Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

KENTUCKY STATE MEDICAID FRAUD CONTROL UNIT: 2017 ONSITE REVIEW

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EXECUTIVE SUMMARY - KENTUCKY STATE MEDICAID FRAUD CONTROL UNIT: 2017 ONSITE REVIEW
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WHY WE DID THIS STUDY

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

HOW WE DID THIS STUDY

We conducted an onsite review of the Kentucky Unit in January 2017. We based our review on an analysis of data from seven sources: (1) policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) financial documentation for fiscal years (FYs) 2014 through 2016; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) a sample of files for cases that were open in FYs 2014 through 2016; and (7) observation of Unit operations.

WHAT WE FOUND

For FYs 2014 through 2016, the Unit reported 52 criminal convictions; 49 civil judgments and settlements; and combined criminal and civil recoveries of approximately $121 million. Our review found that the Kentucky Unit was generally in compliance with applicable laws, regulations, and policy transmittals. The Unit maintained proper fiscal control of its resources. The Unit collaborated with other government and industry stakeholders to encourage effective referrals of fraud, and appointed an executive advisor to mentor and support staff. We identified one area where the Unit should improve its operations: timeliness of reporting. The Unit did not report all convictions or adverse actions to Federal partners within the appropriate timeframes.

WHAT WE RECOMMEND

We recommend that the Kentucky Unit implement processes to ensure that it reports convictions and adverse actions to Federal partners within the appropriate timeframes. The Unit concurred with our recommendation.

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OBJECTIVES

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

BACKGROUND

The mission of MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse or neglect under State law.[1] The Social Security Act (SSA) requires each State to operate a MFCU, 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 a particular State and the State has other adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.[2] Currently, 49 States and the District of Columbia (States) have MFCUs.[3]

Each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.[4] Unit staff review referrals of provider fraud and patient abuse or neglect to determine their potential for criminal prosecution and/or civil action. In fiscal year (FY) 2016, the 50 Units collectively reported 1,564 convictions; 998 civil settlements and judgments; and approximately $1.9 billion in recoveries.[5, 6]

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

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

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[1] SSA § 1903(q). Regulations at 42 CFR § 1007.11(b)(1) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities.

[2] SSA § 1902(a)(61).

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

[4] SSA § 1903(q)(6); 42 CFR § 1007.13.

[5] Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2016*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2016-statistical-chart.pdf on April 4, 2017.

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

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

[8] 42 CFR § 1007.9(d).

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

MFCU Funding

Each MFCU is funded jointly by its State and the Federal government. Federal funding for the MFCUs is provided as part of the Federal Medicaid appropriation, but it is administered by the Department of Health and Human Services' (HHS) Office of Inspector General (OIG).[10] Each Unit receives Federal financial participation equivalent to 75 percent of its total expenditures, with State funds contributing the remaining 25 percent.[11] In FY 2016, combined Federal and State expenditures for the Units totaled nearly $258 million, $194 million of which represented Federal funds.[12]

Oversight of the MFCU Program

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

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

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

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[9] SSA § 1903(q)(1).

[10] SSA § 1903(a)(6)(B).

[11] Ibid.

[12] Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2016*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on March 28, 2017.

[13] The SSA authorizes the Secretary of HHS to award grants to the Units; (SSA § 1903(a)(6)); the Secretary delegated this authority to the OIG.

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

[15] 77 Fed. Reg. 32645 (June 1, 2012). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf on February 28, 2017.

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

OIG provides additional oversight including the collection and dissemination of performance data, training, and technical assistance.

Kentucky MFCU

The Kentucky Unit is located within Kentucky's Office of the Attorney General and has the authority to investigate and prosecute cases of Medicaid fraud and patient abuse or neglect. To investigate and prosecute such cases, the Unit employs investigators, attorneys, and members of a fraud investigations support team, which includes auditors, healthcare data administrators, and nurse consultants/inspectors. The Unit's management is composed of a director, assistant director/litigation manager, investigator manager, investigator supervisors, and a fraud investigations support team manager.

