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Nevada Medicaid
Fraud Control
Unit: 2018 Onsite
Inspection

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Nevada Medicaid Fraud Control Unit: 2018 Onsite Inspection

What OIG Found

We found that during fiscal years (FYs) 2015–2017, the Nevada Medicaid Fraud Control Unit (MFCU or Unit) generally operated in accordance with applicable laws, regulations, policy transmittals, and the MFCU performance standards. However, from the data we reviewed, we identified three areas in which the Unit should improve its adherence to performance standards:

1. The Unit did not maintain approved staffing levels because of air contamination in the workspace, and it declined to fill vacant positions until this issue was resolved.
2. The Unit investigated few cases of patient abuse or neglect.
3. The Unit did not maintain an annual training plan.

What OIG Recommends

To address the three findings, we recommend that the Unit:

1. Fill vacant positions now that the Unit is in a temporary workspace and continue to ensure that the Unit has a safe and adequate work environment.
2. Continue to take steps to increase the number of investigations of patient abuse and neglect.
3. Establish an annual training plan covering all professional disciplines within the Unit.

Unit Case Outcomes

FYs 2015–2017

- 43 indictments
- 42 convictions
- 27 civil settlements and judgments
- \$11.7 million in recoveries

Unit Snapshot

The Unit is part of the Office of the Nevada Attorney General.

The Unit has a total of 16 employees, with 12 employees in its Las Vegas office and 4 employees in its Carson City office.

Why OIG Did This Inspection

The Office of Inspector General (OIG) administers the MFCU grant awards, annually recertifies each Unit, and oversees the Unit's performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic onsite reviews of Units and prepares public reports.

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BACKGROUND

Objective

To examine the performance and operations of the Nevada State Medicaid Fraud Control Unit (MFCU or Unit)

Medicaid Fraud Control Units

The function of MFCUs is to investigate Medicaid provider fraud and patient abuse or neglect in facility settings, and to prosecute those cases under State law or refer them to other prosecuting offices.¹ Under the Social Security Act (SSA), a MFCU is a “single, identifiable entity of State government” and must be “separate and distinct” from the State Medicaid agency and employ one or more investigators, attorneys, and auditors.² Each State must operate a MFCU or receive a waiver.³ MFCUs operate in 49 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.⁴

Each Unit receives a Federal grant award equivalent to 75 percent of total expenditures.⁵ In fiscal year (FY) 2018, combined Federal and State expenditures for the Units totaled approximately \$294 million, with a Federal share of \$220.5 million.⁶

OIG Grant Administration and Oversight of the MFCUs

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.⁷ As part of its oversight, OIG reviews and recertifies each Unit annually. The recertification review consists of examining the following, which are collectively referred to as “recertification data”: the Unit’s annual report; questionnaire responses from the Unit’s director and stakeholders; and annual case statistics.

Through the recertification review, OIG assesses a Unit’s performance, as measured by the following: its adherence to published performance

¹ SSA § 1903(q)(3). Regulations at 42 CFR § 1007.11(b)(1) add that the Unit’s responsibilities may include reviewing complaints of misappropriation of patients’ private funds in residential health care facilities.

² SSA § 1903(q).

³ SSA § 1902(a)(61).

⁴ The State of North Dakota and the territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

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

⁶ OIG analysis of FY 2018 MFCU annual statistical reporting data.

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

standards;⁸ its compliance with applicable laws, regulations, and OIG policy transmittals;⁹ and its case outcomes. See Appendix A for MFCU performance standards, including performance indicators for each standard.

OIG further assesses a Unit's performance by periodically conducting onsite reviews of each Unit that may identify findings and make recommendations for improvement. During the onsite review, OIG may also make observations of Unit operations and practices, including identifying beneficial practices. In addition, OIG provides training and technical assistance to Units, as appropriate, both during onsite reviews and on an ongoing basis.

Nevada MFCU

The Nevada MFCU is part of the Bureau of Criminal Justice within the Nevada Attorney General's Office. The Nevada MFCU has one office in Las Vegas and another in Carson City, the State capital. The MFCU has the authority to investigate and prosecute Medicaid fraud and patient abuse and neglect. In May 2018, the Unit had 16 employees: 3 attorneys (including the Director and the Deputy Director), 8 investigators (including 3 supervisors), 2 auditors, and 3 support staff. The Unit Director and 11 employees were located in the Las Vegas office. Four additional employees were located in Carson City. During our review period of FYs 2015–2017, the Unit spent approximately \$6.1 million (with a State share of approximately \$1.5 million).

Referrals. The Unit receives fraud referrals from private citizens, providers, and other sources. As of October 2018, the State Medicaid program requires managed care organizations (MCOs) to make referrals of suspected fraud directly to the Unit and send copies of the referrals to the State Medicaid program integrity unit, referred to as the Surveillance and Utilization Review unit. The Unit receives most of its referrals of patient abuse and neglect from other State agencies—such as the Bureau of Health Care Quality and Compliance and the Nevada Aging and Disability Services Division—and from private citizens.^{10, 11}

⁸ MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012). The performance standards were developed by OIG, in conjunction with the MFCUs, and were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

⁹ OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals may be found at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>.

