Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OHIO STATE MEDICAID FRAUD CONTROL UNIT: 2014 ONSITE REVIEW

Suzanne Murrin
Deputy Inspector General
for Evaluation and Inspections

April 2015
OEI-07-14-00290

EXECUTIVE SUMMARY: OHIO STATE MEDICAID FRAUD CONTROL UNIT: 2014 ONSITE REVIEW
OEI-07-14-00290

WHY WE DID THIS STUDY

The Office of Inspector General (OIG) oversees the activities of all 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 Ohio Unit in April 2014. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for fiscal years (FYs) 2011 through 2013; (2) a review of financial documentation for FYs 2011 through 2013; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) an onsite review of a sample of files for cases that were open in FYs 2011 through 2013; and (7) an onsite observation of Unit operations.

WHAT WE FOUND

For FYs 2011 through 2013, the Ohio Unit reported 403 criminal convictions and recoveries of nearly $214 million. Our review found that the Unit did not consistently submit reports of convictions within the appropriate timeframe to OIG for the purpose of program exclusion. Our review also found that 13 percent of case files lacked documentation of supervisory approval for the closing of cases; nearly all case files contained documentation of periodic supervisory review. Finally, the Unit allowed non-Unit personnel to use its vehicles, resulting in unallowable expenditures.

WHAT WE RECOMMEND

We recommend that the Ohio Unit (1) submit reports of all convictions within the appropriate timeframe to OIG for the purpose of exclusion from Federal health care programs, (2) include documentation of supervisory approval for the closing of all case files, and (3) ensure that vehicles are used exclusively by Unit personnel and repay grant funds for unallowable vehicle-related expenditures. The Unit concurred with our first and third recommendations and did not concur with our second recommendation, but said that it took action to address all of our recommendations.

TABLE OF CONTENTS

OBJECTIVE

To conduct an onsite review of the Ohio 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 determines that operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in that State and that the State has other adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.[2] Currently, 49 States and the District of Columbia (States) have created such Units.[3] In fiscal year (FY) 2013, combined Federal and State grant expenditures for the Units totaled $230 million.[4, 5] That year, the 50 Units employed 1,912 individuals.[6]

To carry out its duties and responsibilities in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.[7] Unit staff review complaints provided by the State Medicaid agency and other sources and determine their potential for criminal prosecution and/or civil action. In FY 2013, the 50 Units collectively obtained 1,341 convictions and 879 civil settlements and

---

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

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

[3] North Dakota and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units.

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

[5] Office of Inspector General (OIG), *Medicaid Fraud Control Units Statistical Data for Fiscal Year 2013*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2013-statistical-chart.htm on June 5, 2014.

[6] Ibid.

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

judgments.[8] That year, the Units reported recoveries of approximately $2.5 billion.[9]

Units are required to have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.[10] In Ohio and 44 other States, the Units are located within offices of State Attorneys General; in the remaining 6 States, the Units are located in other State agencies.[11, 12] Generally, Units located outside of an Attorney General's Office must refer cases to other offices with prosecutorial authority.

Each Unit must be a single, identifiable entity of State government, distinct from the single State Medicaid agency, and each Unit must develop a formal agreement (i.e., a memorandum of understanding (MOU)) that describes the Unit's relationship with that agency.[13]

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to OIG the authority both to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.[14] All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.[15] To receive Federal reimbursement, each Unit must submit an initial application to OIG.[16] OIG reviews the application and notifies the Unit if the application is approved and the Unit is certified. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.[17]

---

[8] OIG, *State Medicaid Fraud Control Units Fiscal Year 2013 Grant Expenditures and Statistics*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on June 5, 2014.

[9] Ibid.

[10] SSA § 1903(q)(1).

[11] OIG, *Medicaid Fraud Control Units*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on June 11, 2014.

[12] Among those States with a Unit, the Unit shares responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States also employ an Office of Medicaid Inspector General who conducts and coordinates activities to combat fraud, waste, and abuse for the State agency.

[13] SSA § 1903(q)(2); 42 CFR § 1007.9(d).

[14] 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 called Federal Financial Participation.

[15] SSA §1903(a)(6)(B).

[16] 42 CFR § 1007.15(a).

[17] 42 CFR § 1007.15(b) and (c).

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.[18] To clarify the criteria that OIG applies in assessing whether a Unit is effectively carrying out these functions and meeting program requirements, OIG developed and issued 12 performance standards.[19] Examples of the standards include maintaining an adequate caseload through referrals from several sources, maintaining a training plan for all professional disciplines, and establishing policy and procedure manuals. For a complete listing of the 1994 and 2012 performance standards, see Appendixes A and B respectively.[20]

When considering a Unit's eligibility for recertification, OIG reviews a recertification questionnaire along with quarterly and annual reports to determine the Unit's level of compliance with the 12 performance standards and whether Federal funding was effectively used in investigating and prosecuting cases.

The Unit must also demonstrate that it is complying with laws, regulations, and policy transmittals.[21] For example, as a part of the recertification process, OIG will review a Unit's MOU with the State Medicaid agency to confirm that the Unit is separate and distinct from the State's Medicaid agency, as required by regulation.

OIG also schedules periodic onsite reviews to help determine whether Units operate in accordance with the performance standards, as well as all applicable laws, regulations, and policy transmittals. As a part of these reviews, OIG issues reports with findings and, as appropriate, recommendations. OIG makes these reports available to the general public.

---

[18] SSA § 1902(a)(61).

[19] 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at http://www.gpo.gov/fdsys/pkg/FR-1994-09-26/html/94-23692.htm on August 29, 2014. 77 Fed. Reg. 32645 (June 1, 2012). Accessed at http://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf on May 30, 2014.

[20] OIG initially published performance standards in 1994 (59 Fed. Reg. 49080) and issued revised standards on June 1, 2012. (See 77 Fed. Reg. 32645.) Although the 1994 Performance Standards were in effect during most of the review period, we apply the 2012 performance standards where appropriate in the findings and report recommendations.

[21] On occasion, OIG issues policy transmittals to provide guidance and instructions to MFCUs. The transmittals may also provide interpretations of Federal regulations, statutes, and other policies as they apply to MFCUs.

