reported were beneficial to Unit operations. Specifically, the Unit: (1) took steps to ensure it received fraud referrals from managed care organizations, (2) used a field representative to conduct outreach and provide training, and (3) co-located Unit investigators in an OIG field office.

WHAT WE RECOMMEND

We recommend that the California Unit: (1) develop and implement procedures to ensure that the Unit documents relevant information in its case files, (2) fully implement the new training plans for investigators and auditors, (3) develop and implement procedures to overcome challenges in obtaining information needed to report convictions and adverse actions to Federal partners within required timeframes, and (4) develop and implement procedures to ensure that the Unit properly claims its indirect costs. The Unit concurred with all four of our recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.¹ Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services (HHS) determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State; and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.² Currently, 49 States and the District of Columbia (States) have created such Units.³ In Federal fiscal year (FY) 2014, combined Federal and State grant expenditures for the Units totaled \$235 million.^{4,5} That year, the 50 Units employed 1,958 individuals.⁶

To carry out its duties in an effective and efficient manner, each MFCU 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 (Medicaid agency) and other sources and determines their potential for criminal prosecution and/or civil action. In FY 2014, the 50 Units reported a collective 1,318 convictions

¹ Social Security Act (SSA) § 1903(q). Regulations at 42 CFR § 1007.11(b)(1) add that the MFCU'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 MFCUs. *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 April 7, 2015.

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

⁵ OIG, *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on April 7, 2015.

⁶ Ibid.

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

and 874 civil judgments and settlements. That year, the Units reported recoveries of approximately \$2 billion.⁸

MFCUs 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 California 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.^{10,11} Additionally, each Unit must be a single, identifiable entity of State government, distinct from the Medicaid agency, and each Unit must develop a formal agreement—i.e., a memorandum of understanding (MOU)—that describes the Unit’s relationship with that agency.¹²

Oversight of the MFCU Program

The Secretary of HHS 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.¹³ All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹⁴ To receive Federal reimbursement, each Unit must submit an initial application to OIG.¹⁵ OIG reviews the application and notifies the Unit whether it is approved and the Unit is

⁸ OIG, *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on April 7, 2015. 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 State and Federal agencies.

⁹ SSA § 1903(q)(1).

¹⁰ *Medicaid Fraud Control Units*, OIG web site. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp> on April 7, 2015.

¹¹ In States with a Unit, the Unit shares responsibility for protecting the integrity of the Medicaid program with the section of the Medicaid agency that functions as the Program Integrity Unit. Some States also employ a Medicaid Inspector General who conducts and coordinates efforts to combat fraud, waste, and abuse for the State agency.

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

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

¹⁴ SSA § 1903(a)(6)(B).

¹⁵ 42 CFR § 1007.15(a).

certified. Approval and certification are valid for a 1-year period; the Unit must be recertified each year thereafter.¹⁶

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁷ OIG developed and issued 12 performance standards to define the criteria that OIG applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements.¹⁸ 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 description of each of the 12 performance standards.¹⁹

California MFCU

The Unit's headquarters office and a regional office are located in Sacramento. The Unit also has regional offices in Burbank, Laguna Woods, San Diego, and West Covina. The Unit is an autonomous entity within the California Office of the Attorney General with the authority to prosecute cases of Medicaid fraud and cases of patient abuse and neglect.²⁰ At the time of our review, the Unit director served as the interim chief attorney and directly supervised all regional attorney supervisors, the chief investigator, the chief civil auditor and the chief administrative officer. The chief investigator directly supervised all regional investigator supervisors and the chief criminal auditor.²¹ The chief civil auditor acted as chief of both the Unit's data mining team and the Case Intake and Development (CID) unit.

The Unit receives referrals of provider fraud primarily from the California Medicaid agency—the Department of Health Care Services (DHCS). The Unit also receives referrals of provider fraud from private citizens. The Unit receives referrals of patient abuse and neglect from the Long-term

¹⁶ 42 CFR § 1007.15(b) and (c).

¹⁷ SSA § 1902(a)(61).

¹⁸ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov> on April 7, 2015.

¹⁹ In June 2012, OIG published a revision of the original 1994 performance standards (77 Fed. Reg. 32645, June 1, 2012). The performance standards referred to in this report are the revised standards published in 2012, which were in effect during FYs 2012-2014. Our onsite data collection took place in February 2015. When referring to the performance standards, we refer to the 2012 standards, unless otherwise noted. Full text of the 1994 standards is available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf>.

²⁰ For the purposes of this report, the misappropriation or theft of residential health care facility patients' private funds is included in the category of patient abuse and neglect.

²¹ The Unit director retired in August 2015, after our onsite review. At the time of this report's publication, the Unit's chief investigator was serving as the interim Unit director.

Care Ombudsman's Office, the State Survey and Certification agency, and private citizens.

The CID unit processes all referrals of fraud or abuse and neglect. According to Unit management and staff, CID staff evaluate all referrals for substance and to determine whether the allegation is within the Unit's grant authority. CID staff enter the details of all accepted referrals into the Unit's electronic case file tracking system and forward the accepted criminal and civil fraud referrals to the CID chief for approval. CID staff forward all accepted patient abuse and neglect referrals to regional investigation managers for approval. After a referral is approved, the Unit opens the referral as a case. Unit management reported that, in some instances, the Unit may place the case on a regional backlog list until an investigator is available to conduct a full investigation. After the Unit completes the full investigation, a regional attorney supervisor determines whether to prosecute the case or close it.

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

Previous Review

OIG conducted the last onsite review of the California Unit in 2008. The review found that the Unit did not routinely document the progress of MFCU cases using interim investigative memorandums. OIG noted that inclusion of interim investigative memorandums in the Unit's case files could enable a Unit to ensure continuous case flow. In response, the Unit stated that it implemented a policy requiring that active cases be the subject of progress reviews at least every 3 months. Our 2015 onsite review found no evidence of a failure to document the progress of investigations.

