



**U.S. Department of Health & Human Services  
Office of Inspector General**

# **Tennessee Medicaid Fraud Control Unit: 2017 Onsite Inspection**

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**Suzanne Murrin**  
Deputy Inspector General





## Tennessee Medicaid Fraud Control Unit: 2017 Onsite Inspection

### What OIG Found

The Tennessee Medicaid Fraud Control Unit (MFCU or Unit) reported strong case outcomes for fiscal years (FYs) 2014–2016. From the data we reviewed, we found that the Unit generally operated in accordance with applicable laws, regulations, policy transmittals, and the MFCU performance standards. However, we made four findings, two involving the Unit’s adherence to program requirements and two potentially affecting the Unit’s success and impact:

1. The Unit investigated 11 cases that were ineligible for Federal matching funds because they involved allegations of patient abuse or neglect in nonfacility settings.
2. Although the Unit reported all convictions and adverse actions to Federal partners, it did not always do so within the established timeframes.
3. The Unit’s staff size had not kept pace with increasing Medicaid program expenditures.
4. The Unit made program integrity recommendations to the Medicaid agency orally, limiting its ability to monitor responses.

In addition to the four findings, we made observations regarding Unit operations and practices, many of which were favorable, including:

- A high level of collaboration with Federal law enforcement;
- Low turnover of management and staff; and
- Good training opportunities for staff, including an annual training conference for all Unit staff that provided valuable training and team building.

### What OIG Recommends and How the Unit Responded

To address the four findings, we recommend that the Unit: (1) repay Federal matching funds spent on cases that were ineligible for Federal funding and ensure that cases it investigates are within grant authority; (2) implement processes to ensure that it reports convictions and adverse actions to Federal partners within the appropriate timeframes; (3) continue to pursue its proposed expansion plan and work towards increasing Unit staff size to be commensurate with Medicaid expenditures; and (4) develop a policy to document its program recommendations to the State Medicaid agency and to monitor the response to those recommendations. The Unit concurred with all four recommendations.

### Unit Case Outcomes

FYs 2014–2016

- 89 indictments
- 80 convictions
- 62 civil settlements and judgments
- \$208 million in recoveries

### Unit Snapshot

36 MFCU staff in Nashville headquarters and 6 regional offices

The Unit is part of the Tennessee Bureau of Investigation

The Unit operates in a State where the Medicaid program has been 100-percent managed care since 1994

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# BACKGROUND

## Objective

To examine the performance and operations of the Tennessee State Medicaid Fraud Control Unit

## Medicaid Fraud Control Units

The function of Medicaid Fraud Control Units (MFCUs or Units) is to investigate Medicaid provider fraud and patient abuse or neglect, and to prosecute those cases under State law or refer them to other prosecuting offices.<sup>1</sup> Under the Social Security Act (SSA), a MFCU is a “single, identifiable entity” of State government that must be “separate and distinct” from the State Medicaid agency and employ one or more investigators, attorneys, and auditors.<sup>2</sup> Each State must operate a MFCU or receive a waiver.<sup>3</sup> Currently, 49 States and the District of Columbia operate MFCUs.<sup>4</sup> Each Unit receives a Federal grant award equivalent to 75 percent of total allowable expenditures.<sup>5</sup> In fiscal year (FY) 2016, combined Federal and State expenditures for the Units totaled approximately \$259 million.<sup>6</sup>

## OIG Grant Administration and Oversight of the MFCUs

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.<sup>7,8</sup> As part of its oversight, OIG reviews and recertifies each Unit annually. The recertification review examines the following: the Unit’s annual report; questionnaire responses from the Unit’s director and stakeholders; and annual case statistics (collectively referred to

<sup>1</sup> SSA § 1903(q)(3). 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.

<sup>2</sup> SSA § 1903(q).

<sup>3</sup> SSA § 1902(a)(61).

<sup>4</sup> “State” refers to the States, the District of Columbia, and the U.S. Territories. North Dakota and the territories of American Samoa, Guam, the Northern Marianas Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units.

<sup>5</sup> SSA § 1903(a)(6). For a Unit’s first 3 years of operation, the Federal government contributes 90 percent of funding and the State contributes 10 percent.

<sup>6</sup> OIG analysis of FY 2016 MFCU annual statistical reporting data.

<sup>7</sup> As part of grant administration, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal Financial Reports that detail MFCU income and expenditures.

<sup>8</sup>The SSA authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979.

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as “recertification data”). Through the recertification review, OIG assesses a Unit’s performance, as measured by the Unit’s adherence to published performance standards;<sup>9</sup> the Unit’s compliance with applicable laws, regulations, and OIG policy transmittals;<sup>10</sup> and the Unit’s case outcomes. (See Appendix A for MFCU performance standards, including performance indicators for each standard.) OIG further assesses Unit performance by periodically conducting onsite Unit reviews that may identify findings and make recommendations for improvement. During an onsite review, OIG may also make observations regarding Unit operations and practices, including identifying beneficial practices that may be useful to share with other Units. In addition, OIG provides training and technical assistance to Units while onsite, as appropriate, and on an ongoing basis.