Ohio MFCU

The Ohio Unit is located within the Office of Attorney General, and expended $7,344,992 in combined State and Federal funds in FY 2013.[22] The Unit does not maintain any field offices; all 85 staff are located in Columbus. The Unit management is composed of a director, an assistant director, a chief investigator known as the special agent in charge, and an assistant special agent in charge. There are currently seven investigation teams: five teams that investigate fraud and two that investigate abuse and neglect. A typical team includes a special agent supervisor, seven special agents, and two assistant attorneys general. The Unit also has a chief auditor, who supervises three intake officers, two nurse analysts, and a special projects team supervisor who supervises five fraud analysts, all of whom support the investigative teams.

Referrals. The Unit receives referrals from a variety of sources, including the State Medicaid agency, the State Survey and Certification agency, the State Long-Term Care Ombudsman, and private citizens. Unit referrals by referral source for FYs 2011 through 2013 can be found in Appendix C. Allegations of Medicaid fraud or patient abuse and neglect are recorded on a standardized intake form and reviewed by an intake committee. This committee includes the director, assistant director, special agent in charge, assistant special agent in charge, chief auditor, intake officers, and bailiff/paralegal. The committee meets twice a month to review all referrals and determine whether each referral should be opened for investigation.

Investigations and Prosecutions. When a case is opened, the assistant director (or his designee) assigns it to a team for investigation, and the team supervisor assigns it to a lead investigator. The team supervisor meets with the lead investigator and attorneys to plan the investigation. Staff document investigative activities, time reporting, monthly reporting, and other statistical measurements using the Unit's case management database.

The Ohio Unit opens all fraud cases as potential criminal investigations, but some cases may be closed by a civil settlement. State law grants the Unit original criminal jurisdiction to investigate and prosecute Medicaid provider fraud cases under Ohio Revised Code Section 109.85. State law requires that—following an

---

[22] OIG, *State Medicaid Fraud Control Units Fiscal Year 2013 Statistical Chart*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on June 11, 2014.

investigation—all patient abuse and neglect cases be referred to a local (i.e., county or municipal) prosecuting attorney.[23] The local prosecuting attorney may elect whether to prosecute or decline a case. If the local prosecuting attorney elects to decline a case, the Unit then makes a decision whether to prosecute the case in-house.

METHODOLOGY

We conducted the onsite review in April 2014. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for FYs 2011 through 2013; (2) a review of financial documentation for FYs 2011 through 2013; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) an onsite review of a sample of files for cases that were open at any time in FYs 2011 through 2013; and (7) an onsite observation of Unit operations. Appendix D provides a detailed methodology.

Standards

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

[23] Ohio Revised Code §109.86 (2013).

FINDINGS

For FYs 2011 through 2013, the Ohio Unit reported 403 criminal convictions and recoveries of nearly $214 million

During the period we reviewed, the Unit obtained 403 criminal convictions, charged 400 individuals, closed 1,458 investigations, and reported 70 civil judgments and settlements. Six cases were dismissed. Details on investigations opened and closed by provider category for FYs 2011 through 2013 can be found in Appendix E.

The Unit reported combined criminal and civil recoveries of nearly $214 million for FYs 2011 through 2013. Most of the recoveries were obtained from "global" settlements, which accounted for 81 percent of the Unit's recoveries during the period of our review.[24] (See Table 1 for details regarding criminal and civil recoveries for FYs 2011 thru 2013.)

Table 1: Ohio Criminal and Civil Recoveries, FYs 2011–2013

Type of Recovery	FY 2011	FY 2012	FY 2013	3-Year Total
Criminal Recoveries	$3,333,680	$3,196,079	$5,944,122	$12,473,881
Civil Recoveries—Global	$48,355,657	$86,230,829*	$38,678,399	$173,264,885
Civil Recoveries—Nonglobal	$26,815,561**	$436,537	$995,388	$28,247,486
Total Recoveries	**$78,504,898**	**$89,863,445**	**$45,617,909**	**$213,986,252**
Total Expenditures	$5,066,678	$6,712,714	$7,344,992	$19,124,384

*The "Civil Recoveries—Global" amount in FY 2012 was higher than in FY 2011 or FY 2013 because of three large cases that were settled during 2012.

**The "Civil Recoveries—Nonglobal" amount for 2011 included a large Ohio-specific civil recovery.

Source: OIG analysis of Unit-submitted documentation, FYs 2011–2013.

[24] "Global" cases are civil false claims cases that are brought by the U.S. Department of Justice and involve a group of State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the States.

The Unit did not consistently submit reports of convictions within the appropriate timeframe to OIG for the purpose of program exclusion

According to the 1994 Performance Standard 8(d), the Unit should transmit to OIG reports of all convictions for the purpose of exclusion from Federal health care programs "within 30 days [of sentencing] or other reasonable time period." The 2012 revised Performance Standard 8(f) states that it is the Unit's responsibility to transmit "all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders."

The Unit did not consistently submit reports of conviction information within the appropriate timeframe to OIG for the purpose of program exclusion. Of the 403 reports of convictions that should have been sent to OIG for exclusion, the Unit reported 320 convictions within the appropriate timeframe. Eighty-three convictions were reported more than 45 days after sentencing. Fifty-two of these eighty-three convictions were submitted to OIG after the beginning of our review and more than 160 days after sentencing, with 13 of these submitted more than 1,000 days after sentencing. During onsite discussions, the Unit stated that it was revising its policies and procedures for reporting convictions to OIG.

Thirteen percent of case files lacked documentation of supervisory approval for the closing of cases; nearly all case files contained documentation of periodic supervisory review

According to 1994 Performance Standard 6(b) and 2012 Performance Standard 5(b), Unit supervisors should approve the opening and closing of cases in part to ensure a continuous case flow and timely completion of cases. Supervisory approval to open and close cases indicates that Unit supervisors are monitoring the intake and resolution of cases, thereby facilitating progress. All case files in our review contained documentation indicating supervisory approval to open the case; however, 13 percent of the files for closed cases did not contain documentation indicating supervisory approval to close the case. Unit management considered the 13 percent of case files to be adequately documented because they contained the record of court dispositions, such as convictions. However, we did not consider the cases to be adequately documented because the court dispositions did not indicate that a supervisor had reviewed and approved the closing of the cases. Including the closing

documentation in such files would also allow Unit supervisors to monitor whether all appropriate administrative steps were taken in the case, such as reporting convictions to OIG for exclusion.

According to 1994 Performance Standard 6(c) and 2012 Performance Standard 7(a), supervisory reviews should be conducted periodically and noted in the case file to ensure timely case completion.[25] The Unit's policy required that the special agent supervisor and prosecuting attorneys on each team review each case at least every 60 days. In addition to these reviews, the special agent supervisor and prosecuting attorneys (i.e., assistant attorneys general) on each team were responsible for conducting quarterly reviews of all closed case files. Ninety-seven percent of files for cases that were open longer than 60 days contained documentation of periodic reviews. Related estimates and confidence intervals can be found in Appendix F.