METHODOLOGY

We conducted an onsite review of the California Unit in February 2015. We analyzed data from seven sources: (1) a review of any documentation related to the Unit's policies and procedures, operations, staffing, and FYs 2012-2014 caseload; (2) a review of financial documentation for FYs 2012-2014; (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 a sample of case files associated with cases that were open at any point during FYs 2012-2014; and (7) an onsite review of Unit operations. Appendix D contains a detailed methodology. Appendix E contains the point estimates and 95-percent confidence intervals for the statistics in this report.

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.²²

²² Full text of these standards is available online at <http://www.ignet.gov/pande/standards/oeistds11.pdf>

FINDINGS

From FY 2012 through FY 2014, the Unit reported recoveries of almost \$800 million, 337 convictions, and 67 civil judgments and settlements

During FYs 2012-2014, the Unit reported total criminal and civil recoveries of \$795 million—an annual combined average of \$265 million (see Table 1).²³ Of the \$795 million in total recoveries, \$264 million were from “global” cases, which are civil False Claims Act cases that are brought by the U.S. Department of Justice and involve a group of State MFCUs.^{24, 25} Of the \$531 million in recoveries from non-global cases, \$398 million was from civil cases and \$133 million was from criminal cases. During this period, the Unit expended \$83 million (State and Federal share); the Unit’s annual average expenditures for this period were \$28 million. The Unit’s total recoveries were significantly higher in FY 2012 than in FYs 2013 or 2014.²⁶

Table 1: California MFCU Reported Recoveries and Total Expenditures, by Year, FYs 2012 through 2014*

	FY 2012	FY 2013	FY 2014	3-Year Total	Annual Average
Criminal Recoveries	\$44,926,431	\$55,059,439	\$33,224,470	\$133,210,340	\$44,403,447
Global Civil Recoveries	\$122,709,283	\$25,363,893	\$115,877,872	\$263,951,048	\$87,983,683
Non-global Civil Recoveries	\$342,424,940	\$6,465,553	\$48,568,782	\$397,459,275	\$132,486,425
Total Civil and Criminal Recoveries	\$510,060,654	\$86,888,885	\$197,671,124	\$794,620,663	\$264,873,555
Total Expenditures	\$26,933,544	\$30,069,750	\$25,817,174	\$82,820,468	\$27,606,823

Source: OIG review of MFCU self-reported quarterly statistical reports and other data, FYs 2012-2014.

²³ Figures in this paragraph and Table 1 are rounded.

²⁴ The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the States. However, we note that the California Unit was one of the Units that directly participated in global cases.

²⁵ Global cases accounted for 482 of the Unit’s 4,602 cases over the 3-year period.

²⁶ The Unit reported that this difference reflected a civil case resolved in FY 2012 that produced a significant recovery.

During FYs 2012-2014, the Unit reported 337 convictions and 67 civil judgments and settlements (see Table 2).

Table 2: California MFCU Convictions and Civil Judgments and Settlements, FYs 2012 through 2014

	FY 2012	FY 2013	FY 2014	3-Year Total
Total Convictions	122	100	115	337
Total Civil Judgments and Settlements	28	19	20	67

Source: OIG review of MFCU self-reported quarterly statistical reports and other data, FYs 2012-2014.

During FYs 2012-2014, the Unit opened an average of 877 cases annually, including an average of 346 cases of provider fraud and 531 cases of patient abuse and neglect.²⁷ During this time, the Unit closed an average of 839 cases annually, including an average of 333 cases of provider fraud and 506 cases of patient abuse and neglect.^{28, 29} During FYs 2012-2014, the Unit received an average of 3,584 referrals annually, with an average of 495 referrals of provider fraud and 3,090 referrals of patient abuse and neglect.³⁰

Some Unit case files lacked certain required documentation

To ensure that a Unit maintains a continuous case flow and maintains case files in an effective manner, Unit supervisors are expected to approve the opening and closing of cases and conduct periodic reviews of case files. However, our reviews revealed that some of the Unit’s case files lacked documentation regarding: (1) supervisory approval to open and close cases, (2) periodic supervisory reviews, and (3) relevant facts and information to explain investigative delays.³¹ Unit management reported that supervisors always approve the opening and closing of cases and conduct periodic reviews of case files in accordance with Unit policy, but

²⁷ The averages in this paragraph are rounded.

²⁸ Closures include multiple cases opened before FY 2012.

²⁹ For additional information on the Unit’s opened and closed investigations, including a breakdown by case type and provider category, see Appendix C.

³⁰ For additional information on Unit referrals, see Appendix B.

³¹ For the purposes of our case file review, we examined existing documentation in both the case files and case file tracking system. We considered both of these sources to be part of the “case file.” For the purpose of assessing whether supervisors noted their approval to open, close, or review a case, we considered a supervisor’s signature or notation in the Unit’s paper case files or case file tracking system to be sufficient. We also used both of these sources to determine whether the case files contained documentation of relevant facts or information to explain investigative delays.

acknowledged that these approvals and reviews were not always documented in the case files.