¹⁰ The Division of Public and Behavioral Health, Health Facilities. This webpage describes the Bureau of Health Care Quality and Compliance, which licenses medical and other health facilities in Nevada. Accessed at http://dpbh.nv.gov/Reg/HealthFacilities/HealthFacilities_-_Home/ on April 23, 2019.

¹¹ The Nevada Aging and Disability Services Division, Elder Protective Services. This webpage describes elder protective services, which are for persons over 60 years old who may experience abandonment, abuse, neglect, or exploitation. Accessed at http://adsd.nv.gov/Programs/Seniors/EPS/EPS_Prog/ on March 28, 2019.

When the Unit receives a referral, Unit staff enter the referral into the Unit's electronic case file system. On a biweekly basis, a referral team, consisting of the Unit Director, the Senior Deputy Attorney General, and the Deputy Chief Investigator, reviews the referrals and determines whether to open an investigation or refer them to another agency. See Appendix B for numbers of Unit referrals by source for FYs 2015–2017.

Investigations. Once the Unit decides to accept a referral, it conducts a preliminary investigation, during which the Unit Director or another member of the referral team determines whether to accept the case as a field project or a full investigation. Field projects are designed to serve one of two purposes: (1) to obtain additional information about a referral, such as supporting documentation or responses from individuals involved in the case; or (2) to educate providers regarding relatively minor allegations of Medicaid fraud, abuse, or neglect and deter them from any future questionable actions. If the Unit determines that an allegation involves a monetary overpayment and not fraud, the Unit will refer the matter to the State Medicaid agency for collection.

If the Unit opens a full investigation, the MFCU Director or another member of the referral team assigns an investigative team to the case.

An investigative team consists of an investigator, an attorney, and (if necessary) an analyst. The investigative team develops an investigative plan within 5 days of the case opening and assigns key tasks to the team members. The Unit uses a combination of shared network drives and its electronic case file system to manage and store all case records—including opening documentation, interviews, summaries, case file reviews, and closing requests.

Prosecutions. The Nevada MFCU has Statewide authority to criminally prosecute Medicaid fraud and patient abuse or neglect. If a case is not within the Unit's prosecutorial authority, the MFCU typically refers it to another division of the State Attorney General's Office, OIG, or the appropriate U.S. Attorney's Office (Northern or Southern Districts of Nevada). The Unit also works with the U.S. Attorneys' Offices on criminal and civil fraud cases.

Nevada Medicaid Program

The Nevada Department of Health and Human Services' Division of Health Care Financing and Policy (DHCFP) administers the State Medicaid program. In FY 2017, the Nevada Medicaid program enrolled an average of 203,334 beneficiaries per month in fee-for-service Medicaid, and an average of 466,404 beneficiaries per month in managed care organizations

(MCOs).¹² In FY 2018, total program expenditures were approximately \$4.1 billion.¹³

Prior OIG Report

OIG conducted a previous onsite review of the Nevada Unit in 2012. In that review, OIG found that (1) Unit professional staff (including attorneys, investigators, auditors, and managers) occasionally performed non-Unit duties and that the associated costs were not subtracted from claimed Unit expenditures; (2) the Unit's policies and procedures manual had not been updated to reflect Unit operations, and the Unit's memorandum of understanding (MOU) with DHCFP did not reflect current law and practice; (3) the Unit did not always comply with the MOU provisions; and (4) although the Unit maintained proper fiscal control of its resources, it incorrectly claimed indirect costs.

OIG recommended that the Unit (1) ensure that its professional staff perform duties exclusively related to Unit operations; (2) revise its policies and procedures manual to reflect current Unit operations; (3) revise its MOU with DHCFP to reflect current law and practice; (4) ensure that DHCFP consistently receives Unit case information in a timely manner; and (5) ensure that indirect costs are claimed correctly.

In response to the recommendations, the Unit (1) ceased duties unrelated to MFCU operations and refunded OIG for unallowable personnel costs; (2) initiated periodic reviews of its policies and procedures manual to ensure that it reflected current Unit operations; (3) worked with DHCFP to revise the MOU; (4) incorporated measures to ensure that DHCFP received Unit case information in a timely manner; and (5) worked with OIG to ensure that indirect costs were claimed accurately. On the basis of the information received from the Unit, OIG considered these recommendations to be implemented.

Methodology

We conducted our onsite review in May 2018. Our review covered the 3-year period of FYs 2015–2017. We analyzed data from eight sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's managers and selected staff; (5) a survey of Unit staff; (6) a review of a random sample of 76 case files for cases that were open at some point during the review period; (7) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (8) observations of Unit operations. See Appendix C for a detailed methodology. In examining the Unit's operations and performance, we

¹² Medicaid MCO enrollment data provided to OIG by DHCFP.

¹³ OIG, *MFCU Statistical Data for Fiscal Year 2018*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2018-statistical-chart.pdf on March 28, 2018.

Standards

applied the published performance standards listed in Appendix A, but did not consider every performance indicator for every standard.