The Unit allowed non-Unit personnel to use its vehicles, resulting in unallowable expenditures

According to the 1994 Performance Standards 1 and 11 and the 2012 Performance Standards 1 and 11, the Unit must conform to all applicable statutes, regulations, and policy directives and must exercise proper fiscal controls over its equipment, including vehicles.[26] We also identified an internal Unit policy that specified that only Unit personnel may drive Unit vehicles.[27] Further, Federal financial participation is limited to only the expenditures attributable to the establishment and operation of the Unit.[28]

However, the Unit used Federal grant funds to purchase and maintain vehicles that were used by non-Unit staff. Specifically, for

---

[25] For the purposes of this report, supervisory approval to open and close a case does not constitute a periodic supervisory review. Periodic supervisory review indicates that a supervisor *reviewed* a case more than once between the case's opening and closing.

[26] 2 CFR part 225, Appendix A, contains the principles for determining the allowable costs incurred by State, local, and federally recognized Indian tribal governments (governmental units) under grants, cost reimbursement contracts, and other agreements with the Federal Government. Section (C)(3)(a) of the Appendix establishes the basic guideline that, to be allowable for Federal funding, expenditures must be allocable, meaning that they must be charged and assigned to the cost objective "in accordance with the relative benefits received."

[27] Ohio Attorney General, Health Care Fraud Section, Medicaid Fraud Control Unit, Employee Handbook, Section A-14, I.A., which states: "Only authorized Medicaid Fraud Control Unit ('MFCU') personnel may drive MFCU vehicles" (effective March 24, 2008; last reissued March 1, 2013).

[28] 42 CFR § 1007.19(d)(1).

the period FY 2011 through 2013, we identified staff in other divisions of the Attorney General's Office who used Unit-owned and Unit-maintained vehicles 149 times, totaling 20,074 miles. The Unit claimed 100 percent of the vehicle expenditures for Federal reimbursement, resulting in unallowable expenditures of $11,092 (with a Federal share of $8,319 and a State share of $2,773).

We did not identify any other weaknesses in fiscal controls relating to accounting, budgeting, personnel, procurement, property, and nonvehicle equipment.

Other observations

Program integrity groups and referrals

According to 2012 Performance Standard 4(a), the Unit should take steps to ensure that the State Medicaid agency, managed care organizations, and other agencies refer to the Unit all cases of suspected provider fraud. In an effort to improve the quantity and quality of referrals, the Unit developed two innovative program integrity groups. The Ohio Program Integrity Group (referred to as the "PIG") combines the knowledge and resources of all the State agencies that are responsible for Medicaid program integrity, including the Unit; the Ohio Department of Job and Family Services' Office of Ohio Health Plans and Surveillance and Utilization Review Section; the Zone Program Integrity Contractor, the Recovery Audit Contractor, and the Ohio Auditor of State's Medicaid Contract Audit Section. The group meets monthly to craft data mining algorithms to identify aberrant Medicaid provider behavior, discuss data mining results, and coordinate an appropriate response to the results. The Unit has also spearheaded the Managed Care Program Integrity Group (referred to as the "McPIG"), which meets quarterly and is composed of the Unit, the State Medicaid agency's Bureau of Managed Care, and representatives of Ohio's five Medicaid managed care plans. The purpose of meetings is to coordinate program integrity efforts and facilitate the exchange of information.

Use of technology

The Unit employs a special projects team to provide technical support to all of the investigative teams. The team provides data analysis and tools for conducting undercover surveillance activities to assist in developing cases. During our onsite visit, we observed the team's use of technology and its ability to build in-house innovative tools that the Unit reported as having deployed successfully during investigations.

Initiation of investigative activity

Although most cases appeared to be completed in an appropriate timeframe after the initiation of investigative activities (e.g., after the first interview), 15 of the 50 sampled cases selected for indepth review revealed a significant delay between when the referrals were reviewed during the intake process and when investigative activities were initiated. These delays ranged between 136 days and 642 days; the average delay was 285 days. In one such case, the referral was received in mid-May, the case was opened in late June, and investigative activity was not initiated until April of the following year. The Unit stated that it is in the process of adding 11 new staff over the next year and that it also refined its intake process to better evaluate the quality of referrals before opening cases.

CONCLUSION AND RECOMMENDATIONS

For FYs 2011 through 2013, the Unit closed 1,458 investigations and obtained 403 criminal convictions. The Unit reported combined civil and criminal recoveries of nearly $214 million.

Our review did not identify significant noncompliance with the performance standards; however, some opportunities for Unit improvement exist. Specifically, our review found that the Unit did not submit reports of 83 convictions for purposes of program exclusion within the appropriate timeframe. Our review also identified that the Unit's vehicles were used by non-Unit staff, resulting in unallowable expenditures. Although all case files contained approval for the opening of cases, the files for 13 percent of closed cases (i.e., cases that were closed based on a conviction or other court disposition) lacked documentation of supervisory approval for the closing of cases, relying instead on court disposition documents. The Unit's active participation in the Ohio PIG and McPIG work groups allowed it to better foster relationships and increase referrals.

We recommend that the Ohio Unit:

Submit reports of all convictions within the appropriate timeframe to OIG for the purpose of exclusion from Federal health care programs

The Unit should ensure that all individuals convicted of fraud or patient abuse and/or neglect are reported to OIG within 30 days of their sentencing.

Include documentation of supervisory approval for the closing of all case files

Consistent with 2012 Performance Standard 5(b), the Unit should include closing documentation in every case file, including those for cases in which a conviction was obtained. Closing documentation in such files would allow Unit supervisors to monitor whether all appropriate administrative steps were taken in the case, such as reporting convictions to OIG for exclusion, maintaining additional information regarding secondary disposition actions, and tracking other case subjects who were not convicted.

Ensure that vehicles are used exclusively by Unit personnel and repay grant funds for unallowable expenditures

The Unit should ensure that vehicles are used exclusively by Unit staff as required by Unit policy, and the Unit should work with OIG to repay grant funds for unallowable expenditures.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with our first and third recommendations and did not concur with our second recommendation, but said that it took action to address all of our recommendations.

The Unit concurred with our recommendation that it submit reports of all convictions within the appropriate timeframe to OIG for the purpose of exclusion. The Unit stated that it believes it is currently in compliance and stated that it has recently amended its policies and procedures to ensure future compliance.