## Tennessee MFCU

The Tennessee MFCU is headquartered in Nashville and has six regional offices throughout the State. The Unit is a division of the Tennessee Bureau of Investigation (TBI), and is one of six MFCUs that is not part of a State Attorney General’s office. At the time of our April 2017 review, the Unit employed a director (Special Agent in Charge), 3 Assistant Special Agents in Charge (ASACs), 21 agents, 2 attorneys, 2 auditors, a support staff manager, and 6 support staff. The Unit director supervises the ASACs, the attorneys, and the support staff manager. The ASACs supervise the Unit’s agents in the Unit’s headquarters and six regional offices. The Unit attorneys do not conduct criminal prosecutions, but they have other wide-ranging duties, such as advising agents on cases; working on civil fraud cases; drafting and monitoring proposed legislation; and advising local district attorneys on appropriate statutes. During our review period of FYs 2014–2016, the Unit spent \$13.4 million (with a State share of \$3.3 million).

**Referrals.** The primary sources of fraud referrals to the Unit are the State Medicaid agency and managed care organizations, but referral sources also include private citizens, local prosecutors, law enforcement, and others. A key source of referrals of patient abuse and neglect is the State’s Adult Protective Services unit. Appendix B lists Unit referrals by source for FYs 2014 through 2016. When the Unit receives a referral, the ASAC determines whether to open a preliminary investigation or a full investigation.

**Investigations.** Once the Unit opens a preliminary or full investigation, the ASAC assigns an agent to the case. Typically, the agent works the case independently but may receive support from other agents. The ASACs

<sup>9</sup> MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012). The performance standards were developed by OIG in conjunction with the MFCUs and were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

<sup>10</sup> OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals may be found at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>.

## Tennessee Medicaid Program

conduct supervisory reviews quarterly to ensure timely completion of cases. The Unit stores all case records—including opening documentation, interviews, summaries, case file reviews, and closing requests—in the Unit’s case management system.

**Prosecutions.** As neither the Tennessee Bureau of Investigation nor the Tennessee Attorney General has statewide criminal prosecutorial authority, the Unit—as required by the Federal statute<sup>11</sup>—refers cases for prosecution to other prosecutorial agencies. For criminal fraud, the Unit typically refers cases for Federal prosecution to the appropriate U.S. Attorney’s Office (Western, Middle, or Eastern District of Tennessee). The Unit typically refers cases of patient abuse or neglect to local district attorneys in Tennessee’s 31 judicial districts.<sup>12</sup> For civil cases, the Unit works closely with the Tennessee Attorney General’s office, which has statutory authority to bring civil actions under the Tennessee Medicaid False Claims Act. For “global” cases,<sup>13</sup> the Unit is the point of contact for the National Association of Medicaid Fraud Control Units’ global case committee. However, the State Attorney General has the ultimate authority to sign off on all civil settlements, including global cases, for the State of Tennessee.

**TennCare.** Since 1994, the Tennessee Medicaid program, known as TennCare, has provided services for its beneficiaries through managed care organizations (MCOs). At the time of our inspection, TennCare contracted with four MCOs to provide medical services for a fixed amount to 1.5 million beneficiaries.<sup>14</sup> In addition, a pharmacy benefits manager covered prescription drugs and a dental benefits manager covered dental services for children under age 21. In FY 2016, total TennCare expenditures were \$9.9 billion.<sup>15</sup>

**MCO Contract.** The Statewide MCO contract requires that MCOs notify—simultaneously and in a timely manner—both the TennCare Office of Program Integrity and the MFCU regarding referrals. There are two categories of referrals: “internal tips,” such as identified patterns of data

<sup>11</sup> SSA § 1903(q)(1)(B).

<sup>12</sup> Tennessee Bar Association, *Tennessee Judicial Districts*. Accessed at <http://www.tba.org/info/tennessee-judicial-districts> on March 15, 2018.

<sup>13</sup> “Global” cases are civil False Claims Act cases that are litigated in Federal courts by the U.S. Department of Justice and typically involve a group of MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the States.

<sup>14</sup> At the time of our review, the four MCOs were UnitedHealthcare Community Plan, BlueCare, TennCare Select, and Amerigroup.

<sup>15</sup> OIG, *MFCU Statistical Data for FY 2016*. Accessed at [https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures\\_statistics/fy2016-statistical-chart.pdf](https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2016-statistical-chart.pdf) on October 20, 2017.