Forty percent of the Unit's case files lacked documentation of supervisory approval to open the cases; 8 percent of the closed Unit cases lacked documentation of supervisory approval to close the cases

Performance Standard 5(b) states that supervisors should approve the opening and closing of all cases. In addition, according to Unit policy, supervisory approval to open and close investigations should be noted in the Unit's electronic case file tracking system. However, 40 percent of Unit case files lacked documentation of supervisory approval to open the cases; 8 percent lacked documentation of approval to close the cases.³²

Twenty-six percent of Unit case files open for at least 6 months lacked documentation of periodic supervisory reviews

Performance Standard 7(a) states that supervisors should review Unit cases periodically and note their reviews in the case files.³³ However, among Unit cases that were open for at least 6 months, 26 percent of the case files lacked documentation of such reviews.³⁴ It was not possible to determine whether this was primarily a documentation deficiency or rather that supervisors were not meeting with agents periodically to discuss and review their cases. In interviews, Unit supervisors and staff reported that the Unit director and chief investigator made quarterly visits to field offices to review cases.

Twelve percent of Unit case files had unexplained delays of a year or more during the case's investigation phase

During our case file review and interviews with Unit staff, we determined that 12 percent of the Unit's cases open for more than 1 year had investigation delays of a year or more with no documentation of relevant facts or information in the case files to explain the delays. Performance Standard 5 states that the MFCU should "complete cases in an appropriate timeframe based on the complexity of the cases." Performance Standard 5(c) states that investigation and prosecution delays should be "limited to

³² The lack of this documentation does not necessarily indicate that supervisors did not approve the opening or closing of these cases.

³³ For the purposes of this report, supervisory approval to open and close a case does not constitute a periodic supervisory review. Periodic supervisory reviews are demonstrated by a supervisor's reviewing a case more than once between the case's opening and closing and documenting those reviews in the case file.

³⁴ We reviewed the files of 62 cases that were open for at least 6 months for documentation of supervisory reviews.

situations imposed by resource constraints or other exigencies.” In addition, Performance Standard 7(b) states that case files should contain all relevant facts and information. Unit management and stakeholders reported that a lack of investigators delayed investigations and forced the Unit to place many relatively low-priority cases on the Unit’s “backlog” list. For example, the Unit was approved for 205 staff, but only 185 positions were filled. Although the Unit had 74 investigator positions, 13 of these were unfilled.³⁵ However, the case files did not contain documentation of relevant facts and information to explain that a lack of investigators, or any other factor, caused investigation delays for these cases.³⁶

The Unit lacked a training plan for its investigators and auditors

Although the Unit had a training plan in place for its attorneys, it did not have a training plan in place for its investigators and auditors until the time of our onsite review.³⁷ Performance Standard 12(a) states that a Unit should have a training plan that includes an annual number of required training hours for each professional discipline. Although the Unit lacked a training plan for its investigators and auditors, Unit management documented that it provided some relevant, job-specific training to all Unit professional staff in FYs 2012-2014. For example, the Unit had staff with specialized subject matter knowledge provide in-house training to other Unit staff. The Unit also required staff to take training necessary to maintain professional credentials.

Although the Unit reported all adverse actions to the National Practitioner Data Bank (NPDB) and convictions to OIG, it did not report most within appropriate timeframes

Although the Unit reported 283 adverse actions to the National Practitioner Data Bank (NPDB) during FYs 2012-2014, the Unit reported 224 (79 percent) of these more than 90 days after the final adverse action

³⁵ Unit management reported that they are trying to hire more investigators, but, because the salary scale for Unit investigators is relatively low, it is difficult to attract good candidates.

³⁶ For the purpose of this report, we defined a “delay” as a period of at least a year with no documented activity.

³⁷ The Unit implemented a training plan for its investigators in January 2015, a few weeks before our onsite review, and a training plan for auditors during the week of our onsite review in February 2015.

was taken.³⁸ According to Federal regulations, all State and Federal government agencies must report any final adverse actions resulting from investigations or prosecutions of healthcare providers to the NPDB.³⁹ Final adverse actions must be reported to the NPDB “within 30 days following the action.”^{40, 41} The NPDB restricts 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 other adverse actions. Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions.

Although the Unit reported all 270 of its FYs 2012-2014 convictions to OIG, the Unit reported 176 (65 percent) of these more than 90 days after sentencing. According to Performance Standard 8(f), a Unit should report all convictions to OIG within 30 days of sentencing so that OIG can determine whether to exclude convicted providers from billing Federal healthcare programs.⁴²

According to Unit management and staff, Unit staff enter convictions and other adverse actions into the Unit’s electronic case file tracking system when cases are resolved. Unit staff monitor the system daily and periodically send reminders to Unit prosecutors to send supporting case documentation to OIG and/or case information to the NPDB. Unit staff reported that it typically takes up to 6 weeks, and occasionally up to 3 months, for the courts to submit the necessary supporting documentation and/or case information to the Unit. The Unit reported that these delays in obtaining court documentation and/or case information from the various courts in which individuals are sentenced contributed to untimely reporting of convictions to Federal partners. However, although these

³⁸ An “adverse action” is any action that involves “reducing, restricting, suspending, revoking, or denying clinical privileges or membership in a health care entity.” 45 CFR § 60.3. For a more detailed list of adverse action types, see SSA § 1128E(g)(1)(A) and 45 CFR § 60.5.

³⁹ SSA § 1128E(b) and 45 CFR § 60.5. In addition to the Federal Regulations, Performance Standard 8(G) states that Units should report “qualifying cases to the Healthcare Integrity & Protection Databank, 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 in May 2013, during FYs 2012-2014, and the requirement for reporting that apply to the MFCUs did not change under the new NPDB regulation, contained in 45 CFR pt. 60.

⁴⁰ 45 CFR § 60.5.

⁴¹ HHS provided the Unit’s NPDB reporting data to OIG on July 24, 2014.

⁴² Although the Unit generated 337 provider convictions during FYs 2012-2014, only 270 of the convicted providers had been sentenced at the time of our onsite review. Therefore, our analysis is based on these 270 providers.

timeframes can potentially affect the Unit's ability to report some convictions and adverse actions to OIG and the NPDB within 30 days, it should not result in the Unit's reporting 65 percent of its convictions more than 90 days after sentencing.