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program, but they are subject to the same internal quality controls as other OIG evaluations, including peer review.

PERFORMANCE ASSESSMENT

We reviewed the Nevada Unit's compliance with applicable laws, regulations, and policy transmittals, as well as its adherence to each of the MFCU performance standards. For this review, we made observations about the Unit's case outcomes, identified opportunities for improvement, and made observations regarding the Unit's adherence to each of the performance standards.

CASE OUTCOMES

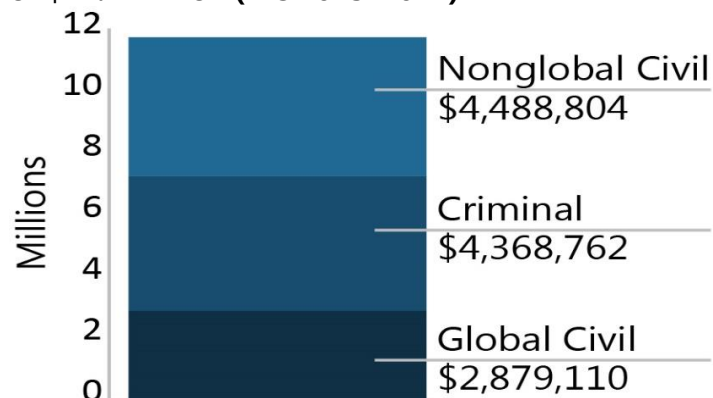
Observation

For FYs 2015–2017, the Unit reported **43 indictments; 42 convictions; and 27 civil settlements and judgments**. Of the 42 convictions, 41 involved provider fraud and 1 involved patient abuse and neglect.



Additionally, the Unit reported total recoveries of \$11.7 million for FYs 2015–2017. See Exhibit 1 for the source of the recoveries.

Exhibit 1: The Unit reported combined civil and criminal recoveries of \$11.7 million (FYs 2015–2017)



Source: OIG analysis of Unit statistical data from FYs 2015–2017.

Note: "Global" civil cases are False Claims Act cases that are litigated in Federal court by the U.S. Department of Justice and typically involve a group of MFCUs.

STANDARD 1

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

Observation

From the data we reviewed, the Nevada Unit generally complied with applicable laws, regulations, and policy transmittals. We did not identify any legal or compliance concerns related to Unit operations.

STANDARD 2

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

Finding

The Unit did not maintain approved staffing levels because of air contamination in the workspace, and it declined to fill vacant positions until this issue was resolved. According to Performance Standard 2(e), Unit offices should be adequately staffed commensurate with the volume of case referrals and workload for each office. The OIG-approved staffing level for the Unit is 19 employees, but the Unit declined to fill 2 vacant positions in its Las Vegas office, which at the time of our review was located in the Grant Sawyer State building.¹⁴ According to Unit management, staff, and the documentation we reviewed, air contamination in this building significantly disrupted Unit operations and had caused health issues for Unit staff for more than 3 years. Because of the impact of this health hazard on Unit staff and operations, Unit management decided not to fill the vacant positions in the Unit's Las Vegas office while it was ongoing. The air-contamination issue appeared to have been resolved after the conclusion of our onsite review.

Timeline of Air Quality Testing in the Grant Sawyer State Building

January 2016

- The Nevada Public Works Division (PWD) conducts internal environmental test, identifying leaks in air conditioning system.

September 2017

- PWD hires consultants to conduct air quality test, identifying yellow dust containing isocyanate particles.

December 2017

- PWD hires an external expert to conduct another air quality test, identifying mold in the air and on surfaces.

In 2015, Unit staff reported that they began experiencing symptoms of air contaminants (e.g., fatigue, headaches, and skin irritation) when working inside the Grant Sawyer State building. For one employee, the adverse reactions led to short-term hospitalization. Over the next 3 years, the Public Works Division (PWD)—the Nevada agency responsible for State buildings and facilities—conducted three separate air quality tests with varied results, finding yellow dust with isocyanate particles as well as finding mold. Exposure to isocyanate particles can cause asthma, skin irritation, and eye irritation.

At the time of our review, 6 of the 12 Las Vegas MFCU employees had been teleworking full-time for the preceding 9 months because of the unhealthy working conditions in the building. Although half of the employees were teleworking, the Unit maintained its office space in the Grant Sawyer State building to store documents (e.g., evidence for case files); to connect remotely to the Unit's computer systems and network; and to use shared

¹⁴ The Unit had another vacant position in its Carson City office.

office equipment, such as copiers. Because the Unit was not set up or prepared for telework—lacking both telework policies and experience—it initially found the telework arrangement to be challenging. In particular, Unit management and staff noted that they did not have a common workspace to discuss investigations, exchange information, and conduct supervisory reviews of cases. They also stated that the lack of a common workspace affected team cohesiveness. However, staff reported maintaining a strong morale despite these challenges.