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mining outliers, audit concerns, and critical incidences, and “external tips,” such as hotline calls. Along with requiring such notification, the contract also requires MCOs to take steps to triage and/or substantiate these tips and to provide timely updates to the MFCU and the TennCare Office of Program Integrity when they authenticate any allegations in tips.<sup>16</sup>

Additionally, the Statewide MCO contract states that MCO provider agreements will include a statement that as a condition of participation in TennCare, enrollees and providers shall give the MFCU (and other authorized agencies) access to their records. Enrollees and providers must make records available and furnish them immediately upon request at no cost to the MFCU.<sup>17</sup>

## Prior OIG Report

OIG conducted a previous onsite review of the Tennessee Unit in 2012. In that review, OIG found that the Unit: (1) investigated a case that was not eligible for Federal funding under Federal regulations; (2) referred all convicted health care providers to OIG for program exclusion, but did not refer nonproviders, such as business owners or foster parents; and (3) had a training plan, but did not establish training-hour requirements for each professional discipline.<sup>18</sup>

OIG recommended that the Unit (1) repay Federal funds for investigating the case that was ineligible for Federal funding; (2) refer convictions of all defendants, including both health care providers and nonproviders, to OIG for exclusion; and (3) establish a minimum number of annual training-hour requirements in its training plan for each professional discipline. In response to the recommendations, the Unit repaid the Federal funds, began referring all convictions to OIG for exclusion, and established training-hour requirements. Based on information received from the Unit, OIG considered these recommendations implemented.

## Methodology

We conducted the onsite inspection of the Tennessee MFCU in April 2017. Our review covered the 3-year period of FYs 2014-2016. We based our inspection on an analysis of data from seven sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit’s managers and selected staff; (5) a review of a purposive sample of 20 case files that were

<sup>16</sup> TennCare, *Statewide Contract with Amendment 7*, Section A.2.20.2.3, January 1, 2018. Accessed at <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf> on April 10, 2018.

<sup>17</sup> TennCare, *Statewide Contract with Amendment 7*, Section A.2.12.9.15, January 1, 2018. Accessed at <https://www.tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf> on April 10, 2018.

<sup>18</sup> Office of Inspector General, *Tennessee State Medicaid Fraud Control Unit: 2012 Onsite Review*. Accessed at <https://oig.hhs.gov/oei/reports/oei-06-12-00370.asp> on September 21, 2017.

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open at some point during the review period; (6) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (7) observation of Unit operations. (See Appendix C for a detailed methodology.) In examining the Unit's operations and performance, we applied the published performance standards in Appendix A, but we did not assess every performance indicator for every standard.

## 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. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program, but they are subject to the same internal quality controls as other OIG evaluations, including internal peer review.

# PERFORMANCE ASSESSMENT

We reviewed the Tennessee Unit's adherence to the MFCU performance standards, including its compliance with applicable laws, regulations, and policy transmittals. In this review, we observed the Unit's strong case outcomes, identified some opportunities for improvement, and made other observations regarding the Unit's adherence to the performance standards.

## CASE OUTCOMES

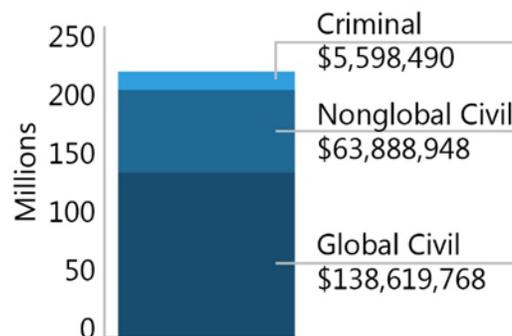
### Observations

**The Unit reported strong criminal and civil outcomes.** From FYs 2014 through 2016, the Unit reported 89 indictments; 80 convictions; and 62 civil settlements and judgments.



**The Unit reported a high amount of civil and criminal recoveries.** The Unit reported total recoveries of \$208 million from FYs 2014 through 2016. (See Exhibit 1 for the sources of those recoveries.)

**Exhibit 1: The Unit reported combined civil and criminal recoveries of \$208 million (FYs 2014–2016).**



Source: OIG analysis of Unit statistical data FYs 2014–2016.

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**STANDARD 1**

A Unit conforms with all applicable statutes, regulations, and policy directives.

**Observation**

**In the data we reviewed, the Tennessee Unit generally complied, with applicable laws, regulations, and policy transmittals, with one notable exception.** In our review, we identified only one compliance concern related to the Unit's investigation of cases that were ineligible for Federal funds, as explained below.

**Finding**

**Eleven cases were ineligible for Federal matching funds.** We found that 11 cases of patient abuse or neglect that were open during the review period did not involve alleged abuse or neglect in a Medicaid-funded facility or board and care facility, and were therefore—according to statute and regulation—not eligible for Federal financial participation (FFP).<sup>19</sup> These 11 investigations involved alleged abuse or neglect occurring in private residences. As a result, costs associated with these cases were not eligible for FFP.<sup>20</sup> Ten of the eleven cases involved alleged misappropriation of funds, such as a personal care aide's using a client's debit card in an unauthorized manner. One case involved neglect of a TennCare beneficiary. The Unit's policies and procedures manual provided correct guidance on the Unit's authority for patient abuse or neglect cases; however, the Unit did not adhere to its policy for the 11 cases.<sup>21</sup> OIG's 2012 onsite review of the Unit similarly found that the Unit investigated a case that was not eligible for Federal funding. The Unit ultimately repaid the Federal funds spent on that case.