The Unit generally exercised proper fiscal control of its resources; however, it improperly claimed some indirect costs

Consistent with Performance Standard 11, the Unit generally exercised proper fiscal control of its resources related to accounting, budgeting, personnel, procurement, and equipment. However, the Unit improperly claimed a total of \$7,596 (Federal share) of indirect costs for the purchase of information technology equipment during FYs 2012-2014.^{43, 44} According to the Unit's approved indirect cost rate agreement, the purchase of that type of equipment should not be included as indirect costs.⁴⁵ In addition, the Unit did not include some grant and contract costs that should have been included as indirect costs. As a result, the Unit under-claimed approximately \$63,128 (Federal share) during FYs 2012-2014.⁴⁶

Other observations

During our onsite review, we noted three practices, among others, that the Unit reported were beneficial to Unit operations: (1) the Unit took steps to ensure that managed care organizations (MCOs) refer fraud allegations to the Unit, (2) the Unit used a field representative to conduct outreach and provide training, and (3) Unit workstations within an OIG field office reportedly promoted cooperation between the Unit and OIG.

The Unit took steps to ensure that MCOs refer fraud allegations to the Unit

The Unit took several steps to ensure that MCOs refer fraud allegations to the Unit. Performance Standard 4(a) states that a Unit should take steps to ensure that MCOs refer all suspected Medicaid provider fraud cases to the

⁴³ Generally, Units claim indirect costs to fund general operations, such as administrative costs.

⁴⁴ The Unit improperly claimed the Federal share of indirect costs by \$2,812 in FY 2012, by \$3,938 in FY 2013, and by \$846 in FY 2014. Therefore, the net total of improperly claimed indirect costs for the 3-year period was \$7,596 (Federal share).

⁴⁵ 2 CFR § 225 Appendix B, Section 15(a)(2).

⁴⁶ The Unit under-claimed the Federal share of indirect costs by a net total of \$20,606 in FY 2012, by \$14,611 in FY 2013, and by \$27,911 in FY 2014. Therefore, the net total of under-claimed indirect costs for the 3-year period was \$63,128 (Federal share).

Unit. California State law requires that MCOs refer all provider fraud allegations to DHCS.⁴⁷ However, MCOs are not required to refer such allegations to the Unit. In 2012 and 2015, the Unit director sent letters to the DHCS director requesting that DHCS program integrity management incorporate language into State contracts with MCOs that would require MCOs to notify the Unit of all fraud allegations sent to DHCS.

In addition, the Unit provides quarterly training conferences for MCO representatives in four cities throughout the State. Unit management reported that 21 of the 26 California MCOs send representatives to these conferences, and that, in FY 2014, the Unit received 10 fraud referrals from MCOs as a direct result of these training conferences. Also as a result of these conferences, some California MCOs now voluntarily copy the Unit on every fraud referral sent to DHCS.

Finally, the Unit entered into a MOU with the California Department of Managed Health Care that allows the Unit to request MCO data from it on a “case-by-case” basis. Whenever an MCO fraud case is referred to the Unit, the Unit requests data, as needed, from that department.

The Unit used a field representative to conduct outreach and provide training

The Unit hired a field representative in 2014 to increase the number of fraud referrals the Unit receives. According to Performance Standard 4(f), a Unit should take steps “through public outreach or other means” to encourage the public to refer cases to the Unit. In addition, Performance Standard 4(a) states that a Unit should take steps to ensure that other agencies refer all suspected fraud cases to the Unit. The Unit’s field representative acts as a liaison between the Unit and other State agencies, conducts public outreach, and trains staff from other agencies about Medicaid fraud and the Unit’s role in combatting Medicaid fraud and patient abuse and neglect. According to Unit management, the activities of the field representative have increased fraud referrals from other State agencies to the Unit. Because the field representative was a recent hire, however, we did not have sufficient information at the time of our onsite review to determine whether the field representative’s activities resulted in an increase in referrals.

Unit management and OIG reported that colocation of staff promoted cooperation between the agencies

Although the Unit closed its San Francisco Bay Area office in 2013 because of fiscal constraints, two Unit investigators have

⁴⁷ *California Business & Professions Code*, Section 805.

workstations at the OIG field office in the San Francisco Bay Area. The Unit investigators use the workstations part-time. According to Performance Standards 8(a) and 8(b), a Unit should communicate with OIG on a regular basis and cooperate with OIG and other Federal agencies on joint cases. According to Unit management and OIG staff, stationing Unit investigators in OIG's field office maintains an active Unit presence in the region, facilitates the mutual referral of cases between the Unit and OIG, and improves communication and cooperation with OIG on joint cases. OIG reported it spends no additional funds beyond the MFCU grant to maintain these workstations.

CONCLUSION AND RECOMMENDATIONS

During FYs 2012-2014, the Unit expended \$83 million and generated 337 convictions, 67 civil judgments and settlements, and total recoveries of \$795 million, \$531 million of which was attributed to cases investigated directly by the Unit. Our review found that the Unit was generally in compliance with applicable laws, regulations, and policy. However, the Unit should improve some areas of its operations to ensure adherence to Performance Standards and compliance with Federal laws and regulations. Operational areas that should be improved by the Unit include: some Unit case files lacked certain required documentation, the Unit lacked a training plan for its investigators and auditors, and the Unit did not report most adverse actions or convictions within appropriate timeframes. Although the Unit generally exercised proper fiscal control of its resources, it improperly claimed some indirect costs during FYs 2012-2014 and failed to claim other indirect costs it was entitled to claim. Finally, we noted three practices, among others, that the Unit reported were beneficial to Unit operations. Specifically, the Unit: took steps to ensure it received fraud referrals from managed care organizations, used a field representative to conduct outreach and provide training, and co-located Unit investigators in an OIG field office.