In September 2018, the Attorney General’s Office granted the MFCU’s request to relocate to a temporary office in another State building, and the lease for this temporary office was set to expire in May 2019. In December 2018, the Unit Deputy Director informed OIG that the Attorney General’s Office was searching for a permanent space for the Unit. The Unit Deputy Director also reported that since moving out of the Grant Sawyer State building, the Unit had hired a new attorney and started the hiring process for two investigators.¹⁵ These three hires (once the latter two were completed) would bring the Unit to its approved staffing levels.

STANDARD 3

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

Observation

The Unit maintained written policies and procedures. The Unit maintained its own policies and procedures manual, which it updated in January 2018. This manual included general guidelines on the Unit roles and responsibilities of Unit staff as well as specific procedures related to processing referrals; opening and closing cases; outreach and collaboration with Federal and State partners; and case management.

The Unit also reported using policy manuals of the Nevada Attorney General’s Office, such as an investigations policy manual for general law enforcement matters and supplemental policy manuals for attorneys and support staff. (The latter manuals provide guidance for MFCU staff on performing certain tasks and assignments.) Additionally, the Unit reported that for its internal fiscal controls and accounting matters, it used the Office of the State Controller’s manual on accounting policies and procedures.

¹⁵ After our onsite review, the Unit Director and a support staffer retired. The Unit prioritized filling these two positions before hiring new staff for the two existing vacant investigative positions.

STANDARD 4

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

Observation

The Unit conducted outreach to encourage referrals. The Unit took steps to increase the volume and quality of referrals through a number of outreach efforts. The Unit reported that it had regular meetings and contact with agencies, prosecutors, and law enforcement across the State to encourage referrals. For example, the Unit reported communicating with the Surveillance and Utilization Review unit (the State Medicaid program integrity unit); the Nevada Aging and Disability Services Division; and MCOs, among others, to encourage referrals.

During FYs 2015–2017, the Unit received a total of 926 referrals—290 referrals in FY 2015, 289 referrals in FY 2016, and 347 referrals in FY 2017. Of these referrals, 86 percent were related to fraud, and the remaining 14 percent were related to patient abuse or neglect. See Appendix B for numbers of Unit referrals by source for FYs 2015–2017.

STANDARD 5

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

Observation

Unit case files generally contained supervisory approval of case openings and closings. According to Performance Standard 5(b), supervisors should approve the opening and closing of all investigations, 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. Our review found that the case files generally contained supervisory approval of case openings and closings. An estimated 83 percent of cases were closed at the time of our review. Of these closed cases, we estimate that 3 percent lacked supervisory approval to close the case. An estimated 66 percent of cases were open longer than 90 days and thus subject to periodic supervisory reviews. All Unit case files that we reviewed for cases that were open longer than 90 days received periodic supervisory reviews. See Appendix D for confidence intervals for the point estimates derived from our review of case files.

STANDARD 6

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

Finding

The Unit's caseload included a broad mix of provider types. At the end of FY 2017, the Unit's cases were distributed among more than 40 provider types, including hospitals, nursing homes, hospices, pharmacies, physicians, dentists, and mental health providers.

Observation

The Unit investigated few cases of patient abuse or neglect. According to Performance Standard 6, the Unit's case mix should include a balance of fraud and patient abuse or neglect cases, where appropriate. During FYs 2015–2017, the Unit investigated a total of only 12 cases of patient abuse or neglect (4 cases in each year), representing approximately 1 percent of the 919 cases that the Unit opened during the review period. This was a decrease from the previous 3-year period (FYs 2012–2014), during which the Unit investigated a total of 39 cases of patient abuse or neglect, representing 13 percent of the 294 cases it opened during that period. Moreover, only 2 percent of the Unit's criminal convictions during our review period—1 of 42 convictions—involved patient abuse or neglect, compared to 14 percent (6 of 42 convictions) during the previous 3-year period (FYs 2012–2014).

Unit staff attributed the low number of investigations involving patient abuse or neglect to the challenges the Unit experienced in obtaining quality referrals from State partners. For example, staff explained that many of the referrals that the Unit receives—such as those involving exploitation of funds in a private setting—were not within the Unit's grant authority. The Unit reported taking steps to increase its visibility and generate more referrals of patient abuse and neglect. For example, the Unit reported that it had begun providing trainings to skilled nursing facilities, the Senior Medicare Patrol, and Elder Protective Services about when and how to refer allegations of patient abuse or neglect to the Unit.¹⁶ The Unit also provided trainings to the Bureau of Health Care Quality and Compliance and to the Division of Health Care Financing and Policy (which administers the State Medicaid program) to explain its role as a law enforcement agency that investigates and prosecutes cases of patient abuse and neglect.

¹⁶ The Senior Medicare Patrol program is part of the Nevada Department of Health and Human Services, Aging and Disability Services Division, and assists Medicare beneficiaries, their families, and caregivers to prevent, detect, and report healthcare fraud, errors, and abuse through outreach, counseling, and education.