<sup>19</sup> One case was identified in our case file review sample, and one case was identified by Unit documentation and reviewed onsite. The Unit identified the additional nine cases after the onsite inspection. OIG reviewed the additional cases and determined them to be ineligible for Federal financial participation (FFP).

<sup>20</sup> Although the 11 cases identified in the inspection are not available for FFP under existing statute and regulation, OIG has—for several years—supported the future expansion of MFCU statutory authority to investigate and prosecute patient abuse or neglect in home- and community-based settings.

<sup>21</sup> The Unit's written policy (dated March 2002) stated that Unit authority for abuse or neglect cases "is limited to care facilities receiving Medicaid/TennCare funding and to patients residing in an institutional or care home setting."

## STANDARD 2

A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.

### Finding

**The number of Unit employees did not keep pace with the growth of the Tennessee Medicaid program in recent years.** The Unit experienced limited growth despite a significant increase in the State's Medicaid expenditures. In FY 2001, after a recent increase in staff, the Unit had 37 approved positions. In FY 2016, the Unit had 39 approved positions with 36 staff on board. During the same period, Tennessee Medicaid expenditures nearly doubled, from \$5.6 billion in FY 2001<sup>22</sup> to nearly \$10 billion in FY 2016.<sup>23</sup> Performance Standard 2(b) states that a Unit should employ "a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect."

During our onsite inspection, all Unit management and staff we interviewed expressed the need for additional staff. Unit management reported that they developed a staff expansion plan for particular types of positions that would be distributed between two of the Unit's regional offices over a 3- to 5-year period. However, State funds have not been available to implement the plan.

### Observation

**Unit management reported low staff turnover.** The reasons some staff cited for low staff turnover were good working conditions; adequate training and equipment; and an excellent management team. Additionally, the Unit had consistent leadership over time; the director at the time of our review had been in his position since 2010.<sup>24</sup>

<sup>22</sup> Centers for Medicare & Medicaid Services, *Program Information on Medicaid and State Children's Health Insurance Program (SCHIP)*, 2004 Edition, p. 33 (Chart 28, Total (State and Federal) Medicaid Expenditures, Fiscal Year 2001). Accessed at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/TheChartSeries/downloads/Medicaid\\_prog\\_info\\_p.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/TheChartSeries/downloads/Medicaid_prog_info_p.pdf) on January 10, 2018.

<sup>23</sup> OIG, *MFCU Statistical Data for FY 2016*. Accessed at [https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures\\_statistics/fy2016-statistical-chart.pdf](https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2016-statistical-chart.pdf) on October 20, 2017.

<sup>24</sup> The Unit director at the time of our review retired in September 2017.

### STANDARD 3

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

#### Observation

**The Unit maintained policies and procedures.** The Unit reported relying on the Tennessee Bureau of Investigation Policies and Procedures manual for general law enforcement matters. The Unit also reported relying on and periodically updating a MFCU Standard Operating Procedures manual with specific guidelines for Unit operations and for investigating cases of Medicaid fraud and cases of patient abuse or neglect. However, we found that the Unit did not adhere to its policy of not investigating cases of patient abuse or neglect in private residences and that it lacked written procedures for reporting convictions and adverse actions to Federal partners, as noted elsewhere in this report.

### STANDARD 4

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

#### Observations

**The Unit conducted outreach to encourage referrals.** The Unit took steps to maintain volume and quality of referrals through a number of outreach efforts to increase exposure to the general public and to other agencies involved in the oversight of health care delivery. The Unit built and maintained positive relationships with referral sources and attended regularly scheduled meetings in which representatives from agencies that provide referrals were present. The Unit's agents provided training and presentations to private groups and civic groups. The Unit also worked to increase exposure by issuing press releases regarding case outcomes and by posting information about its cases on the websites of TennCare and the Tennessee Bureau of Investigation.

**Referrals to the Unit from managed care organizations increased significantly.** The Unit received 116 fraud referrals from MCOs in FY 2016, more than double the 52 referrals in FY 2015. Unit management reported that participating in quarterly meetings with the MCOs has helped foster good relationships between the MCOs and the Unit.

## STANDARD 5

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

### Observation

**The Unit maintained a continuous case flow.** Our review found no significant delays in the completion of the investigations or in the subsequent prosecutions/settlements. Further, all of the 20 sampled case files contained appropriate documentation of case openings and closings as well as periodic supervisory case review.