At the time of our January 2017 onsite review, the Unit's 28 employees were located in 6 offices. The main office is in the State capital, Frankfort, which is where we conducted our onsite review. The Unit's five branch offices are in western Kentucky (Louisville and Bowling Green) and eastern Kentucky (Monticello, Alexandria, and Prestonsburg). The Kentucky Unit spent approximately $3.4 million in combined State and Federal funds in FY 2016.[16]

Referrals. The Unit receives most of its fraud referrals from the State's Cabinet for Health and Family Services (CHFS) OIG and most of its patient abuse and neglect referrals from the Department for Community Based Services (DCBS).[17] The Unit also receives referrals from other sources, such as private citizens and law enforcement agencies. Appendix B lists Unit referrals by source for FYs 2014 through 2016.

Prior to submitting a fraud referral to the Unit, CHFS-OIG conducts a preliminary investigation and meets with the Unit, together with the

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[16] OIG, *MFCU Statistical Data for Fiscal Year 2016*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2016-statistical-chart.pdf on February 22, 2017.

[17] CHFS-OIG is the regulatory and licensing agency for all health care and long-term care facilities and is responsible for the prevention, detection, and investigation of fraud, waste, mismanagement, and misconduct. Accessed at http://chfs.ky.gov/os/oig/ on March 28, 2017. DCBS includes Adult and Child Protection Services. Both agencies are located within CHFS, along with the Department for Medicaid Services (DMS), Kentucky's Medicaid agency.

Department for Medicaid Services (DMS), to discuss potential referrals.[18] Within 1 week after meeting with the Unit, CHFS-OIG refers a list of cases to the Unit. The Unit management decides which referrals, if any, the Unit will accept and open as cases.

The Unit receives referrals of patient abuse and neglect from DCBS through a shared electronic system, from which the Unit downloads every day. When the Unit downloads a referral, an investigations supervisor conducts a preliminary analysis to determine whether a full investigation is warranted. The Unit director and the investigations manager then review the analysis to decide whether to proceed with a full investigation.

Investigations. The Unit uses the following team approach to investigate cases. Once the Unit decides to open a case, the Unit management assigns an investigator, an attorney, and a member of the fraud investigations support team. The Unit management rotates weekly meetings among the Unit's branch offices to discuss the progress and prioritization of cases. Unit policy requires that all investigative activities and team meetings be documented and maintained in the Unit's electronic case-management system. Appendix C illustrates opened and closed investigations by case type for FYs 2014 through 2016.

Previous Onsite Review

In 2010, OIG conducted an onsite review of the Kentucky Unit. OIG found that Unit supervisors did not conduct periodic reviews of investigative case files to monitor the progress of investigations. OIG recommended that the Unit supervisors conduct regularly scheduled reviews of investigative case files and maintain supervisory notes of these reviews. The Unit concurred with these recommendations. Our 2017 onsite review found that Unit supervisors conducted periodic investigative case file reviews.

METHODOLOGY

Data Collection and Analysis

We conducted the onsite review in January 2017. We based our review on an analysis of data from seven sources: (1) policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) financial documentation for FYs 2014 through 2016; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured

[18] According to the MOU between DMS and the Unit, DMS delegated to CHFS-OIG the exclusive authority to conduct preliminary investigations for the Medicaid program for the purpose of detecting, preventing, and substantiating fraud and abuse. Kentucky Revised Statutes 194A.030(1)(c)(1) and 205.8453. DMS also designated CHFS-OIG as the exclusive referral agency.

interviews with the Unit's management; (6) a sample of files for cases that were open in FYs 2014 through 2016; and (7) observation of Unit operations. Appendix D provides details of our methodology.

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.

FINDINGS

For FYs 2014 through 2016, the Kentucky Unit reported 52 criminal convictions; 49 civil judgments and settlements; and combined criminal and civil recoveries of approximately $121 million

For FYs 2014 through 2016, the Unit reported 52 criminal convictions and 49 civil judgments and settlements. Exhibit 1 provides details of the Unit's yearly convictions and civil judgments and settlements. Of the Unit's 52 convictions over the 3-year period, 29 involved provider fraud and 23 involved patient abuse or neglect.

Exhibit 1: Kentucky MFCU Criminal Convictions and Civil Judgments and Settlements, FYs 2014–2016

Outcomes	FY 2014	FY 2015	FY 2016	3-Year Total
Criminal Convictions	19	15	18	52
Civil Judgments and Settlements	19	14	16	49

Source: OIG analysis of Unit-submitted data, 2017.

The Unit reported criminal and civil recoveries of approximately $121 million for FYs 2014 through 2016—ranging from $3.8 million to $69 million over the 3 years (shown in Exhibit 2). During the 3-year review period, "global"[19] cases accounted for 21 percent of the Unit's recoveries.