STANDARD 7

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

Observation

The Unit maintained case files in an effective manner. According to Performance Standard 7(e), the Unit should have an information management system that manages and tracks case information from initiation to resolution. The Unit used an electronic case file system to record and track information for both civil and criminal cases; however, it did not store all case information in this system. For example, for civil cases, the Unit recorded opening and closing dates and monetary amounts from settlements in the electronic case file tracking system, but it maintained case documents on a separate secured shared folder on the Attorney General's network. Although we determined that the Unit maintained case information appropriately using both systems, we provided the Unit with technical assistance to further enhance its electronic case file system.

STANDARD 8

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

Observation

The Unit maintains a positive working relationship with Federal agencies, including OIG and U.S. Attorneys' Offices. OIG agents have regular communication with Unit investigators and reported a positive working relationship with Unit staff. The U.S. Attorneys' Offices also reported regular communication with the Unit—both informally and as part of a Health Care Fraud Task Force—and described the relationship as effective. Recent areas of collaboration included opioid and behavioral health cases.

Observation

The Unit reported convictions and adverse actions to Federal partners within the appropriate timeframes. Standard 8(f) states that the Unit should transmit to OIG all pertinent information on convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders, for purposes of exclusion from Federal health care programs. The Unit transmitted all 42 convictions to OIG either within 30 days of sentencing or within 1 day of receiving pertinent information from the court. Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in improper payments to providers by Medicaid or other Federal health care programs or possible harm to beneficiaries.

Similarly, the Unit reported 38 adverse actions to NPDB within 30 days after the final action occurred. Federal regulations require Units to report any adverse actions resulting from investigations or prosecution of healthcare

providers to the NPDB within 30 calendar days of the date of the final adverse action.¹⁷ Examples of final adverse actions include convictions, civil judgments (but not civil settlements), and program exclusions.

STANDARD 9

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

Observation

The Unit made recommendations regarding program deficiencies to the State Medicaid agency. The Unit informed the DHCFP of Medicaid program deficiencies that MFCU investigations had identified. The Unit made recommendations and conducted followup through regular phone and email communication with the Surveillance and Utilization Review unit (DHCFP's program integrity unit). For example, the Unit proposed amendments to the Medicaid Services Manual to stop improper billing practices for rehabilitative mental health providers and to close a loophole in policy where certain case management services were not covered under the Medicaid Services Manual. The Unit also recommended revisions to billing edits for certain types of case management services that were consistently billed for the maximum allowable amount.

STANDARD 10

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

Observation

The Unit's MOU with the State Medicaid agency reflected current practice, policy, and legal requirements. The Unit and DHCFP had a current MOU, most recently amended in February 2017.

STANDARD 11

A Unit exercises proper fiscal control over its resources.

Observation

The Unit maintained proper fiscal control of its resources during our review period. Our review of the Unit's financial documentation indicated that the Unit's requests for reimbursement for FYs 2015–2017 represented allowable, allocable, and reasonable costs. Further, we identified no internal control issues related to the Unit's accounting, budgeting, personnel, property, or equipment.

STANDARD 12

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

Finding

The Unit did not maintain an annual training plan. According to Performance Standard 12, the Unit should maintain a training plan covering all professional disciplines that includes an annual minimum number of training hours. Although the Unit reported that all staff regularly attended

¹⁷ 45 CFR § 60.5. See also SSA § 1128E(g)(1) and 45 CFR § 60.3.

training paid for by the Unit—such as the National Association of Medicaid Fraud Control Units’ annual training—the Unit did not require a minimum number of training hours for each professional discipline. In August 2018, the Unit Director informed OIG that the Unit had begun working on an annual training plan for its employees.

CONCLUSION AND RECOMMENDATIONS

For FYs 2015–2017, the Nevada Unit reported 43 indictments; 42 convictions; 27 civil settlements and judgments; and combined criminal and civil recoveries of \$11.7 million.

From the data we reviewed, we found that the Unit generally adhered to applicable legal requirements and performance standards, but we identified three areas in which the Unit should improve its adherence to program requirements: (1) the Unit did not maintain OIG-approved staffing levels because of air contamination in the workspace; (2) the Unit investigated few cases of patient abuse or neglect; and (3) the Unit did not maintain an annual training plan for its professional staff. We recommend that to address these findings, the Nevada Unit:

Fill vacant positions now that the Unit is in a temporary workspace and continue to ensure that the Unit has a safe and adequate work environment

Now that the Unit has relocated to a temporary workspace, it should continue to fill its vacant positions. The Unit should also continue to work with the Nevada Attorney General’s Office to identify and maintain a permanent workspace free of air contaminants and other health hazards. A safe working environment is a basic necessity that will help the Unit recruit and retain staff and ensure that it has appropriate staffing levels. OIG will continue to monitor this situation to ensure that Unit staff can perform their activities in a safe and adequate workspace.

Continue to take steps to increase the number of investigations of patient abuse and neglect

The Unit should increase the number of investigations of patient abuse and neglect. This could include (as appropriate) opening more investigations from referrals that the Unit receives through trainings and outreach efforts. The Unit conducts trainings—intended to help boost referrals—for the Bureau of Health Care Quality and Compliance and for the Division of Health Care Financing and Policy. The Unit could also assess and (as needed) revise its referral process using information it obtains during these trainings. Additionally, the Unit could coordinate with other stakeholders, such as the Long-Term Care Ombudsman, to increase the quality and number of referrals.