## STANDARD 6

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

### Observation

**The Unit's caseload included both fraud cases and patient abuse or neglect cases, covering a broad mix of provider types.** At the end of FY 2016, the Unit's cases were distributed among 49 provider types. On average, during the review period, 85 percent of the Unit's cases involved fraud and 15 percent involved patient abuse or neglect.

## STANDARD 7

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

### Observation

**The Unit's case files were well-organized and complete.** All of the 20 sampled case files were well-organized and contained appropriate and pertinent documentation, including summaries of interviews and summaries of investigative activities. We judged the case files to be complete and organized in such a way that an investigator unfamiliar with the case could understand the case history and continue the investigation with little to no difficulty.

## Observation

**OIG reported a high level of collaboration between the Unit and law enforcement partners, particularly OIG agents.** Unit management also reported a good working relationship with OIG. During the review period, the Unit and OIG worked on 85 joint cases involving 298 subjects. A representative from one of the three U.S. Attorney's Offices noted the Unit's invaluable assistance in resolving Federal health care fraud civil cases.

## Finding

**Although the Unit reported all convictions and adverse actions to Federal partners, it did not always do so within the established timeframe.** The Unit reported 39 percent of its convictions (41 of 106) to OIG more than 30 days after sentencing. Specifically, the Unit reported 25 convictions within 31 to 60 days after sentencing, 4 convictions within 61 to 90 days after sentencing, and 12 convictions more than 90 days after sentencing. Performance Standard 8(f) states that the Unit should transmit information on convictions to OIG within 30 days of sentencing for the purpose of exclusion from Federal health care programs.<sup>25</sup> The 2012 OIG onsite review also found that the Unit had not reported all convictions to OIG. As a result of OIG's recommendation, the Unit began referring all convictions to OIG. In addition, the 2012 review found that of the convictions the Unit had reported, 52 percent were reported more than 30 days after sentencing.

Similarly, the Unit reported all adverse actions to the National Practitioner Data Bank (NPDB), but did not always do so within the required timeframe. Specifically, the Unit reported 27 percent of its adverse actions (20 of 73) to the NPDB more than 30 days after the action occurred. Of the 19 late reports, the Unit reported 14 adverse actions within 31 and 60 days after the action, 1 adverse action within 61 to 90 days after the action, and 5 adverse actions more than 90 days after the action. Federal regulations require that Units report any adverse actions resulting from investigations or prosecution of healthcare providers to the NPDB within 30 calendar days of the date of

<sup>25</sup> Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in improper payments to providers by Medicaid or other Federal health care programs or possible harm to beneficiaries.

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the final adverse action.<sup>26</sup> Performance Standard 8(g) also states that the Unit should report qualifying cases to the NPDB.<sup>27</sup>

According to Unit management, some late submissions to OIG and NPDB are outside of the Unit's control, such as when court delays in providing evidence of final judgment prevent timely reporting. However, the Unit also identified internal control issues that led to late reporting. For example, the Unit reported that eight late submissions were the result of delayed paperwork after agents transferred or retired from the Unit.

At the time of our review, the Unit did not have written procedures for reporting convictions to OIG or adverse actions to the NPDB. Instead, the Unit relied informally on Unit support staff to email reminders to agents about forwarding sentencing information to be used in the submissions to OIG and the NPDB. Agents also had to remember to follow up with the courts to obtain copies of the sentencing documents for their cases. Unit management acknowledged that obtaining sentencing documents in a timely manner had not been a priority for all agents, but suggested that it should be.

## STANDARD 9

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

### Finding

**The Unit made program integrity recommendations orally, limiting its ability to monitor responses.** According to Unit management and staff, Unit managers made program recommendations orally at quarterly meetings with TennCare, but reported that the Unit had no formal process in place. Performance Standard 9(b) states that 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." During our review, we did not identify any method or procedure that the Unit had or used for monitoring responses to the oral recommendations.

<sup>26</sup> 45 CFR § 60.5. Examples of final adverse actions include but are not limited to convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(g)(1) and 45 CFR § 60.3.

<sup>27</sup> The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions.

## STANDARD 10

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

### Observation

**The Unit's memorandum of understanding with the Medicaid agency reflected current practice, policy, and legal requirements.** The Tennessee Bureau of Investigation and the Tennessee Department of Finance and Administration's Division of Health Care Finance and Administration (of which the Bureau of TennCare is a part) had a current memorandum of understanding, amended on April 5, 2017.

## STANDARD 11

A Unit exercises proper fiscal control over its resources.

### Observation

**From our limited review, we identified no significant deficiencies in the Unit's fiscal control of its resources.** From the responses to a detailed fiscal-controls questionnaire and interviews with fiscal staff, we identified no internal controls issues related to the Unit's budget process, accounting system, cash management, procurement, electronic data security, property, or personnel. In our inventory review, we located 26 of the 28 sampled inventory items. The Unit had placed the remaining two items (a desktop computer and a portable radio) in surplus status, but had not removed them from the Unit's current list of inventory.