The Unit did not concur with our recommendation that it include documentation of supervisory approval for the closing of all case files, but said that it had implemented the recommended procedure. The Unit stated that it believes including copies of the plea/judgment entry and sentencing entry in the master file for each case, combined with other information, is sufficient to meet the requirement. However, the Unit said that it has modified its internal policy/procedure to require closing documentation and supervisory approval for each case closed as a result of a criminal conviction.

The Unit concurred with our recommendation that it ensure that vehicles are used exclusively by Unit personnel and that it repay grant funds for unallowable expenditures. The Unit stated that it had notified the employees of the Workers' Compensation Fraud Unit—which, together with the MFCU, forms the Health Care Fraud Section of the Ohio Attorney General's Office—that they are not permitted to use MFCU-owned vehicles. The Unit also said that it took steps to ensure these individuals are not able to access the Unit's reservation system.

The Unit also responded to OIG observations related to a significant delay between the intake of cases and the initiation of investigative activities for 15 of the sampled cases. The Unit stated that it has seen an increase in case intakes over the last 5 years and has undergone four successive expansions to address the increased caseload and the Unit's capabilities in the area of patient abuse and institutional neglect.

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

APPENDIX A

1994 Performance Standards[29]

1. **A Unit will be in conformance with all applicable statutes, regulations and policy transmittals.** In meeting this standard, the Unit must meet, but is not limited to, the following requirements:

    a. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.

    b. The Unit must be separate and distinct from the State Medicaid agency.

    c. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.

    d. The Unit must submit annual reports, with appropriate certifications, on a timely basis.

    e. The Unit must submit quarterly reports on a timely basis.

    f. The Unit must comply with the Americans with Disabilities Act, the Equal Employment opportunity requirements, the Drug Free workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.

2. **A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.** In meeting this standard, the following performance indicators will be considered:

    a. Does the Unit employ the number of staff that was included in the Unit's budget as approved by the OIG?

    b. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?

[29] 59 Fed. Reg. 49080, Sept. 26, 1994.

c. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?

d. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?

3. **A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.** In meeting this standard, the following performance indicators will be considered:

   a. Does the Unit have policy and procedure manuals?

   b. Is an adequate, computerized case management and tracking system in place?

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

   a. Does the Unit work with the State Medicaid agency to ensure adequate fraud referrals?

   b. Does the Unit work with other agencies to encourage fraud referrals?

   c. Does the Unit generate any of its own fraud cases?

   d. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?

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

   a. Does the Unit seek to have a mix of cases among all types of providers in the State?

   b. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?

   c. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?

d. Are there any special Unit initiatives targeting specific provider types that affect case mix?

e. Does the Unit consider civil and administrative remedies when appropriate?

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

   a. Is each stage of an investigation and prosecution completed in an appropriate time frame?

   b. Are supervisors approving the opening and closing of investigations?

   c. Are supervisory reviews conducted periodically and noted in the case file?

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

   a. The number, age, and type of cases in inventory.

   b. The number of referrals to other agencies for prosecution.

   c. The number of arrests and indictments.

   d. The number of convictions.

   e. The amount of overpayments identified.

   f. The amount of fines and restitution ordered.

   g. The amount of civil recoveries.

   h. The numbers of administrative sanctions imposed.

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

a. Does the Unit communicate effectively with the OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?

b. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?

c. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?

d. Does the Unit transmit to the OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

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

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

b. Does the Unit provide program recommendations to State Medicaid agency when appropriate?

c. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?

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

a. Is the MOU more than 5 years old?

b. Does the MOU meet Federal legal requirements?

c. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?

d. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?

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

    a. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?

    b. Does the Unit maintain an equipment inventory?

    c. Does the Unit apply generally accepted accounting principles in its control of Unit funding?

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

    a. Does the Unit have a training plan in place and funds available to fully implement the plan?

    b. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?

    c. Are continuing education standards met for professional staff?

    d. Does the training undertaken by staff add to the mission of the Unit?

APPENDIX B

2012 Revised Performance Standards[30]

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.

[30] 77 Fed. Reg. 32645, June 1, 2012.

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.

c. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests

information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).

d. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.

e. The Unit provides timely information, when requested, to those agencies identified in (D) above regarding the status of referrals.

f. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.

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

a. Each stage of an investigation and prosecution is completed in an appropriate timeframe.

b. Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.

c. Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.

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

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

b. For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.

c. The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.

d. As part of its case mix, the Unit maintains a balance of fraud and patient abuse and neglect cases for those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases.

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

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

a. Reviews by supervisors are conducted periodically, consistent with MFCU policies and procedures, and are noted in the case file.

b. Case files include all relevant facts and information and justify the opening and closing of the cases.

c. Significant documents, such as charging documents and settlement agreements, are included in the file.

d. Interview summaries are written promptly, as defined by the Unit's policies and procedures.

e. The Unit has an information management system that manages and tracks case information from initiation to resolution.

f. The Unit has an information management system that allows for the monitoring and reporting of case information, including the following:

1. The number of cases opened and closed and the reason that cases are closed.

2. The length of time taken to determine whether to open a case referred by the State Medicaid agency or other referring source.

3. The number, age, and types of cases in the Unit's inventory/docket.

4. The number of referrals received by the Unit and the number of referrals by the Unit to other agencies.

5. The dollar amount of overpayments identified.
6. The number of cases criminally prosecuted by the Unit or referred to others for prosecution, the number of individuals or entities charged, and the number of pending prosecutions.
7. The number of criminal convictions and the number of civil judgments.
8. The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of recoveries and the types of relief obtained through civil judgments or prefiling settlements.

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

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

b. The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, 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 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 CMS.

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

e. The MOU incorporates by reference the CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit.

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

a. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.

b. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.

c. The Unit maintains an effective time and attendance system and personnel activity records.

d. The Unit applies generally accepted accounting principles in its control of Unit funding.

e. The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.