Exhibit 2: Kentucky MFCU Recoveries and Expenditures, FYs 2014–2016

Type of Recovery	FY 2014	FY 2015	FY 2016	3-Year Total
Global Civil	$4,534,964	$2,511,192	$23,279,694	$30,325,850
Nonglobal Civil	$63,718,239	$853,496	$24,224,083	$88,795,818
Criminal	$1,141,776	$387,035	$130,634	$1,659,445
Total Recoveries	**$69,394,979**	**$3,751,723**	**$47,634,411**	**$120,781,113**
Total Expenditures	$2,989,940	$3,393,619	$3,408,063	$9,791,622

Source: OIG analysis of Unit-submitted data, 2017.

[19] "Global" cases are civil False Claims Act cases that are litigated in Federal courts by the U.S. Department of Justice and involve a group of MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the States. Global cases accounted for 88 of the Unit's 416 cases over the 3-year period.

The Unit did not report all convictions or adverse actions to Federal partners within the appropriate timeframes

The Unit did not report all convictions or adverse actions to OIG and the National Practitioner Data Bank (NPDB) within the appropriate timeframes required by these entities. Performance Standard 8(f) states that the Unit should transmit to OIG reports of all convictions for the purpose of exclusion from Federal health care programs within 30 days of sentencing. Additionally, Federal regulations require that Units report any adverse actions resulting from prosecutions of health care providers to the NPDB within 30 calendar days from the date of the adverse action.[20, 21]

The Unit reported 35 percent of its convictions to OIG after the appropriate timeframes

The Unit reported 35 percent of its convictions (18 of 52) to OIG more than 30 days after sentencing. Exhibit 3 illustrates the number of days after sentencing that the Unit reported these convictions to OIG. Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in improper payments to providers by Medicare or other Federal health care programs or possible harm to beneficiaries.

Exhibit 3: Number of Late Convictions Reported to Federal Partners

Federal Partner Reported To	Convictions or Adverse Actions Reported 1–30 Days Late	Convictions or Adverse Actions Reported 31-60 Days Late	Convictions or Adverse Actions Reported More Than 60 Days Late	Total Convictions or Adverse Actions Reported Late
OIG (Convictions)	8	2	8	18
NPDB (Adverse Actions)	0	3	1	4

Source: OIG analysis of Unit convictions and dates reported to OIG and NPDB, 2017.

The Unit also reported adverse actions to NPDB, but reported 36 percent of these actions later than the 30 days required

As required, the Unit reported 11 adverse actions to the NPDB. However, it reported 4 of these adverse actions more than 30 days after the action occurred. Exhibit 3 illustrates the number of days after the adverse actions

[20] 45 CFR § 60.5. Examples of adverse actions include criminal convictions; civil judgements (but not civil settlements); exclusions; and other negative actions or findings.

[21] Performance Standard 8(g) states that the Unit should report "qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases." The HIPDB and the NPDB were merged during our review period (FYs 2013 through 2015); therefore, we reviewed the reporting of adverse actions under NPDB requirements. See 78 Fed. Reg. 20473 (April 5, 2013).

that the Unit reported them to NPDB. 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. If a Unit fails to report adverse actions to the NPDB, individuals may be able to find new health care employment with an organization that is not aware of the adverse actions made against them.

Unit managers explained that the Unit relied solely on one administrative staff member to report convictions to OIG and adverse actions to the NPDB, which caused delays when that staff member was out of the office or working on other projects.

The Unit maintained proper fiscal control of its resources

The Unit maintained proper fiscal control of its resources during the review period, in accordance with the terms of Performance Standard 11. The Unit's financial documentation indicated that the Unit's requests for reimbursement for FYs 2014 through 2016 represented allowable, allocable, and reasonable costs. In addition, the Unit maintained adequate internal controls relating to accounting, budgeting, personnel, procurement, property, and equipment.

Other observation: The Unit collaborated with other government and industry stakeholders to encourage effective referrals of fraud

The Unit reported several collaborative efforts with DMS, CHFS-OIG, and the five Kentucky managed care organizations (MCOs) to encourage effective referrals of fraud.[22] The Unit stated that these efforts improved the quality, completeness, and timeliness of referrals from these government and industry stakeholders.