## STANDARD 12

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

### Observation

**Unit staff and management reported good training opportunities.**

From July 1, 2016, to June 30, 2017, all but one staff member in the professional disciplines met or exceeded the Unit's required minimum number of training hours. (The Unit's annual training plan requires 40 hours for investigators and 15 hours for attorneys and auditors.)

An annual training conference for all Unit staff provided valuable training and team building. Since 2010, the Unit has held an annual training conference at a central location for all Unit staff from across the State. At the training conferences, agents present information about significant cases, attorneys provide legal updates, and administrative staff present on Unit-wide issues. Unit agents receive specialized training, often from outside trainers. For example, during one conference, an expert on

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dental fraud provided training to agents. Unit management reported that the annual conference is valuable both for both training purposes and for strengthening team and individual relationships among staff across the State.

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# CONCLUSION AND RECOMMENDATIONS

The Tennessee Unit reported strong case outcomes for FYs 2014–2016. A number of practices may have contributed to the Tennessee Unit’s success in combating Medicaid fraud and patient abuse and neglect, including low turnover of management and staff, strong collaboration with Federal law enforcement, and a commitment to training.

From the data we reviewed, we found that the Tennessee Unit also generally adhered to applicable legal requirements and performance standards, but we found several opportunities for improvement.

We identified two areas in which the Unit should improve its adherence to program requirements. We found that the Unit investigated some cases that, under applicable Federal statute and regulation, were ineligible for Federal matching funds. We also found that the Unit did not always report its convictions and adverse actions to Federal partners within established timeframes. Late reporting delays the initiation of the program exclusion process, which excludes fraudulent and abusive providers from Federal health care programs. We made recommendations (below) to address these opportunities for improvement.

We also observed two opportunities for the Unit to enhance its success and impact. First, we found that the number of Unit employees did not keep pace with the growth of the Tennessee Medicaid program. We also found that the Unit made oral program recommendations at quarterly meetings with TennCare, but had no formal process in place for making recommendations. We question the Unit’s ability to monitor the actions taken by TennCare in response to its oral recommendations since they are not also conveyed in writing.

To address these findings, we recommend that the Tennessee Unit:

**Repay Federal matching funds spent on cases that were ineligible for Federal funding and ensure that cases worked are within grant authority**

The Unit should work with OIG to identify staff hours and expenditures associated with investigating the ineligible cases and repay those Federal matching funds. The Unit should ensure that—consistent with Federal statute and regulation—it reviews only complaints of patient abuse or neglect that occur in Medicaid-funded facilities or board and care facilities, not complaints of patient abuse or neglect that occur elsewhere.

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**Implement processes to ensure that it reports convictions and adverse actions to Federal partners within the appropriate timeframes**

The Unit should implement processes to ensure that it reports convictions to OIG within 30 days of sentencing and adverse actions to NPDB within 30 days of the action. The Unit could implement automated reminders that alert Unit agents to follow up on obtaining the sentencing documents for convictions.

**Continue to pursue its proposed expansion plan and work towards increasing Unit staff size to be commensurate with Medicaid program expenditures**

The Unit should continue to pursue its plan to increase staff, as appropriate.

**Develop a policy to document its program recommendations to TennCare and to monitor the response to those recommendations**

The Unit should establish a policy to memorialize program recommendations in writing and to ensure monitoring of recommendations.

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# UNIT COMMENTS AND OIG RESPONSE

The Tennessee Unit concurred with all four of our recommendations.

First, the Unit concurred with our recommendation to repay Federal matching funds spent on cases that were ineligible for Federal funding and ensure that cases worked are within grant authority. The Unit stated that it is calculating the amount of Federal matching funds and will submit it to OIG for approval within 30 days.

Second, the Unit concurred with our recommendation to implement processes to ensure that it reports convictions and adverse actions to Federal partners within the appropriate timeframes. The Unit stated that it has developed a standard operating procedure to monitor and track timeframes for reporting convictions and adverse actions.

Third, the Unit concurred with our recommendation to continue to pursue its proposed expansion plan and work towards increasing Unit staff size to be commensurate with Medicaid program expenditures. The Unit stated that, as State funds become available, it will request additional staff for needed positions.

Finally, the Unit concurred with our recommendation to develop a policy to document its program recommendations to TennCare and to monitor the response to those recommendations. The Unit stated that it will follow up with TennCare management after any recommendations and will retain notes from quarterly meetings with TennCare that document Unit recommendations and from any follow up information.

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

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# APPENDIX A: MFCU Performance Standards<sup>28</sup>

**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;<sup>29</sup>
- D) OIG policy transmittals as maintained on the OIG website; and
- E) Terms and conditions of the notice of the grant award.

**2) A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.**

- A) The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
- B) The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
- C) The 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.