We recommend that the California Unit:

Develop and implement procedures to ensure that the Unit documents relevant information in its case files

The Unit should develop and implement procedures to ensure that supervisory approval to open and close all cases is documented in the Unit's case files and/or electronic case file tracking system. These procedures also should ensure that documentation of periodic supervisory reviews is included in all case files. If extended investigation delays result from resource constraints or other exigencies, the Unit should document such circumstances in the associated case files.

Fully implement the new training plans for Unit investigators and auditors

The Unit should fully implement the training plans for investigators and auditors which were newly developed around the time of our onsite review in February 2015. Implementation activities should include ensuring that staff are aware of the training plans and that they receive the required training.

Develop and implement procedures to overcome challenges in obtaining information needed to report convictions and adverse actions to Federal partners within required timeframes

The Unit should develop and implement procedures to ensure it reports all adverse actions to the NPDB and convictions to OIG within 30 days. For example, the Unit could configure its electronic case file tracking system to provide automated reminders to report convictions and adverse actions to Federal partners in a timely manner.

Develop and implement procedures to ensure that the Unit properly claims its indirect costs

The Unit should work with OIG to assess whether its current procedures are sufficient to ensure that the Unit properly claims its indirect costs.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with the four report recommendations.

The Unit concurred with our recommendation to develop and implement procedures to ensure that the Unit documents relevant information in its case files. The Unit reported that it transmitted memoranda to all staff reminding them of the Unit's procedures for documenting supervisory approval to open and close all cases, as well as its procedures for documenting quarterly supervisory reviews. The Unit also reported that its supervisors will now note in the case files the reasons for any investigation delays.

The Unit concurred with our draft recommendation to develop and implement training plans for its investigators and auditors. The Unit reported that it had developed training plans for its investigators and auditors at the time of our onsite review in February 2015. In response, we revised the draft recommendation to focus on implementation of the newly developed training plans.

The Unit concurred with our recommendation to develop and implement procedures to overcome challenges in obtaining information needed to report convictions and adverse actions to Federal partners within required timeframes. The Unit reported that it is evaluating whether to use courier services to transmit needed documents from the courts to the Unit in a timely manner. In addition, the Unit reported that it is now using its electronic case file tracking system to prompt the Unit's legal staff to retrieve needed court documents as soon as possible.

The Unit concurred with our recommendation to develop and implement procedures to ensure that the Unit properly claims its indirect costs. The Unit reported that it will now follow a bulletin, released by the California Department of Justice, that provides direction for claiming indirect costs and monitoring direct costs associated with capitalized equipment and contracts.

The full text of the Unit's comments is provided in Appendix F.

APPENDIX A

2012 Performance Standards⁴⁸

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.
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.

⁴⁸ 77 Fed. Reg. 32645, June 1, 2012.

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

Referrals of Provider Fraud and Patient Abuse and Neglect to the California MFCU by Source, FYs 2012 through 2014

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

Case Type	FY 2012	FY 2013	FY 2014	3-Year Total	Annual Average*
Patient Abuse and Neglect	3,772	2,529	2,968	9,269	3,090
Provider Fraud	338	651	495	1,484	495
Total	4,110	3,180	3,463	10,753	3,584

Source: MFCU response to OIG data request.

*Averages in this table are rounded.

Table B-2: MFCU Referrals, by Referral Source

Referral Source	FY 2012		FY 2013		FY 2014		Total	Percentage of All Referrals*
	Fraud	Abuse and Neglect	Fraud	Abuse and Neglect	Fraud	Abuse and Neglect		
State Survey and Certification Agency	13	1,435	14	1,306	19	1,950	4,737	44.1%
Private Citizens	251	343	452	608	359	533	2,546	23.7%
LTC Ombudsman	8	1,927	4	393	1	177	2,510	23.3%
Other State Agencies	4	25	16	105	20	165	335	3.1%
State Medicaid Agency	42	6	118	14	49	10	239	2.2%
Law Enforcement	0	23	1	38	7	24	93	0.9%
Self-Generated	0	6	16	10	16	8	56	0.5%
Adult Protective Services	0	4	2	13	0	22	41	0.4%
Managed Care Organizations	0	0	0	0	10	0	10	<0.1%
Other	20	3	28	42	14	79	186	1.7%
Total	338	3,772	651	2,529	495	2,968	10,753	100%
Annual Total	4,110		3,180		3,463			
Annual Average*								3,584

Source: MFCU response to OIG data request.

*These figures are rounded.

APPENDIX C

Investigations Opened and Closed by the California MFCU, by Provider Category and Case Type, FYs 2012 through 2014

Table C-1: Total Annual Opened and Closed Investigations

Case Type	FY 2012	FY 2013	FY 2014	3-Year Total	Annual Average*
Opened	811	867	954	2,632	877
Patient Abuse and Neglect	455	462	676	1,593	531
Provider Fraud	356	405	278	1,039	346
Closed	847	808	862	2,517	839
Patient Abuse and Neglect	464	480	575	1,519	506
Provider Fraud	383	328	287	998	333

Source: MFCU response to OIG data request.

*Averages in this column are rounded.

Table C-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Home Health Aides	6	7	15	10	7	7
Non-Direct Care	0	0	0	0	3	0
Nursing Facilities	124	102	118	129	173	188
Other Long-Term Care Facilities	18	14	34	26	38	27
Physician's Assistants/Nurses/Nurse Practitioners/Certified Nurse Aides	119	151	109	138	253	180
Other	188	190	186	177	202	173
Total	455	464	462	480	676	575

Source: Unit response to OIG data request.