Establish an annual training plan covering all professional disciplines within the Unit

The Unit should establish formal training plans for each professional discipline that include the type and duration of training (e.g., number of hours) that employees are expected to complete each year. The Unit could

work with the National Association of Medicaid Fraud Control Units or OIG to identify additional relevant training opportunities for staff.

UNIT COMMENTS AND OIG RESPONSE

The Nevada Unit concurred with all three of our recommendations.

The Unit concurred with our first recommendation (for it to fill vacant positions). The Unit reported that it is in the process of obtaining a permanent workspace, and that it will fill the vacant positions once it moves into the new workspace. The Unit expects to do this in the summer of 2019.

The Unit concurred with our second recommendation (for it to continue to take steps to increase its number of investigations of patient abuse and neglect). The Unit reported that it is using its outreach program—Project SNF—to increase the number of patient abuse and neglect referrals it receives. The Unit also reported using other means to increase referrals, including meeting with the State licensing agency and local law enforcement and providing trainings to the Bureau of Health Care Quality and Compliance. The Unit stated that it will continue to work with local law enforcement, the local District Attorney's Office, and OIG to identify ways to increase referrals of patient abuse or neglect.

The Unit concurred with our third recommendation (for it to establish an annual training plan covering all professional disciplines within the Unit). The Unit reported that it has obtained samples of training plans that another MFCU uses. The Unit will update its current training plan to reflect the minimum number of training hours for each professional discipline in the Unit. The Unit also reported that it will ensure that staff are provided with opportunities to attend trainings provided by the National Association of Medicaid Fraud Control Units.

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

APPENDIX A: MFCU Performance Standards¹⁸

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;¹⁹
- D) OIG policy transmittals as maintained on the OIG website; and
- E) Terms and conditions of the notice of the grant award.

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

- A) The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
- B) The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
- C) The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
- D) The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
- E) To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.

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

- A) The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.
- 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

¹⁸ 77 Fed. Reg. 32645, June 1, 2012.

¹⁹ For FYs 2016 and later, grant administration requirements and cost principles are found at 45 CFR part 75.

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 providers types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

- A) The Unit seeks to have a mix of cases from all significant provider types in the State.
- B) For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.

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- C) The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.
 - D) As part of its case mix, the Unit maintains a balance of fraud and patient abuse and neglect cases for those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases.
 - E) As part of its case mix, the Unit seeks to maintain, consistent with its legal authorities, a balance of criminal and civil fraud cases.

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

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

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

- A) The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.
- B) The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly,

case involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.

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

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

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

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

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

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- E) The MOU incorporates by reference the *CMS Performance Standard for Referrals of Suspected Fraud From a State Agency to a Medicaid Fraud Control Unit*.

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

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

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

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

APPENDIX B: Unit Referrals by Source for Fiscal Years (FYs) 2015–2017

Referral Source	FY 2015		FY 2016		FY 2017	
	Fraud	Abuse or Neglect	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect
Nevada Aging and Disability Services Division	1	2	0	2	0	3
Anonymous	5	0	3	0	4	0
HHS-Office of Inspector General (OIG)	6	2	3	2	2	0
Licensing Board	1	0	3	0	1	1
Local Prosecutor	2	0	0	0	0	0
Long-Term Care Ombudsman	0	1	1	0	0	0
Managed Care Organizations	0	0	0	0	9	0
Medicaid Agency–PI/SURS ¹	7	1	5	1	15	0
Medicaid Agency–Other	1	0	2	0	1	1
Other Law Enforcement	13	7	12	4	19	4
Private Citizen	115	10	87	17	99	14
Provider and Provider Association	29	1	43	4	45	1
State Agency–Other	19	1	14	7	13	42
State Survey and Certification	0	0	0	1	0	0
Other	66	0	76	2	73	0
Total (By Type of Case)	265	25	249	40	281	66
Totals (For Each Fiscal Year)	290		289		347	

Source: OIG analysis of Unit Quarterly and Annual Statistical Reports, FYs 2015–2017.

¹ The abbreviation "PI" stands for program integrity; the abbreviation "SURS" stands for Surveillance and Utilization Review Subsystem.

APPENDIX C: Detailed Methodology

Data Collection and Analysis

We collected and analyzed data from the eight sources below to identify any opportunities for improvement and instances in which the Unit did not adhere to the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.²⁰ We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards.

Review of Unit Documentation. Prior to the onsite review, we analyzed the Unit's recertification data for FYs 2015–2017, including (1) the annual reports, (2) the Unit Director's recertification questionnaires, (3) the Unit's MOU with the State Medicaid agency, (4) the Program Integrity Director's questionnaires, and (5) the OIG Special Agent-in-Charge questionnaires. We also reviewed the Unit's self-reported annual statistical reports about case outcomes for FYs 2015–2017. We reviewed the 2012 OIG onsite review recommendations and the Unit's implementation of those recommendations. Finally, we reviewed the Unit's policies and procedures.