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

a. The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.

b. The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.

c. Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.

d. The Unit participates in MFCU related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.

e. The Unit participates in cross training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

APPENDIX C

Ohio Medicaid Fraud Control Unit (Unit) Referrals by Referral Source for FYs 2011 Through 2013

	FY 2011			FY 2012			FY 2013		
Referral Source	**Fraud**	**Abuse & Neglect**	**Patient Funds**	**Fraud**	**Abuse & Neglect**	**Patient Funds**	**Fraud**	**Abuse & Neglect**	**Patient Funds**
Medicaid agency – PI/SURS[31]	23	0	0	23	0	0	19	0	0
Medicaid agency – other	189	2	0	174	1	0	223	1	1
State survey and certification agency	8	123	20	3	109	34	3	176	88
Other State agencies	38	0	0	30	1	1	32	4	2
Licensing board	8	2	0	11	2	1	1	0	0
Law enforcement	57	5	4	45	1	1	46	1	0
Office of Inspector General	13	0	1	21	4	1	7	5	0
Prosecutors	6	0	0	0	1	0	1	1	1
Providers	15	1	1	28	4	0	30	1	1
Provider associations	0	0	0	0	0	0	0	0	0
Private health insurer	0	0	0	0	0	0	0	0	0
Long-term-care ombudsman	0	0	0	7	2	0	9	3	1
Adult protective services	0	0	0	0	0	0	0	0	0
Private citizens	149	48	2	158	52	0	140	114	4
MFCU hotline	0	0	0	0	0	0	0	0	0
Self-generated	12	0	0	6	1	0	5	4	0
Other	17	5	0	24	3	0	20	1	0
Total	**535**	**186**	**28**	**530**	**181**	**38**	**536**	**311**	**98**
Annual Total			**749**			**749**			**945**

Source: OIG analysis of Unit-submitted documentation, FYs 2011–2013.

[31] The abbreviation "PI" stands for program integrity; the abbreviation "SURS" stands for Surveillance and Utilization Review Subsystem.

APPENDIX D

Detailed Methodology

Data collected from the seven sources below was used to describe the caseload and assess the performance of the Ohio State Medicaid Fraud Control Unit (Unit).

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information from several sources regarding the Unit's investigation of Medicaid cases, including information about the number of referrals the Unit received, the number of investigations the Unit opened and closed, the outcomes of those investigations, and the Unit's case mix. We also collected and analyzed information about the number of cases that the Unit referred for prosecution and the outcomes of those prosecutions. We gathered this information from several sources, including the Unit's quarterly statistical reports, its annual reports, its recertification questionnaire, its policy and procedures manuals, and its MOU with the State Medicaid agency. Additionally, we confirmed with the Unit director that the information we had was current as of January 2014, and as necessary, we requested any additional data or clarification.

Review of Unit Financial Documentation. To evaluate internal control of fiscal resources, OIG auditors determined whether the Unit (1) claimed expenditures that represented allowable, allocable, and reasonable costs in accordance with applicable Federal regulations; and (2) maintained adequate internal controls related to accounting, budgeting, personnel, procurement, property, and equipment for FYs 2011 through 2013. OIG auditors also obtained from the Unit its claimed grant expenditures for FYs 2011 through 2013, which was used to: (1) reviewed quarterly and final financial status reports that the Unit submitted along with supporting documentation, (2) judgmentally selected and reviewed transactions within the direct cost categories, and (3) confirmed whether indirect costs were accurately reported using the negotiated and approved indirect cost rates during the period of our review. Finally, auditors reviewed records in the Department of Health and Human Services Payment Management System (PMS), tested selected expenditures by reviewing supporting documentation, and determined whether there was any unallowable Federal Medicaid reimbursement.

Interviews with Key Stakeholders. In April 2014, we interviewed key stakeholders, including officials in the United States Attorneys'

Offices, the State Attorney General's Office, and State Agencies that interacted with the Unit (i.e., Adult Protective Services, the Medicaid Program Integrity Unit, the Office of the State Long-Term Care Ombudsman, and the Professional Licensure Division). We also interviewed supervisors from OIG's Region V offices who work regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities, and we identified opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Survey of Unit Staff. In January 2014, we conducted an online survey of all 72 nonmanagerial Unit staff within each professional discipline (i.e., investigators, auditors, and attorneys) as well as support staff. The response rate was 100 percent. Our questions focused on operations of the Unit, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Onsite Interviews with Unit Management. We conducted structured interviews with the Unit's management in April 2014. We interviewed the Unit director, assistant director (who also served as the Unit's lead attorney), special agent in charge, assistant special agent in charge, chief auditor, and the team supervisors. We asked these individuals to provide information related to (1) the Unit's operations, (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance, (3) opportunities for the Unit to improve its operations and/or performance, and (4) clarification regarding information obtained from other data sources.

Onsite Review of Case Files and Other Documentation. We requested that the Unit provide us with a list of cases that were open at any point during FYs 2011 through 2013. This list of 2,535 cases included, but was not limited to, the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened. From this list of cases, we excluded 52 cases that were categorized as "global" and 2 cases that had been closed prior to the period of our review and thus should not have been included in the list. We then selected a simple random sample of 100 cases from the remaining 2,481 cases. This sample of 100 cases included 89 cases that were open longer than 60 days and 80 cases that were closed at some point during our review. We reviewed all

100 sampled case files. During the onsite review, one case file was determined to be a global case. As a result, the number of eligible case files in our sample was reduced from 100 to 99. To project the number of eligible case files in the entire population, we used the proportion of the eligible case files from our sample. This resulted in a reduction of the eligible population from 2,481 to an estimated 2,456 case files. Our estimates of the percentages of all case files with certain characteristics apply to the estimated population of 2,456 files for nonglobal cases that were open during the period of our review. All estimates and 95-percent confidence intervals for projections can be found in Appendix F. From the initial sample of 100 case files, we selected a further simple random sample of 50 files for a more indepth review of selected issues by an OIG investigator, such as the timeliness of investigations and case development. We did not estimate any population or subpopulation proportions from this additional sample of 50 case files.

Onsite Review of Unit Operations. During our April 2014 site visit, 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. We also checked to ensure that the Unit referred sentenced individuals to OIG for program exclusion and that the Unit reported adverse actions to the National Practitioner Data Bank (NPDB).[32, 33]

Data Analysis

We analyzed data to identify any opportunities for improvement and any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.[34] In addition, we noted practices that appeared to be beneficial to the Unit. We based these observations on

---

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

[33] Examples of adverse actions include criminal convictions; civil judgments (but not civil settlements); exclusions; and other negative actions or findings, including "…but not limited to, limitations on the scope of practice, liquidations, injunctions and forfeitures." SSA § 1128E(g)(1) and 45 CFR § 61.3 (2012). Current Unit requirements for reporting to the merged NPDB are in 45 CFR pt. 60.

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

statements from Unit staff, data analysis, and our own judgment. We did not independently verify the effectiveness of these practices, but included the information because it may be useful to other Units in their operations.