Table C-3: Provider Fraud Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
Facilities	Opened	Closed	Opened	Closed	Opened	Closed
Hospitals	10	3	4	6	4	3
Nursing Facilities	9	8	4	9	4	3
Other Long-Term Care Facilities	2	1	3	3	0	0
Substance Abuse Treatment Centers	2	3	68	7	30	4
Other Facilities	26	0	10	16	9	17
Subtotal	49	15	89	41	47	27
Practitioners	Opened	Closed	Opened	Closed	Opened	Closed
Chiropractors	2	0	0	1	0	0
Counselors/ Psychologists	0	1	0	0	0	0
Dentists	20	16	10	19	5	13
Doctors of Medicine or Osteopathy	40	55	40	50	35	34
Podiatrists	3	1	0	0	1	0
Other Practitioners	4	3	1	2	5	2
Subtotal	69	76	51	72	46	49
Medical Support	Opened	Closed	Opened	Closed	Opened	Closed
Durable Medical Equipment Suppliers	16	33	8	10	13	30
Home Health Care Agencies	4	6	2	2	3	1
Home Health Care Aides	40	63	46	53	5	35
Laboratories	5	23	6	6	5	6
Nurses and Physician Assistants Physician's Assistants/Nurses/Nurse Practitioners/Certified Nurse Aides	5	17	4	11	12	8
Pharmaceutical Manufacturers	38	6	26	19	22	10
Pharmacies	36	29	36	17	24	18
Radiologists	0	2	1	0	1	2
Transportation Services	7	8	7	14	4	10
Other Medical Support	17	3	7	18	6	9
Subtotal	168	190	143	150	95	129
Program Related	Opened	Closed	Opened	Closed	Opened	Closed
Billing Company	0	2	3	2	1	2
Managed Care	0	0	1	1	0	1
Medicaid Program Administration	0	2	1	0	0	1
Other Program Related	70	98	117	62	89	78
Subtotal	70	102	122	65	90	82
Total	356	383	405	328	278	287

Source: Unit response to OIG data request.

APPENDIX D

Methodology

We analyzed data from seven sources to describe the caseload and assess the performance of the MFCU. We also analyzed the data to identify any opportunities for improvement and any instances in which the MFCU did not meet the performance standards or was not operating in accordance with laws, regulations, and/or policy transmittals.⁴⁹ In addition, we noted practices that appeared to benefit the MFCU. We based these observations on statements from stakeholders and MFCU staff and an analysis of collected data.

Data Collection and Analysis

Review of MFCU Documentation. We collected and reviewed (1) MFCU documentation, including policies and procedures related to the Unit's operations, staffing, and FYs 2012-2014 caseload; (2) the MFCU's annual reports and quarterly statistical reports; and (3) the MFCU's responses to recertification questionnaires. The documentation also included data such as the number of referrals received by the MFCU and the number of investigations opened and closed. We reviewed the documentation to determine how the MFCU investigates and prosecutes Medicaid cases. We also checked documentation to ensure that the MFCU referred sentenced individuals to OIG for program exclusion and that the MFCU reported adverse actions to the NPDB. Additionally, we confirmed with the MFCU director that the documentation we had was current at the time of our review and requested any additional data or clarification, as needed. The data we collected from the MFCU were current as of April 15, 2015. Subsequent changes to the data would therefore not be included in our analyses.

Review of Financial Documentation. To evaluate internal control of fiscal resources, OIG auditors reviewed policies and procedures related to the MFCU's budgeting, accounting systems, cash management, procurement, property, and staffing. We obtained the MFCU's claimed grant expenditures for FYs 2012-2014 to (1) review final Federal Status Reports⁵⁰ and supporting documentation, (2) select and review transactions within direct cost categories to determine if costs were allowable, and (3) verify that indirect costs were accurately computed using the approved

⁴⁹ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov>.

⁵⁰ The MFCU transmits Federal Status Reports to OIG's Office of Management and Policy on a quarterly and annual basis. These financial reports detail MFCU income and expenditures.

indirect cost rate. Finally, we reviewed records in the HHS Payment Management System (PMS)⁵¹ and revenue accounts to identify any unreported program income.⁵²

Structured Interviews With Key Stakeholders. We conducted structured interviews with 11 individual stakeholders among 7 agencies who were familiar with MFCU operations. Specifically, we interviewed one program integrity manager from the Medicaid agency; an Assistant U.S. Attorney; the Criminal Division supervisor for the California Attorney General’s Office;⁵³ three managers from the California Department of Public Health; three managers from the California Department of Social Services; two OIG Assistant Special Agents in Charge for the State of California; and a California Adult Protective Services supervisor. These interviews focused on the MFCU’s interaction with external agencies, MFCU operations, opportunities for improvement, and any practices that appeared to benefit the MFCU.

Survey of MFCU Staff. We conducted an online survey of MFCU staff.⁵⁴ We requested responses from 175 staff members and received 164 responses, for a 94–percent response rate. Our questions focused on MFCU operations, opportunities for improvement, and practices that appeared to benefit the MFCU. The survey also sought information about the MFCU’s compliance with applicable laws, regulations, and policy transmittals.

Structured Interviews With MFCU Management and Selected Staff. We conducted structured interviews with the MFCU’s director, chief investigator, CID supervisor, field representative, and eight regional supervisors. We asked them to provide us with additional information to better understand the MFCU’s operations, identify opportunities for improvement, identify practices that appeared to benefit the MFCU, and to clarify information obtained from other data sources.

Onsite Review of Case Files. We requested that the Unit provide us with a list of cases that were open at any point during FYs 2012-2014. The Unit

⁵¹ The PMS is a grant payment system operated and maintained by the HHS 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.