Review of Unit Financial Documentation. To evaluate internal control of fiscal resources, we reviewed policies and procedures related to the Unit's budgeting, accounting systems, cash management, procurement, property, and staffing. We reviewed records in the Payment Management System (PMS)²¹ and revenue accounts to determine the accuracy of the Federal Financial Reports (FFRs) for FYs 2015–2017. We also obtained the Unit's claimed grant expenditures from its FFRs and the supporting schedules.

We selected three purposive samples to assess the Unit's internal control of fiscal resources. The three samples included the following:

1. To assess the Unit's expenditures, we selected 31 transactions totaling \$64,642²² within the direct cost categories across the 3-year review period. We reviewed supporting documentation to determine whether

²⁰ All relevant regulations, statutes, and policy transmittals are available online at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>.

²¹ The PMS is a grant payment system operated and maintained by the Department of Health and Human Services, Program Support Center, Division of Payment Management. The PMS provides disbursement, grant monitoring, reporting, and case management services to awarding agencies and grant recipients, such as MFCUs.

²² The transaction detail included multiple lines relating to accounting entries that comprised the reported expenditures. We selected 31 transactions from Federal cost categories, which contained 7,000 transactions.

the costs claimed were allowable, allocable, and reasonable, in accordance with Federal regulations.

2. To assess inventory, we selected and verified 10 items from the current inventory list of 69 fixed assets.
3. To assess employee time and effort, we reconciled Unit payroll registers to payroll expenditures. We then reviewed timecard records from five pay periods across the 3-year review period for eight Unit employees on staff.²³

Interviews with Key Stakeholders. In March and April 2018, we interviewed key stakeholders, including officials in the Nevada Department of Health and Human Services' Aging and Disability Services Division; the Division of Health Care Financing and Policy, the Surveillance and Utilization Review Unit; and the U.S. Attorneys' Offices. We also interviewed the supervisor from OIG's Office of Investigations' Region IX who interacts regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities, as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Onsite Interviews with Unit Management. We conducted structured onsite interviews with the Unit's management in May 2018. We interviewed the Unit Director, Chief Attorneys, and the Deputy Chief Investigator. We asked about Unit operations; Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; opportunities for the Unit to improve its operations and/or performance; and clarification regarding information obtained from other data sources.

Survey of Unit Staff. In April 2018, we conducted an online survey of 13 Unit staff members within the professional disciplines (i.e., investigators, auditors, and attorneys) and support staff. 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 Review of Case Files. We requested from the Unit a list of cases that were open at any time during FYs 2015–2017, and we asked the Unit to include the current status of the case; whether the case was criminal, civil, or global; and the date(s) on which the case was opened and (if applicable) closed. The total number of cases was 832. We then excluded a total of 577 cases from our review. We excluded 536 global cases 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

²³ We randomly selected eight Unit employees for review from the payroll registers.

also excluded 30 “agency assist” cases because the Unit does not lead these investigations; instead, the Unit provides assistance to another law enforcement agency in charge of the case. Finally, we excluded an additional 11 referral cases because they were not under full investigation. These cases were under preliminary investigation by the Unit.

From the 255 remaining case files, we selected a simple random sample of 76 cases. With the assistance of OIG Special Agents, we reviewed the Unit’s processes for monitoring the opening, status, and outcomes of these cases. We also reviewed the Unit’s approach to investigating and prosecuting these cases and reviewed them for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals.

Review of Unit Submissions to OIG and NPDB. We also reviewed all convictions submitted to OIG for program exclusion during the review period (45 convictions), and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period (38 adverse actions). We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and all adverse actions to the NPDB for FYs 2015–2017. We also assessed the timeliness of the submissions to OIG and the NPDB.

Onsite Review of Unit Operations. During our onsite review, we observed the Unit’s workspace and the operations of the Unit’s Las Vegas office. Specifically, we observed the Unit’s offices and meeting spaces; security of data and case files; location of select equipment; and the general functioning of the Unit.

APPENDIX D: Point Estimates and 95-Percent Confidence Intervals of Case File Reviews

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases Closed at the Time of Our Review	76	82.9%	74.1%	89.8%
Percentage of All Cases That Lacked Supervisory Approval To Close	63	3.2%	0.9%	10.0%
Percentage of All Cases Opened Longer Than 90 Days	76	65.8%	55.7%	74.9%
Percentage of All Cases That Had Been Open Longer Than 90 Days and For Which the Case Files Lacked Documentation of a Periodic Supervisory Review	50	0.0%	0.0%	6.5%

Source: OIG analysis of Nevada MFCU case files, 2018.

APPENDIX E: UNIT COMMENTS

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April 24, 2019

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**Re: Nevada Medicaid Fraud Control Unit: 2018 Onsite Review,
OEI-06-18-00190**

Dear Ms. Murrin,

Thank you for the opportunity to respond to the Office of Inspector General (OIG) 2018 Onsite Review of the Nevada Medicaid Fraud Control Unit (MFCU), OEI-06-18-00190.