APPENDIX E

Investigations Opened and Closed By Provider Category for FY 2011 Through 2013

Table E-1: Fraud Investigations

Provider Category	FY 2011		FY 2012		FY 2013	
Facilities	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Hospitals	4	4	3	2	3	4
Nursing facilities	6	8	4	4	15	2
Other long-term-care facilities	3	1	2	3	4	1
Substance abuse treatment centers	3	0	2	1	1	3
Other	0	0	0	0	0	0
Subtotal	**16**	**13**	**11**	**10**	**23**	**10**
Practitioners	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Doctors of medicine or osteopathy	37	26	40	36	47	25
Dentists	13	11	15	11	10	9
Podiatrists	3	2	1	1	2	1
Optometrists/opticians	0	1	1	0	2	1
Counselors/psychologists	4	2	11	6	9	4
Chiropractors	1	2	2	2	1	0
Other	14	15	36	20	17	19
Subtotal	**72**	**59**	**106**	**76**	**88**	**59**
Medical Support	**Opened**	**Closed**	**Opened**	**Closed**	**Opened**	**Closed**
Pharmacies	16	7	13	12	5	7
Pharmaceutical manufacturers	32	11	13	7	14	11
Suppliers of durable medical equipment and/or supplies	18	9	11	10	10	13
Laboratories	2	4	2	1	9	2
Transportation services	28	19	19	21	18	18
Home health care agencies	66	38	68	44	58	44
Home health care aides	155	125	160	139	159	123
Nurses, physician assistants, nurse practitioners, certified nurse aides	42	42	40	31	26	29
Radiologists	0	0	2	0	0	1
Medical support—other	3	1	0	1	1	2
Subtotal	**362**	**256**	**328**	**266**	**300**	**250**

continued on next page

Table E-1 (Continued): Fraud Investigations

Program Related	Opened	Closed	Opened	Closed	Opened	Closed
Managed care	1	1	1	1	0	1
Medicaid program administration	0	0	0	0	0	0
Billing company	0	0	0	0	2	0
Other	0	0	0	0	0	0
Subtotal	1	1	1	1	2	1
Total Provider Categories	**451**	**329**	**446**	**353**	**413**	**320**

Source: OIG analysis of Ohio State Medicaid Fraud Control Unit (Unit)-submitted documentation, FYs 2011–2013.

Table E-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2011		FY 2012		FY 2013	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing facilities	38	30	49	33	104	36
Other long-term-care facilities	3	3	1	0	0	1
Nurses, physician's assistants, nurse practitioners, certified nurse aides	102	78	107	82	134	89
Home health aides	0	0	0	0	0	0
Other	5	3	0	4	2	1
Total	**148**	**114**	**157**	**119**	**240**	**127**

Source: OIG analysis of Unit-submitted documentation, FYs 2011–2013.

Table E-3: Patient Funds Investigations

Provider Category	FY 2011		FY 2012		FY 2013	
	Opened	Closed	Opened	Closed	Opened	Closed
Nondirect care	9	7	9	8	12	7
Nurses, physician's assistants, nurse practitioners, certified nurse aides	7	15	7	5	18	7
Home health aides	0	0	0	0	0	0
Other	10	14	18	5	56	28
Total	**26**	**36**	**34**	**18**	**86**	**42**

Source: OIG analysis of Unit-submitted documentation, FYs 2011–2013.

APPENDIX F

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

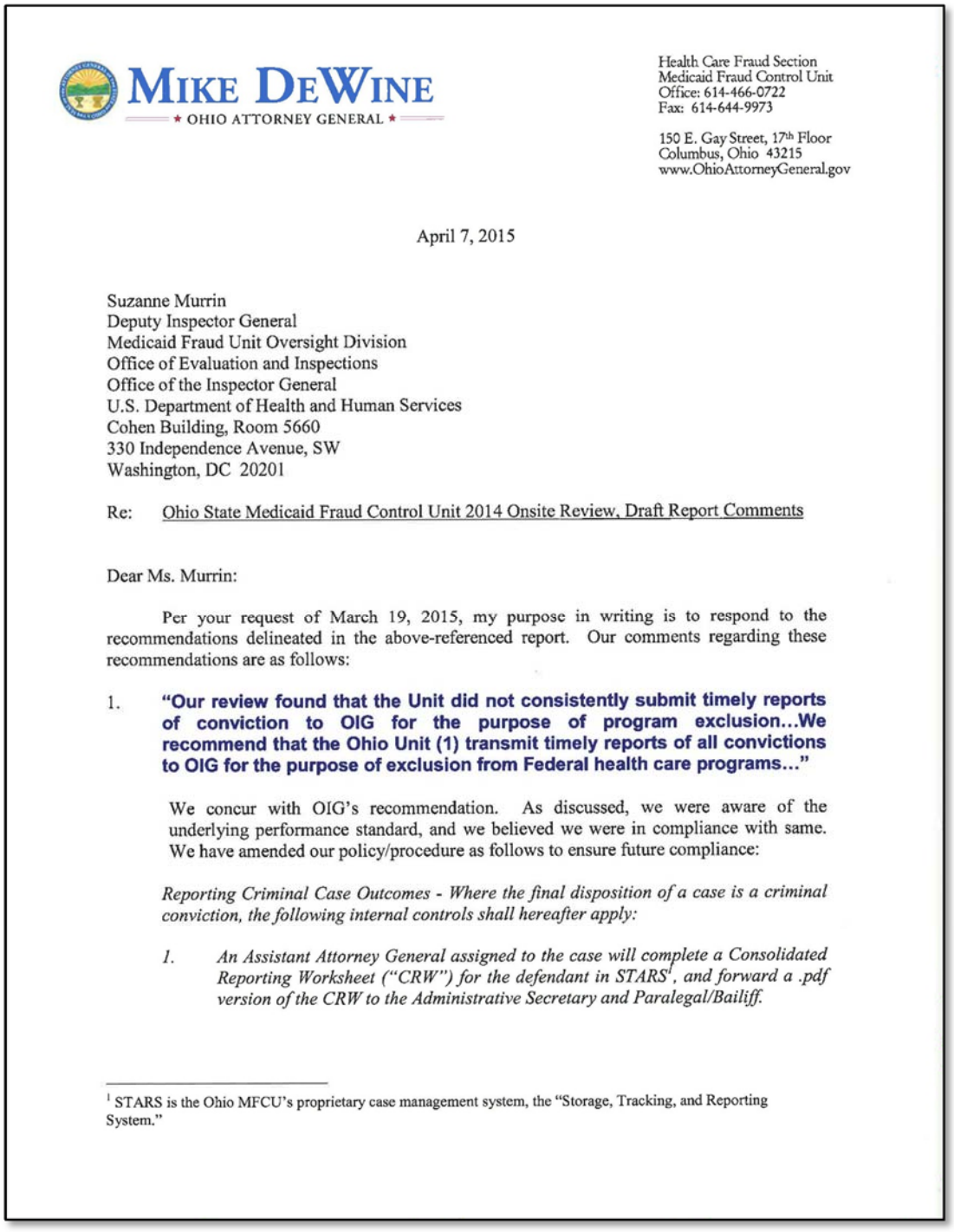
Estimate	Sample Size*	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of case files containing documentation of supervisory approval for opening	99	100%	96.4%	100%
Percentage of closed-case files that did not contain documentation of supervisory approval for closing	80	12.5%	6.9%	21.7%
Percentage of files for cases that were open longer than 60 days that contained documentation of periodic supervisory review	89	96.6%	90.1%	98.9%