The Unit participated in two monthly meetings with DMS and CHFS-OIG. The purpose of the first meeting was to discuss CHFS-OIG's investigations of potential fraud referrals. The Unit reported that these meetings helped ensure that referrals from CHFS-OIG were complete and timely, and assisted the Unit in determining whether to accept or decline a referral.

[22] DMS contracts with MCOs to provide or arrange for healthcare services on a Statewide or community basis. These healthcare services generally include all primary, specialty, and acute medical care. MCOs are paid a fixed prospective payment, referred to as a capitated rate, for each Medicaid beneficiary enrolled with the MCO. MCOs must meet other Federal requirements. See 42 CFR § 438.2.

The Unit reported that the purpose of the second monthly meeting with DMS and CHFS-OIG was to discuss management issues shared across the three agencies, which often included discussion of the referral and investigation processes. For example, the three agencies recently identified ways for streamlining case closings to increase recoupment from inappropriate payments identified during investigations. According to the Unit, these meetings fostered familiarity with how each agency operates, which improved communication and collaboration among the three agencies.

Additionally, the Unit, DMS, and CHFS-OIG met quarterly with representatives from the following: the Special Investigations Units of each of the five Kentucky MCOs; the U.S. Attorneys' Offices; and (often) HHS OIG. These meetings were used to provide training on the elements of an effective referral, discuss potential referrals, and share investigative information and resources. Unit managers reported that the discussion helped MCOs understand the particular information that the Unit needed from the MCOs' investigations, which improved the quality of the referrals. The Unit also reported that the meetings helped identify providers who were under investigation by multiple agencies, which improved collaboration on those cases.

Other observation: The Unit appointed an executive advisor to mentor and support staff

The Unit created a position for an executive advisor, who is appointed at the discretion of the Unit director and approved by the Office of the Attorney General. The executive advisor—currently, an attorney—has a key role in the Unit's training program and supports the Unit by assisting attorneys in developing litigation skills and mentoring new attorneys. The executive advisor also serves as a co-chair on cases, providing input and support to the team in developing the cases.

CONCLUSION AND RECOMMENDATIONS

Our review found that the Kentucky Unit was generally in compliance with applicable laws, regulations, and policy transmittals. For FYs 2014 through 2016, the Unit reported 52 criminal convictions; 49 civil judgments and settlements; and combined criminal and civil recoveries of approximately $121 million. The Unit maintained proper fiscal control of its resources. The Unit collaborated with other government and industry stakeholders to encourage effective referrals of fraud, and appointed an executive advisor to mentor and support staff.

We identified one area in which the Unit should improve its operations: timeliness of reporting. The Unit did not report all convictions or adverse actions to Federal partners within the appropriate timeframes.

We recommend that the Kentucky Unit:

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. Such processes could include designating backup staff to report convictions and adverse actions to Federal partners when the primary staff member for such reporting is out of the office or working on other projects. The Unit could also implement automated reminders that alert the Unit staff to report convictions and adverse actions to Federal partners.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Kentucky Unit concurred with our recommendation. The Unit stated that it has implemented safeguards to ensure that it reports convictions and adverse actions to Federal partners within 30 days of sentencing or adverse action. These safeguards include sending calendar reminders to the employee responsible for reporting convictions to Federal partners, placing the 30-day reporting deadline on the Unit's master calendar, and appointing an additional employee to serve as a backup when the employee responsible for reporting convictions is out of the office or working on other projects. Additionally, the Unit stated that the Unit director and case attorney now monitor the reporting of convictions to ensure that submissions are within the 30-day period.

OIG anticipates that the Unit's planned actions will implement our recommendation. OIG requests that the Unit provide documentation to demonstrate that it has implemented the described actions.

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

APPENDIX A

2012 Performance Standards[23]

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

[23] 77 Fed. Reg. 32645, June 1, 2012.

C. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).
D. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.
E. The Unit provides timely information, when requested, to those agencies identified in (D) above regarding the status of referrals.
F. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.
5. A UNIT TAKES STEPS TO MAINTAIN A CONTINUOUS CASE FLOW AND TO COMPLETE CASES IN AN APPROPRIATE TIMEFRAME BASED ON THE COMPLEXITY OF THE CASES.
A. Each stage of an investigation and prosecution is completed in an appropriate timeframe.
B. Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.
C. Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.
6. A UNIT'S CASE MIX, AS PRACTICABLE, COVERS ALL SIGNIFICANT PROVIDER TYPES AND INCLUDES A BALANCE OF FRAUD AND, WHERE APPROPRIATE, PATIENT ABUSE AND NEGLECT CASES.
A. The Unit seeks to have a mix of cases from all significant provider types in the State.
B. For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.
C. 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.
D. The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.
E. As part of its case mix, the Unit seeks to maintain, consistent with its legal authorities, a balance of criminal and civil fraud cases.
7. A UNIT MAINTAINS CASE FILES IN AN EFFECTIVE MANNER AND DEVELOPS A CASE MANAGEMENT SYSTEM THAT ALLOWS EFFICIENT ACCESS TO CASE INFORMATION AND OTHER PERFORMANCE DATA.
A. Reviews by supervisors are conducted periodically, consistent with MFCU policies and procedures, and are noted in the case file.
B. Case files include all relevant facts and information and justify the opening and closing of the cases.
C. Significant documents, such as charging documents and settlement agreements, are included in the file.
D. Interview summaries are written promptly, as defined by the Unit's policies and procedures.
E. The Unit has an information management system that manages and tracks case information from initiation to resolution.
F. The Unit has an information management system that allows for the monitoring and reporting of case information, including the following:
1. The number of cases opened and closed and the reason that cases are closed.
2. The length of time taken to determine whether to open a case referred by the State Medicaid agency or other referring source.
3. The number, age, and types of cases in the Unit's inventory/docket

4. The number of referrals received by the Unit and the number of referrals by the Unit to other agencies.
5. The number of cases criminally prosecuted by the Unit or referred to others for prosecution, the number of individuals or entities charged, and the number of pending prosecutions.
6. The number of criminal convictions and the number of civil judgments.
7. The dollar amount of overpayments identified.
8. The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of recoveries and the types of relief obtained through civil judgments or 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 MEMORANDUM OF UNDERSTANDING (MOU) WITH THE STATE MEDICAID AGENCY TO ENSURE THAT IT REFLECTS CURRENT PRACTICE, POLICY, AND LEGAL REQUIREMENTS.
A. The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.
B. The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR § 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR § 455.23, "Suspension of payments in cases of fraud."
C. The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).
D. Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.
E. The MOU incorporates by reference the *CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit*.

11. A UNIT EXERCISES PROPER FISCAL CONTROL OVER UNIT RESOURCES.
A. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.
B. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.
C. The Unit maintains an effective time and attendance system and personnel activity records.
D. The Unit applies generally accepted accounting principles in its control of Unit funding.
E. The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.
12. A UNIT CONDUCTS TRAINING THAT AIDS IN THE MISSION OF THE UNIT.
A. The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.
B. The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.
C. Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.
D. The Unit participates in MFCU-related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.
E. The Unit participates in cross-training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

APPENDIX B

Referrals to the Kentucky MFCU by Referral Source for FYs 2014 Through 2016

	FY 2014		FY 2015		FY 2016	
Referral Source	**Fraud**	**Abuse/ Neglect[1]**	**Fraud**	**Abuse/ Neglect**	**Fraud**	**Abuse/ Neglect**
Medicaid agency – PI/SURS[2]	3	0	0	0	1	0
CHFS-OIG	65	7	59	3	94	0
Managed care organizations[3]	18	0	15	0	7	0
State survey and certification agency	1	76	0	53	0	26
Other State agencies	3	1	1	2	1	0
Licensing board	1	0	1	0	0	0
Other law enforcement	2	3	0	2	8	1
HHS OIG	6	1	1	0	1	0
Local prosecutors	2	0	4	1	3	0
Providers	2	0	2	0	2	1
Private health insurers	12	0	0	0	0	0
Department of Community Based Services	17	3,084	16	3,048	0	2,288
Private citizens	13	14	23	17	16	36
MFCU hotline[4]	14	24	NA	NA	NA	NA
Other	34	1	30	18	16	0
Anonymous[5]	NA	NA	0	1	0	0
Total	**193**	**3,211**	**152**	**3,145**	**149**	**2,352**
Annual Total		**3,404**		**3,297**		**2,501**