We appreciate the dedication and assistance provided by OIG staff during the onsite review process. Not just during the Onsite Teams' time in Nevada, but also through the follow up conducted by the OIG after the Onsite. We also look forward to working with the OIG on our continuing relationship and appreciate the positive observations made by the OIG that are included in this report.

For the three recommendations and findings made by the OIG, we concur with those findings. Below we will provide an overview of how the MFCU will be addressing those findings.

Finding #1:

The Unit did not maintain approved staffing levels due to air contamination in the workspace and declined to fill vacant positions until the issue was resolved.

Recommendation #1:

Fill the vacant positions now that the Unit is in a temporary workspace and continue to ensure that the Unit has a safe and adequate work environment.

Response #1:

We concur with this recommendation, in part, however would like to provide some background on current staffing and why the empty investigator positions will be filled upon finding a permanent office location. First and foremost,

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thank you to the OIG Onsite team and staff for recognizing the issues the MFCU has been experiencing with affected staff and the working conditions in the prior building. We are happy to report that the process of obtaining new permanent office space is ongoing and it is looking promising that new permanent office space will be obtained sometime this summer.

The recommendation was correct in referencing that the MFCU made the decision not to hire two vacant investigator positions while the Unit was working at the old building. This was due to the working conditions at that old building as a number of staff were telecommuting due to the air contamination issues at the old building.

Shortly after the MFCU moved to the temporary work space in September 2018, we were informed that our only support staff team member in the Northern office located in Carson City was retiring in December 2018. Due to this being the only support staff for the entire Northern office, the Unit made the decision to prioritize hiring of that position. After multiple rounds of interviews were conducted over the past few months, we have hired a new support staff employee who is scheduled to start on or about April 8, 2019.

Also, the Unit will shortly be going through a change in leadership as the Unit's Director will be retiring this spring. This will cause a change in the attorney structure of the Unit as the current criminal chief of the Unit will be taking over as Director. In order to maintain efficiency and work flow, the Unit has prioritized the hiring of an attorney so there is adequate coverage for investigations and to enable matters to be filed in a timely manner. The Unit is in the process of working with the Attorney General's Office's (AGO) front office and personnel department to post that soon to be empty attorney position to enable a smooth transition with limited loss of attorney presence in cases.

Due to the issues highlighted above, the Unit has prioritized the hiring of other vacancies or soon to be vacancies to enable the Unit to still function at a high level. It is the hope of the Unit that the two empty investigator positions will be filled after it has obtained permanent office space and is set up and running in that space.

Finding #2:

The Unit investigated few patient abuse or neglect cases

Recommendation #2:

Continue to take steps to increase the number of investigations of patient abuse and neglect

Response #2:

We concur with the recommendation and appreciate and highlight that the recommendation was to "continue to take steps" to increase abuse and neglect

referrals. We feel the Onsite report has addressed the lengths at which the Unit is trying to get more abuse/neglect referrals and cases that could be generated by those referrals. As stated in the Onsite report, the Unit has been taking steps to increase the Unit's visibility in this arena. The Unit has used its outreach program, Project SNF (Skilled Nursing Facility), to try an increase the number of abuse/neglect referrals received. The Unit also has met with the State licensing agency and law enforcement to try and increase the number of referrals.

The Unit will continue to provide outreach through Project SNF as well as regular trainings with the Bureau of Health Care Quality and Compliance (BHCQC), the state agency that licenses medical facilities in Nevada. The Unit will reach out to BHCQC and inquire about setting up regular meetings or have discussions on increasing the number of referrals that are sent to the Unit. The Unit will also work with local law enforcement and the local District Attorney's Office to try and obtain additional referrals on abuse/neglect matters. The Unit will also work with our OIG counterparts on ways or means to increase abuse/neglect referrals.

Finding #3

The Unit did not maintain an annual training plan.

Recommendation #3

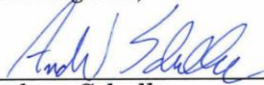
Establish an annual training plan covering all professional disciplines within the Unit

Response #3

We concur with the recommendation for the need to update the MFCU training plan. The MFCU does currently have a training plan in place however we understand it is not as specific regarding the listing of required hours by professional. The Unit has already obtained samples of other training plans used by another MFCU. The current training plan will be updated to reflect the minimum number of training hours for each professional discipline in the Unit. The Unit will also continue to ensure that members of the Unit are informed of and have the opportunity to attend NAMFCU trainings.

The Nevada MFCU again thanks the OIG and the Onsite team for the courtesy, professionalism and assistance they have provided during this process. If there are any questions or concerns regarding our response please feel free to contact me.

Best Regards,



Andrew Schulke
Supervising Senior Deputy Attorney General
Office of the Attorney General, State of Nevada

ACKNOWLEDGMENTS

Anthony Soto McGrath served as the team leader for this study. Others in the Office of Evaluation and Inspections who conducted the inspection include Cory Carr and Richard Stern, the Director of the Medicaid Fraud Policy and Oversight Division. Office of Evaluation and Inspections staff who provided support include Kevin Farber and Christine Moritz.

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