*We found at the time of our review that one case file was for a global case, and we thus excluded this case from our analysis of review questions.

Source: OIG analysis of Ohio State MFCU case files, 2014.

APPENDIX G

Unit Comments



MIKE DEWINE
* OHIO ATTORNEY GENERAL *

Health Care Fraud Section
Medicaid Fraud Control Unit
Office: 614-466-0722
Fax: 614-644-9973

150 E. Gay Street, 17th Floor
Columbus, Ohio 43215
www.OhioAttorneyGeneral.gov

April 7, 2015

Suzanne Murrin
Deputy Inspector General
Medicaid Fraud Unit Oversight Division
Office of Evaluation and Inspections
Office of the Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5660
330 Independence Avenue, SW
Washington, DC 20201

Re: Ohio State Medicaid Fraud Control Unit 2014 Onsite Review, Draft Report Comments

Dear Ms. Murrin:

Per your request of March 19, 2015, my purpose in writing is to respond to the recommendations delineated in the above-referenced report. Our comments regarding these recommendations are as follows:

1. **"Our review found that the Unit did not consistently submit timely reports of conviction to OIG for the purpose of program exclusion...We recommend that the Ohio Unit (1) transmit timely reports of all convictions to OIG for the purpose of exclusion from Federal health care programs..."**

We concur with OIG's recommendation. As discussed, we were aware of the underlying performance standard, and we believed we were in compliance with same. We have amended our policy/procedure as follows to ensure future compliance:

Reporting Criminal Case Outcomes - Where the final disposition of a case is a criminal conviction, the following internal controls shall hereafter apply:

1. An Assistant Attorney General assigned to the case will complete a Consolidated Reporting Worksheet ("CRW") for the defendant in STARS[1], and forward a .pdf version of the CRW to the Administrative Secretary and Paralegal/Bailiff.

[1] STARS is the Ohio MFCU's proprietary case management system, the "Storage, Tracking, and Reporting System."

2. *The Administrative Secretary will file a copy of the CRW in the case master file, and will enter the information from the CRW into the National Practitioner Data Bank ("NPDB").*

3. *Every other week, the Paralegal/Bailiff will generate from STARS a letter to the Special Agent-In-Charge of the U.S. Department of Health and Human Services, Office of the Inspector General, Exclusions Branch, Region V (the "Region V SAC"), reporting all criminal convictions posted during the preceding two (2) weeks. To this letter, the Paralegal/Bailiff will attach copies of the indictment, sentencing entry, and CRW for each defendant. The Paralegal/Bailiff will file a copy of this letter in the case master file for each defendant.*

4 *A case may not be closed in STARS due to a criminal conviction until such time as the case master file includes copies of the CRW, the NPDB confirmation page, and the letter to the Region V SAC.*

5. *At the end of each month, the Administrative Secretary will generate the monthly report from STARS. The Administrative Secretary will reconcile the convictions identified in the monthly report against the Paralegal/Bailiff's letters to the Region V SAC, to ensure that all convictions have been reported. The Administrative Secretary will then pass the monthly report to the Paralegal/Bailiff, who will reconcile the convictions identified in the monthly report against the CRWs posted to the NPDB, again to ensure that all convictions have been reported.*

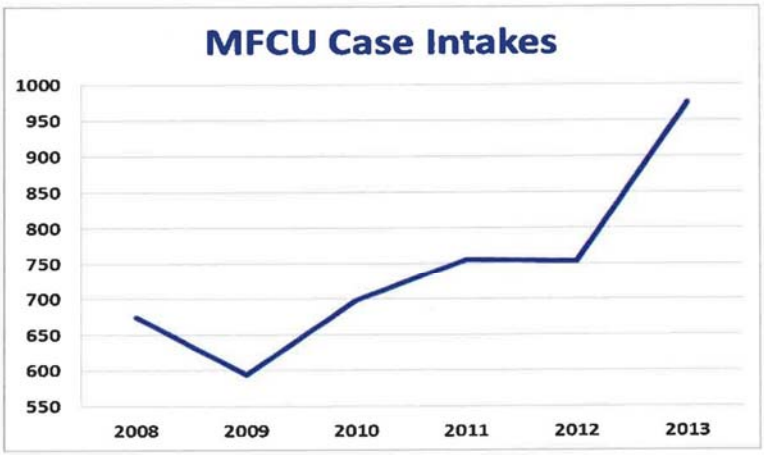
6. *During the monthly post-closure review of the case master file, the Special Agent Supervisor responsible for the investigation shall ensure that the master file contains copies of both the letter to the Region V SAC and the CRW.*

2. **"Our review also found that 13 percent of cases lacked documentation of supervisory approval to close the case…We recommend that the Ohio Unit…(2) include closing memoranda in all case files."**

We do not concur with OIG's recommendation, but we have implemented the recommended procedure nonetheless. As previously discussed, we were aware of the underlying performance standard, and we believed that including copies of the plea/judgment entry and sentencing entry in the case master file, combined with the information captured in our case management system, STARS, indicating that the case was closed due to conviction, met the requirement. We acknowledge that the files identified lacked a closing memorandum, and we have modified our internal policy/procedure to require a closing memorandum and supervisory approval thereof for each case closed as a result of a criminal conviction.