Source: OIG analysis of Unit Quarterly and Annual Statistical Reports, FYs 2014-2016.
[1] The category of referrals of abuse and neglect includes referrals of misappropriation of patient funds.
[2] The abbreviation "PI" stands for program integrity; the abbreviation "SURS" stands for Surveillance and Utilization Review Subsystem. The Medicaid agency sends all referrals to the State's CHFS-OIG to screen and investigate potential fraud. The Medicaid agency delegated to CHFS-OIG its authority to conduct investigations of the Medicaid program for the purpose of detecting, preventing, and substantiating fraud and abuse. Kentucky Revised Statutes 194A.030(1)(c)(1) and 205.8453.
[3] The managed care organizations sends all referrals to CHFS-OIG to screen and investigate potential fraud. CHFS-OIG meets with the MFCU once a month to discuss these referrals.
[4] The referral source "MFCU hotline" was not a category reported on the FY 2015 and FY 2016 Annual Statistical Reports.
[5] The referral source "Anonymous" was not a category reported on the FY 2014 Quarterly Statistical Reports.

APPENDIX C

Investigations Opened and Closed by the Kentucky MFCU by Case Type for FYs 2014 Through 2016

Case Type	FY 2014	FY 2015	FY 2016	3-Year Total	Annual Average*
Opened	551	117	117	**785**	262
Patient Abuse and Neglect	88	45	40	**173**	58
Provider Fraud	458	72	77	**607**	202
Misappropriation of Patient Funds	5	0	0	**5**	2
Closed	64	129	83	**276**	92
Patient Abuse and Neglect	11	33	47	**91**	30
Provider Fraud	53	96	36	**185**	62
Misappropriation of Patient Funds	0	0	0	**0**	0

Source: OIG analysis of Unit data, 2017.
*Averages in this column are rounded.

APPENDIX D

Detailed Methodology

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

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information 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 annual and quarterly statistical reports, its annual reports, its recertification questionnaire, its manuals of policy and procedures, and its MOU with the State Medicaid agency. We requested any additional data or clarification from the Unit as necessary.

Review of Unit Financial Documentation. We reviewed the Unit's control over its fiscal resources to identify any issues involving internal controls or the use of resources. Prior to the onsite review, we reviewed the Unit's financial policies and procedures; its response to a questionnaire on internal controls; and documents (such as financial status reports) related to MFCU grants.

We reviewed three purposive samples to assess the Unit's internal control of fiscal resources. All three samples were limited to the review period of FYs 2014 through 2016. The three samples included the following:

1. To assess the Unit's expenditures, we grouped related lines in the transaction detail into 3,342 transactions and selected a purposive sample of 30 transactions for additional review.[24] We purposively included transactions from different Federal cost categories and included automated as well as manual journal entries. The dollar amounts of the selected transactions varied, ranging from a $76,677 personnel expenditure to a $105 travel expenditure. Our selections totaled $368,673.9, which were taken from $9,799,401.16 in

[24] The transaction detail reports we selected from included multiple lines relating to activities and accounting entries, which contributed to the Unit's reported expenditures. To determine units for our sample selection, we considered all the lines with the same document identifier as a transaction.

expenditures.[25] We then requested and reviewed documentation supporting the selected transactions.

2. To assess employees' "time and effort"—i.e., their work hours spent on various MFCU tasks—we selected a purposive sample of three pay periods, one from each fiscal year. We then requested and reviewed documentation to support the time and effort of the MFCU staff during the selected pay periods.
3. We also reviewed a purposive sample of the Unit's fixed assets inventory. Specifically, we selected and verified 30 of the 84 items from the Unit's inventory.

Interviews with Key Stakeholders. In December 2016 and January 2017, we interviewed key stakeholders, including officials in the U.S. Attorneys' Offices and State agencies that interacted with the Unit, including the CHFS and the DMS. We also interviewed supervisors from OIG's Region IV, 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 December 2016, we conducted an online survey of the 29 nonmanagerial Unit staff within each professional discipline (i.e., investigators, auditors, attorneys, analysts, and nurse investigators) as well as support staff. Our questions focused on Unit operations, 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 onsite interviews with the Unit's management in January 2017. We interviewed the current and former Unit directors, the litigations manager, the investigations manager, and the fraud investigations support team manager. We asked these individuals to provide information 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, and (4) clarification regarding information obtained from other data sources.

[25] The transaction detail reports totaled to $3.85 less than the total expenditures claimed for the grant period. This was immaterial and likely due to rounding effects over the 3 years.

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 time during FYs 2014 through 2016. We requested data on the 416 cases that included, but were 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. 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 all of those cases from our review of a Unit's case files. Therefore, we excluded 88 cases that were categorized as "global" from the list of cases. The remaining number of case files was 328.