⁵² Program income is defined as “gross income received by the grantee or subgrantee directly generated by a grant supported activity, or earned only as a result of the grant agreement during the grant period.” 45 CFR § 92.25(b).

⁵³ The Criminal Division supervisor supervises the MFCU director.

⁵⁴ We did not survey the MFCU director, chief investigator, or other regional supervisors whom we interviewed remotely or onsite.

provided a list of 4,602 cases that were open during FYs 2012-2014.⁵⁵ For each of these 4,602 cases, the Unit provided data, including: the current status of each case; whether each case was criminal, civil, or global; and the date on which each case was opened. From this list of cases, we excluded 482 cases that were categorized as “global.” The remaining number of case files was 4,120.

From the 4,120 remaining case files, we selected a simple random sample of 100 cases for review. To assess the Unit’s processes for monitoring the status and outcomes of cases, we reviewed documentation in the case files and case file tracking system that was associated with the sample of cases. From this initial sample of 100 case files, we selected a simple random sample of 50 files for a qualitative review of selected issues, such as case development. While onsite, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

We did not review 13 of the sampled cases because they were misidentified by the Unit as being open during FYs 2012-2014. Each of these cases were closed before FY 2012 and, therefore, were ineligible to be in our sample. After excluding the ineligible cases, we reviewed 87 sampled case files total. Of these 87 case files, there were 60 closed cases, 61 cases that were open for at least 6 months, and 41 cases that were open for at least 1 year.

Considering that there were 13 ineligible cases in the 100-case sample, it is possible that there were other ineligible cases in the population of 4,120 cases that the Unit identified as “non-global” and open at any point during FYs 2012-2014. Therefore, we estimated the number of case files in the population based on the eligible sample, as shown in Table D-1. We estimated (1) the total number of eligible case files, (2) the number of eligible closed case files, (3) the number of eligible case files that were open for at least 6 months, and (4) the number of eligible case files that were open for at least 1 year.

⁵⁵ This figure includes some cases opened before FY 2012 that remained open at some point during FYs 2012-2014.

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

Estimate Description	Sampled Case Files	Population of Case Files	95-percent Confidence Interval
Total eligible case files	87	3,584	3,250–3,825
Eligible closed case files	60	2,472	2,053–2,866
Eligible case files open for at least 6 months	61	2,513	2,095–2,905
Eligible case files open for at least 1 year	41	1,689	1,292–2,109

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

Using the results of our review of the sampled case files, we report one estimate for each of the above subpopulations. The point estimates and their 95-percent confidence intervals are in Appendix E.

Onsite Observation of MFCU Operations. While onsite, we observed the MFCU’s operations. Specifically, we observed the intake of referrals, security of data and case files, and the general functioning of the MFCU.

APPENDIX E

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

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of case files that did not include documentation of supervisory approval for opening	87	40.2%	30.0%	51.2%
Percentage of closed case files that did not include documentation of supervisory approval for closing	60	8.3%	2.8%	18.3%
Percentage of case files that were open for at least 6 months that did not include documentation of periodic supervisory review	61	26.2%	15.9%	39.0%
Percentage of case files that were open for at least 1 year that did not include documentation explaining investigation delays	41	12.2%	4.1%	26.1%

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

APPENDIX F

Unit Comments

KAMALA D. HARRIS
Attorney General

State of California
DEPARTMENT OF JUSTICE



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January 22, 2016

Ms. Suzanne Murrin
Deputy Inspector General for Evaluations and Inspections
Office of Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue SW
Cohen Building, Room #5660
Washington, DC 20201

Re: California State Medicaid Fraud Control Unit: 2015 Onsite Review, OEI-09-15-00070
Responses by the Unit

Dear Ms. Murrin:

The California Attorney General's Office, specifically the Bureau of Medi-Cal Fraud and Elder Abuse (the Unit), greatly appreciates the opportunity to review and respond to the draft inspection report, entitled *California State Medicaid Fraud Control Unit: 2015 Onsite Review*, OEI-09-15-00070 (California MFCU 2015 Onsite Review), which our office received on December 23, 2015.

We are pleased that the Office of the Inspector General (OIG) concluded therein that the Unit was found to be "generally in compliance with applicable laws, regulations, and policy transmittals," and notably that, during Fiscal Years 2012-2014, the Unit expended \$83 million, generated 337 convictions, obtained 67 civil judgments and settlements, and achieved total recoveries of \$795 million.

Moreover, as a state with a significant Medicaid population, we appreciate the opportunity to gather feedback for improvement, in tandem with our own efforts to combat and control Medicaid fraud effectively. About a year ago, OIG conducted an onsite inspection during the week of February 23, 2015, all of which culminated in four particular recommendations for further improvement. (*See California MFCU 2015 Onsite Review*, pp. 14-15.) We are pleased to report in turn that the Unit concurs with all recommendations and that, as noted below, steps are in place and/or have been taken already to adopt such recommendations.

Recommendation #1: *Develop and implement procedures to ensure that the Unit documents relevant information in its case files. The Unit should develop and implement procedures to ensure that supervisory approval to open and close all cases is documented in the Unit's case files and/or electronic case file tracking system. These procedures also should ensure that documentation of periodic supervisory reviews is included in all case files. If extended investigation delays result from resource constraints or other exigencies, the Unit should document such circumstances in the associated case files.*

Response to Recommendation #1: The Unit concurs.