<sup>28</sup> 77 Fed. Reg. 32645 (June 1, 2012).

<sup>29</sup> For FYs 2016 and later, grant administration requirements are found at 45 CFR pt. 75.

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- 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.

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

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

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

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

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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, case involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.
- C) The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.
- D) For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.
- E) For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.
- F) The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.
- G) The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.

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

- A) The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.
- B) The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.

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

- A) The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.
- B) The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR 455.21, "Cooperation with State Medicaid

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fraud control units," and 42 CFR 455.23, "Suspension of payments in cases of fraud."

- C) The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).
- D) Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.
- E) The MOU incorporates by reference the *CMS Performance Standard for Referrals of Suspected Fraud From a State Agency to a Medicaid Fraud Control Unit*.

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

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

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

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

# APPENDIX B: Unit Referrals by Source for Fiscal Years 2014 Through 2016

| Referral Source                       | FY 2014 |                               | FY 2015 |                  | FY 2016 |                  |
|---------------------------------------|---------|-------------------------------|---------|------------------|---------|------------------|
|                                       | Fraud   | Abuse or Neglect <sup>1</sup> | Fraud   | Abuse or Neglect | Fraud   | Abuse or Neglect |
| Adult protective services             | 1       | 1180                          | 1       | 1340             | 7       | 2432             |
| HHS-OIG                               | 2       | 0                             | 2       | 0                | 3       | 1                |
| Law enforcement—other                 | 5       | 6                             | 23      | 4                | 18      | 6                |
| Local prosecutor                      | 16      | 1                             | 20      | 4                | 20      | 7                |
| Long-term-care ombudsman              | 0       | 1                             | 0       | 2                | 0       | 0                |
| Managed care organizations            | 3       | 0                             | 52      | 0                | 116     | 2                |
| Medicaid agency—PI/SURS <sup>2</sup>  | 65      | 1                             | 96      | 0                | 66      | 0                |
| Medicaid agency—other                 | 0       | 0                             | 36      | 0                | 12      | 0                |
| Private citizen                       | 44      | 6                             | 42      | 18               | 38      | 6                |
| Provider                              | 0       | 1                             | 0       | 3                | 5       | 0                |
| State agency—other                    | 3       | 29                            | 14      | 15               | 15      | 16               |
| State survey and certification agency | 0       | 0                             | 0       | 0                | 4       | 0                |
| Other                                 | 31      | 4                             | 9       | 13               | 36      | 2                |
| Total                                 | 170     | 1229                          | 295     | 1399             | 340     | 2472             |
| Annual Total                          | 1399    |                               | 1694    |                  | 2812    |                  |

Source: OIG analysis of Unit Quarterly and Annual Statistical Reports, FYs 2014-2016.

<sup>1</sup> The category of abuse & neglect referrals includes patient funds referrals.

<sup>2</sup> The abbreviation "PI" stands for program integrity; the abbreviation "SURS" stands for Surveillance and Utilization Review Subsystem.

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# APPENDIX C: Detailed Methodology

## Data Collection and Analysis

We collected and analyzed data from the seven sources below to identify any opportunities for improvement and instances in which the Unit did not adhere to the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.<sup>30</sup> We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards.

**Review of Unit Documentation.** Prior to the onsite inspection, we reviewed the recertification analysis for FYs 2014–2016, which involved examining the Unit's recertification materials, including (1) the annual reports, (2) the Unit Director's recertification questionnaires, (3) the Unit's memorandum of understanding with the State Medicaid agency, (4) the Program Integrity Director's questionnaires, and (5) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's self-reported quarterly statistical reports for FY 2014 and the annual statistical reports for FYs 2015 and 2016 about case outcomes. We examined the recommendations from the 2013 OIG onsite review report and the Unit's implementation of those recommendations. Additionally, while onsite, we reviewed the Unit's policies and procedures.

**Review of Unit Financial Documentation.** We conducted a limited review of the Unit's control over its fiscal resources. Prior to the onsite review, we analyzed the Unit's response to an internal controls questionnaire and conducted a desk review of the Unit's financial status reports. While onsite, we followed up with Tennessee Bureau of Investigation and Unit officials to clarify issues identified in the internal controls questionnaire. We also selected a purposive sample of 28 items from the list of current inventory list of 107 items maintained in the Unit's Nashville office and verified those items onsite.

**Interviews With Key Stakeholders.** In March 2017, we interviewed key stakeholders, including officials in the Tennessee Health Care Finance and Administration's Office of Program Integrity, in Tennessee Adult Protective Services, and in the U.S. Attorneys' Office. We also interviewed the supervisor from OIG's Region IV Office of Investigations who works regularly with the Unit. We focused these interviews on the Unit's relationship and

<sup>30</sup> All relevant regulations, statutes, and policy transmittals are available online at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>.