We then selected a simple random sample of 100 cases from the population of 328 cases. From this initial sample of 100 case files, we selected a further simple random sample of 50 files for a more in-depth, qualitative review of selected issues, such as the timeliness of investigations and case development. While onsite, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

Onsite Review of Unit Operations. During our January 2017 onsite visit, we reviewed the Unit's workspace and operations. Specifically, we visited the Unit's main office in Frankfort, Kentucky. While onsite, we observed the Unit's offices and meeting spaces; the security of data and case files; the location of select equipment; and the general functioning of the Unit.

Data Analysis

We analyzed data to identify any opportunities for improvement and instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.[26]

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

APPENDIX E

Unit Comments

COMMONWEALTH OF KENTUCKY
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September 12, 2017

Deputy Inspector General Sue Murrin
Department of Health and Human Services
Office of the Inspector General
Room 5660, Cohen Building
330 Independence Avenue, SW
Washington, D.C. 20201

Re: Kentucky State Medicaid Fraud Control Unit: 2017 Onsite Review
OEI-06-17-00030

Dear Deputy Murrin:

Thank you for the time and energy devoted by members of Health and Human Services, Office of the Inspector General, in conducting the On-Site Review of the Kentucky Office of Medicaid Fraud and Abuse.

We are very proud of the initial results of the Review. Our 52 criminal convictions and recoveries of approximately $121 million over the last three fiscal years have made the Commonwealth of Kentucky a safer place for Medicaid recipients and has sent a clear message that fraud will not be tolerated. We further appreciate your recognition that the Office maintained proper fiscal control and collaborated with other governmental units and stakeholders to better combat fraud.

While I am proud of the work performed by the Office of Medicaid Fraud and Abuse, I acknowledge that while all convictions were ultimately reported to HHS/OIG or the National Practitioner Data Bank (NPDB), a minority of the convictions were not reported within the required thirty-day period. Therefore, we concur with the recommendations outlined in the draft report and have initiated measures to prevent this from occurring in the future.

The Office discovered the reporting issue after our Attorney General transition in 2016, and we immediately implemented safeguards to ensure that convictions and adverse actions are reported within thirty days of sentencing. These safeguards include a calendar invitation that is sent on the day of the conviction to the employee responsible for reporting the convictions to HHS/OIG and NPDB. The deadline is also placed on the unit master calendar. Within a week of sentencing on a state case, the unit paralegal contacts the court if the judgment has not been

received and continuously renews the request until it is obtained. The unit paralegal also checks Pacer and will contact the prosecuting Assistant United States Attorney to determine the status if the case is prosecuted federally.

In addition to the employee who submits the convictions to HHS/OIG and NPDB, the Executive Director and case attorney now monitor the reporting to ensure submission within the thirty-day period. Finally, when a case is submitted for closure, the Executive Director reviews the cases that were litigated to verify that the conviction or civil settlement was reported. As an additional safeguard, the office has appointed an additional employee to serve as a back-up for times that the employee who reports the convictions is out of the office or working on other projects and unable to report the conviction or adverse action within thirty days of sentencing.

It is important to note that a portion of the cases that were not reported were the result of a misunderstanding of the obligation to report cases investigated with federal agencies and prosecuted federally. A former director understood information that was provided at a Director's Symposium to mean that cases that were prosecuted federally were to be reported by the HHS agent involved in the investigation or the U.S. Attorney's Office prosecuting the case, and not the state Medicaid Fraud and Abuse Control Unit. As a result, many of the cases that fall within this category were not reported by the office. During the HHS/OIG On-Site Review, the current Executive Director learned that the office's understanding was incorrect. After receiving this clarification, the office worked with HHS/OIG to retroactively report the federal convictions.

Please feel free to contact me if I can provide any additional information.

Sincerely,

Andy Beshear
Attorney General

ACKNOWLEDGMENTS

Anthony Soto McGrath served as the team leader for this study. Others in the Office of Evaluation and Inspections who conducted the study include Ben Gaddis and Jamila Murga. Medicaid Fraud Policy and Oversight Division staff who participated in the review include Frantzy Clement. Staff from the Office of Investigations and Office of Audit Services also participated in the review. Central office staff who provided support include Kevin Farber and Christine Moritz.

This report was prepared under the direction of Ruth Ann Dorrill, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and Amy Ashcraft and Petra Nealy, Deputy Regional Inspectors General, and in consultation with 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.

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