3. **"Although most cases appeared to be completed in an appropriate timeframe after the initiation of investigative activities (e.g., first interview), 15 of the sampled cases revealed a significant delay between when the referrals were opened and the initiation of investigative activities."**

Though this is technically not a recommendation, we feel obligated to respond nonetheless. The Ohio Unit has seen a marked increase in case intakes (complaints) over the last five (5) years, from 594 in 2009 to 974 in 2013. The Unit has invested considerable time and effort developing partnerships with agencies (state, federal, and private) that have complimentary program integrity responsibilities, and this has done much to increase both the quantity and quality of the Unit's referrals. The Unit is, at least in this respect, very much a victim of its own success.

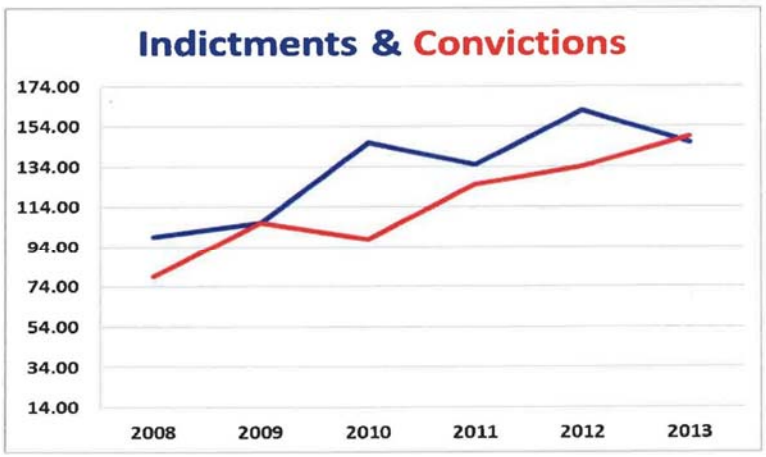


To address these increases, the Unit has undergone four (4) expansions, three (3) of which were focused on addressing Medicaid provider fraud caseloads, and the fourth of which was focused on expanding the Unit's capabilities in the area of patient abuse and institutional neglect. In total, these expansions increased the Unit's investigative staff of Special Agents from twenty-four (24) at the beginning of 2009, to forty-nine (49) at present, and the first two (2) expansions have certainly had the effect of reducing average Agent caseloads, albeit temporarily.

And while these expansions have focused primarily on the addition of Special Agents, increasing caseloads have an impact on the Unit's prosecutors, support staff, and management staff as well. In conjunction with the above-referenced expansions, the Unit added six (6) Assistant Attorneys General, four (4) Special Agent Supervisors, two (2) Fraud Analysts, two (2) Nurse Analysts, and two (2) Intake Officers, all since 2009.

While the Unit expected the 2013 expansions to decrease average agent caseloads as did the earlier expansions, in the interim the Unit needed to reallocate additional resources to focus on a patient abuse and institutional neglect investigation initiative. Consequently to date caseloads have not decreased meaningfully. To address this influx of complex cases, the Unit is undertaking a fifth expansion, to include hiring a total of eleven (11) individuals as follows: one (1) Special Agent Supervisor; two (2) Assistant Attorneys General; seven (7) Special Agents; and one (1) Administrative support staff.

While the increases in case intakes have certainly led to commensurate increases in average Agent case loads, the Unit has responded accordingly, avoiding a negative impact on the Unit's ability to timely conduct investigations by regularly expanding the Unit's capabilities. As demonstrated by the graph below, the Unit has posted steady increases in both indictments and convictions during this time.



The Unit's HHS-OIG on-site occurred just as it is poised to affect its fifth expansion. The observations of the on-site staff are consistent with those of Unit management inasmuch as the Unit's active cases have outpaced its ability to quickly hire additional Agents, creating larger average Agent case loads and necessarily increasing the average length of time required to complete a given investigation. That said, Unit management believes that it has responded to these increases in a responsible and deliberate fashion, and has every reason to believe that the pending fifth expansion will have the desired effect, allowing agents to work their cases quickly and efficiently.

4. **The Unit allowed non-Unit personnel to use its vehicles, resulting in unallowable expenditures.**

We concur with the audit finding, and assert that it was an unintentional oversight. By way of background, the Health Care Fraud Section of the Ohio Attorney General's Office ("AGO") is comprised of two (2) units: The Medicaid Fraud Control Unit ("MFCU") and the Workers' Compensation Fraud Unit ("WCFU"). The MFCU has one hundred one (101) employees, while the much smaller WCFU has only eight (8) employees. Both units share space on the 17th floor of the 150 East Gay Street building in Columbus, Ohio. In 2008, the AGO purchased a number of pool vehicles for the Health Care Fraud Section using state-only funds, and made these pool vehicles available to members of both the MFCU and the WCFU. The vehicles in the Health Care Fraud Section fleet were then, and are today, separate and distinct from those in the AGO main fleet. Over time, these vehicles in the Health Care Fraud Section fleet were replaced with new pool vehicles, the acquisition and maintenance of which was funded, in part, by federal grant dollars. However, members of the WCFU continued to use these pool vehicles, unaware of the funding restrictions.

Our independent analysis confirmed the reported one hundred forty-nine (149) reservations by members of the WCFU, and we do not contest either the 20,074 miles or the $11,092 attributed to same. We would note that these one hundred forty-nine (149) reservations represent roughly 1.5% of the nine thousand seven hundred fifty-eight (9,758) vehicle reservations made during time period under review (10/01/10 – 09/30/13). That said, we concur with the audit recommendation. By way of corrective action, we have notified the employees of the WCFU that they are not permitted to use the Section's pool vehicles, and we have locked these employees out of the application by which these vehicles are reserved. As an alternative, we have directed these employees to use only those pool vehicles in the AGO main fleet. We are confident, moving forward, that only MFCU staff will have access to and will use the pool vehicles funded with federal grant dollars.

Thank you for the opportunity to comment. Should you have questions or concerns regarding any of our comments, please feel free to contact me or our Special Agent-In-Charge, Lloyd Early, at the number provided below.

Sincerely,

Mike DeWine
Attorney General

/S/

Keesha R. Mitchell
Section Chief
Health Care Fraud Section
(614) 466-0722

ACKNOWLEDGEMENTS

This report was prepared under the direction of Brian T. Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Michael Barrett served as the project leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Michael J. Brown and Conswelia McCourt. Office of Investigations staff also participated in the review. Central office staff who provided support include Susan Burbach, Kevin Farber, Christine Moritz, and Andrew VanLandingham. Office of Audit Services staff who contributed to this study include Tate Clark, Michael Cullen, and Lee Gibson.

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.