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interaction with the stakeholders as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

**Onsite Interviews With Unit Management and Selected Staff.** We conducted structured onsite interviews with the Unit's management and selected staff in April 2017. We interviewed the Unit Director, the three ASACs, the two attorneys, and four agents. We asked these individuals questions related to (1) Unit operations, (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance, (3) opportunities for the Unit to improve its operations and/or performance, (4) clarification regarding information obtained from other data sources, and (5) training and technical assistance needs of the Unit.

**Onsite Review of Case Files.** To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2014 through 2016 and to include the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened and closed, if applicable. The total number of cases was 519.

We excluded all global cases from our review of the Unit's case files because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs. We excluded 140 global cases, leaving 379 case files.

We then selected a purposive sample of 20 cases from the population of 379 cases to obtain a mix of cases by status (open/closed), by the type of provider being investigated, by the Unit office that worked on the case (selecting cases from all seven offices), and by whether the case was an independent Unit case or one worked jointly with OIG. We reviewed the 20 case files for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals. During the review of the sampled cases, while onsite, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

In addition to the 20 sampled cases, we reviewed an additional 10 cases to determine whether they were eligible for FFP. Prior to the onsite visit, OIG identified 1 of the 10 cases in the Unit's FY 2016 Annual Report and requested that it be available for review onsite. Based on information we learned while we were onsite about potential ineligible cases, we requested that the Unit provide us with the case files for all cases involving alleged patient abuse or neglect occurring in private residences that were open during the review period. The Unit provided nine case files in response to this request. We examined these nine case files offsite.

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**Review of Unit Submissions to OIG and NPDB.** We also reviewed all convictions submitted to OIG for program exclusion during the review period (106), and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period (72). We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and all adverse actions to the NPDB for FYs 2014–2016. We also assessed the timeliness of the submissions to OIG and the NPDB. While onsite, we followed up with Unit staff to obtain documentation of submissions when needed.

**Onsite Review of Unit Operations.** During the onsite inspection, we observed the Unit’s workspace and operations of the Unit’s headquarters in Nashville. We observed the Unit’s offices and meeting spaces; security of data and case files; location of select equipment; and the general functioning of the Unit.

# APPENDIX D: Unit Comments



**BILL HASLAM**  
Governor

**TENNESSEE BUREAU OF INVESTIGATION**  
901 R.S. Gass Boulevard  
Nashville, Tennessee 37216-2639  
(615) 744-4000  
TDD (615) 744-4001

**W**  
**JASON LOCKE**  
Acting Director

May 24, 2018

Ms. Suzanne Murrin  
Deputy Inspector General for Evaluation and Inspections  
Room 5660, Cohen Building  
330 Independence Avenue, SW  
Washington, D.C. 20201

RE: Tennessee State Medicaid Fraud Control Unit: 2017 Onsite Inspection, OEI-12-17-00230

Dear Ms. Murrin,

In response to your letter dated April 25, 2018, which contained the draft report of the TN MFCU 2017 Onsite Inspection, I would like to begin by thanking your staff members for the professionalism they demonstrated during the review process. The review team represented your department well during their on-site visit and conducted themselves with the utmost integrity. They were careful not to disrupt ongoing activities of the unit while accumulating and reviewing the necessary information for the audit.

I will address the recommendations in the report in the order they are listed.

**The Unit investigated 11 cases that were ineligible for Federal matching funds because they involved allegations of patient abuse or neglect in a non-facility setting.**

We concur with this recommendation. The Unit is currently calculating the amount of the payback for the federal matching funds. Within the next 30 days we will submit an amount to the OIG for approval.

**Although the Unit reported all convictions and adverse actions to Federal partners, it did not always do so within the established time frames.**

We concur with this recommendation. The Unit has developed a standard operating procedure to monitor and track timeframes for reporting convictions and adverse actions.



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**The Unit's staff size had not kept pace with increasing Medicaid program expenditures.**

As noted in the report, the Unit has developed an expansion plan. As State funds become available, the Unit will request additional staff for needed positions.

**The Unit made program integrity recommendations to the Medicaid agency verbally, limiting its ability to monitor responses.**

The Unit will continue to submit recommendations at the quarterly meeting with TennCare. In addition, the Special Agent in Charge of the Unit will follow up with TennCare management after any suggestions. All quarterly meeting notes will be retained to document Unit suggestions and any follow up information.

I appreciate the opportunity to respond to this report, and am available to answer any questions you may have. Please feel free to contact me or Special Agent in Charge Mike Cox at 615-744-4316 if you need additional information.

Sincerely,



Acting Director

JL/le

xc: SAC Mike Cox  
Susan Burbach



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# ACKNOWLEDGMENTS

Susan Burbach of the Medicaid Fraud Policy and Oversight Division served as the team leader for this inspection. Office of Investigations staff also participated in the inspection. Office of Evaluation and Inspections staff who provided support include China Tantameng, Kevin Farber and Christine Moritz.

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

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at [Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov)

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