1a. Generally, supervisory approval for case-openings occur in the majority of the Unit's cases. Identified by a case number (Matter ID number), each case is first approved for opening by a supervisor or manager. Where later-identified suspects to an ongoing investigation are subsequently assigned a separate Matter ID number, however, such derivative cases may not have been opened using the case-opening protocols of the original investigation. Our case-management protocols have since been changed: At this time, the Unit's Case Intake and Development (CID) Section requires, as a condition for opening a case, prior supervisory approval either on the complaint form, itself, or by email, either of which is then scanned into the ProLaw case management system. On December 23, 2015, all staff in the Unit was reminded of this policy by email.

1b. While supervisory approval for case closings do occur in the majority of cases, in some circumstances, official court documents indicating a final disposition have been relied upon to trigger a case-closing. By an internal policy memorandum dated June 25, 2015, all staff in the Unit was reminded of protocols for closing cases, particularly as to documentation therefor. Moreover, on December 23, 2015, all staff in the Unit has been directed that, on adjudicated cases, supervisory approval needs to be documented prior to case-closings.

1c. Documentation of periodic supervisory case reviews was occurring in the majority of investigations every 30 to 90 days. In some circumstances, case review discussions conducted only verbally were not documented in the case file tracking system. By an internal policy memorandum dated June 25, 2015, all staff in the Unit was reminded of the policies on supervisory case reviews and concomitant documentation. Additionally, the Unit has requested Quality Assurance Reports for cases missing a periodic supervisory review. As such, headquarters case management personnel for the Unit conduct quarterly case inquiries on all cases to ensure timely documentation of supervisory case reviews conducted. Cases shall have regular supervisory review (and documentation thereof) every 90 days.

1d. If investigations are delayed due to resource-related constraints, other investigations of greater priority, or other exigencies, the periodic supervisory reviews will briefly document the reason for the delays in developing the case. By an internal policy memorandum dated June 25, 2015, all staff in the Unit was reminded of supervisory case review documentation on case reviews and concomitant documentation.

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Recommendation #2: Develop and implement a training plan for its investigators and auditors. *The Unit should develop and implement a written training plan that includes a minimum number of annual training hours for its investigators and auditors. After our onsite review, the Unit implemented, and provided documentation of, a training plan for Unit investigators and auditors.*

Response to Recommendation #2: The Unit concurs.

At the time of the inspection, the Unit had an Attorney training plan in existence since February 2013, a Special Agent training plan in existence since January 2015, and a training plan covering all primary and secondary professional disciplines since February 2015. The Unit understands the importance of these training plans and will continue to amend them as necessary.

Recommendation #3: Develop and implement procedures to overcome challenges in obtaining information needed to report convictions and adverse actions to Federal partners within required timeframes. *The Unit should develop and implement procedures to ensure it reports all adverse actions to the NPDB and convictions to OIG within 30 days. For example, the Unit could configure its electronic case file tracking system to provide automated reminders to report convictions and adverse actions to Federal partners in a timely manner.*

Response to Recommendation #3: The Unit concurs.

Reporting adjudicated cases to the National Practitioner Data Bank (NPDB) and OIG within 30 days has been an ongoing challenge due to factors beyond the control of the Unit. Some delays have been a result, for example, of overtasked court processing systems through which neither notification to the public nor public access to resulting official documents are immediate. Yet, having such documents on hand are necessary in order for the Unit to process the court documents internally in order to, in turn, meaningfully notify the NPDB and OIG about any given adjudicated case.

At this time, the Unit is evaluating the prospects of utilizing courier contracts to obtain the official documents from courts as soon as such documents have been processed in the court system. If a feasible option, this could alleviate hours spent by staff attempting to locate and retrieve court documents.

Furthermore, the headquarters case management personnel of the Unit is also utilizing the internal electronic case file tracking system and alerting legal staff as soon as a judgment or settlement has been documented in ProLaw. Such alerts have the effect of prompting the legal staff to retrieve as soon as possible any court documents pertaining to the final adjudication of a case.

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Recommendation #4: Develop and implement procedures to ensure that the Unit properly claims its indirect costs. *The Unit should work with OIG to assess whether the Unit's current procedure are sufficient to ensure that the Unit properly claims its indirect costs.*

Response to Recommendation #4: The Unit concurs. After the OIG onsite inspection, the California Department of Justice (DOJ) Accounting Office worked with the OIG inspection auditor to clarify the concerns raised in the 2015 onsite review inspection. As a result, on June 16, 2015, the DOJ Division of Administrative Services (DAS) issued Administrative Bulletin 15-08 on Fiscal Year 2015-16 Indirect Cost Rates, providing specific direction for claiming indirect costs and aiding in the monitoring of direct costs associated with capitalized equipment and contracts, all in order to properly determine the indirect cost base. Administrative Bulletin 15-08 was provided to OIG and approved for the FY 2015-2016 grant year. In order to properly formulate a calculation for the indirect cost base, Administrative Bulletin 15-08 states in part:

FEDERAL INDIRECT COST RATE

DOJ will apply the Federal Indirect Cost Rate of 11.52 percent to all grants that it receives directly from federal agencies, such as the U.S. Department of Health and Human Services and the Office of Justice Programs of USDOD, among others. DOJ will apply this rate to the grant's indirect cost base. To determine the indirect cost base:

- *Begin with the grant's total direct costs;*
- *Subtract capitalized equipment and contracts (which includes consultants);*
- *For each contract, add back in the total value of the contract or \$25,000, whichever is less;*
- *Multiply that amount by the federal indirect cost rate;*
- *The total is the amount that DOJ will claim on the grant or interagency agreement.*

...

We appreciate all your efforts and professionalism, particularly in providing the Unit an opportunity to review and respond to the draft inspection report. Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,



SARALYN M. ANG-OLSON
Director

For KAMALA D. HARRIS
Attorney General

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Tammy Lopes, Director, Division of Administrative Support
Andrew Kraus, Director of the Office of Program Review and Audits
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Office of Inspector General

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Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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