

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CONNECTICUT STATE
MEDICAID FRAUD CONTROL
UNIT: 2013 ONSITE REVIEW**



**Suzanne Murrin
Deputy Inspector General for
Evaluation and Inspections**

**September 2014
OEI-07-13-00540**

**EXECUTIVE SUMMARY: CONNECTICUT STATE MEDICAID FRAUD
CONTROL UNIT: 2013 ONSITE REVIEW
OEI-07-13-00540**

WHY WE DID THIS STUDY

The Office of Inspector General (OIG) oversees the activities of all Medicaid Fraud Control Units (MFCUs or Units). As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. The reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor Unit compliance with Federal grant requirements.

HOW WE DID THIS STUDY

We conducted an onsite review in October 2013. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit Director and supervisors; (6) an onsite review of case files; and (7) an onsite observation of Unit operations.

WHAT WE FOUND

For fiscal years 2010 through 2012, the Connecticut Unit reported combined civil and criminal recoveries of nearly \$84 million and 20 criminal convictions. Our review identified instances in which the Unit did not fully meet Federal regulations or performance standards. Specifically, the Unit did not always maintain case files in an effective manner. The Unit also lacked policies and procedures sufficient to ensure timely completion of cases. Further, the Unit did not provide OIG with adequate information to initiate exclusion of convicted individuals. Additionally, the Unit worked on a case not related to Medicaid. The Unit's vehicle expenditures were not properly allocated, but the Unit otherwise maintained proper fiscal control of its resources. Lastly, during the period we reviewed, the Unit did not regularly communicate and coordinate with OIG to investigate and prosecute health care fraud.

WHAT WE RECOMMEND

The Unit should work with OIG's MFCU oversight division to ensure compliance with the 12 performance standards and adhere to Federal regulations. The Unit concurred with all six of our recommendations.

TABLE OF CONTENTS

Objective	1
Background	1
Methodology	4
Findings.....	5
For FYs 2010 through 2012, the Connecticut Unit reported combined civil and criminal recoveries of nearly \$84 million and 20 criminal convictions	5
The Unit did not always maintain case files in an effective manner.....	6
The Unit did not follow policies and procedures for case management	6
The Unit did not provide OIG with adequate information to initiate exclusion of convicted individuals	7
Unit staff did not work exclusively on Unit-related matters.....	8
The Unit’s vehicle expenditures were not properly allocated, but the Unit otherwise maintained proper fiscal control of its resources	9
During the period we reviewed, the Unit did not regularly communicate and coordinate with OIG to investigate and prosecute health care fraud	10
Other observations: Referrals from the State Medicaid agency ...	10
Conclusion and Recommendations.....	12
Unit Comments and Office of Inspector General Response	14
Appendixes	15
A: 2012 Revised Performance Standards	15
B: 1994 Performance Standards.....	22
C: Methodology	26
D: Point Estimates and 95-Percent Confidence Intervals Based on Reviews of Case Files	29
E: Investigations Opened and Closed By Provider Category for Fiscal Years 2010 Through 2012.....	30
F: Medicaid Fraud Control Unit Referrals by Referral Source for Fiscal Years 2010 Through 2012.....	32
G: Unit Comments	33
Acknowledgments.....	37

OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.¹ Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost effective because (1) minimal Medicaid fraud exists in that State; and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.² Currently, 49 States and the District of Columbia (States) have created such Units.³ In Federal fiscal year (FY)⁴ 2012, combined Federal and State grant expenditures for the Units totaled \$217.3 million, and Units employed 1,901 individuals.

To carry out its duties and responsibilities in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.⁵ Unit staff review complaints provided by the State Medicaid agency and other sources and determine the potential for criminal prosecution and/or civil action. In FY 2012, the 50 Units obtained 1,337 convictions and 823 civil settlements or judgments.⁶ That year, the Units reported recoveries of more than \$2.9 billion.⁷

The Unit must be in an office of the State Attorney General's office, another State government office with statewide prosecutorial authority, or operate under a formal arrangement with the State Attorney General's office.⁸ Units are required to have either statewide authority to prosecute

¹ Social Security Act (SSA) § 1903(q)(3).

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

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

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

⁵ SSA § 1903(q)(6) and 42 CFR § 1007.13.

⁶ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on March 7, 2013.

⁷ Ibid.

⁸ SSA § 1903(q)(1).

cases or formal procedures to refer suspected criminal violations to an office with such authority.⁹ In 44 States, the Units are located within offices of State Attorneys General; in the remaining 6 States, including Connecticut, the Units are located in other State agencies.¹⁰ Generally, Units outside of the offices of State Attorneys General must refer cases to other offices with prosecutorial authority.

Each Unit must be a single identifiable entity of State government, distinct from the State Medicaid agency, and each Unit must develop a formal agreement—i.e., a Memorandum of Understanding (MOU)—that describes the Unit’s relationship with that agency.¹¹

Oversight of the MFCU Program

The Secretary of HHS delegated to the Office of Inspector General (OIG) the authority to both annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.¹² All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹³ To receive Federal reimbursement, each Unit must submit an initial application to OIG.¹⁴ OIG reviews the application and notifies the Unit if the application is approved and the Unit is certified. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.¹⁵

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁶ OIG developed and issued 12 performance standards to further define the criteria it applies in assessing whether a Unit is

⁹ SSA § 1903(q)(1).

¹⁰ The Units share responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States also employ a Medicaid Inspector General who conducts and coordinates the State agency’s activities to combat fraud, waste, and abuse in this area.

¹¹ SSA § 1903(q)(2) and 42 CFR § 1007.9(d).

¹² The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called Federal Financial Participation (FFP).

¹³ SSA §§ 1903(a)(6)(B).

¹⁴ 42 CFR § 1007.15(a).

¹⁵ 42 CFR § 1007.15(b) and (c).

¹⁶ SSA § 1902(a)(61).

effectively carrying out statutory functions and meeting program requirements.¹⁷ Examples of criteria include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all professional disciplines, and establishing policy and procedure manuals to reflect the Unit’s operations. See Appendix A for the 2012 performance standards used in this review and Appendix B for the 1994 performance standards.

Connecticut State MFCU

The Connecticut Unit is located in the Office of the Chief State’s Attorney within the Division of Criminal Justice and is one of seven State MFCUs that are not contained within an Office of Attorney General. Although the Connecticut Unit has jurisdiction over all criminal Medicaid fraud cases, it is not authorized to prosecute civil matters and all civil matters are referred to the Attorney General’s Office. For some civil referrals, the Unit provides support to the Attorney General’s office, such as data analysis and compiling and submitting data on behalf of the State for “global” settlements.¹⁸ The Unit must approve of and sign all global civil settlements as part of its membership and participation in NAMFCU. In addition, the Unit reports to OIG the outcomes in civil recoveries of cases worked by the Attorney General’s Office.

At the time of our review, the Unit’s 10 employees were located in Rocky Hill, a suburb of Connecticut’s State capital, Hartford. For FY 2012, the Connecticut Unit was authorized \$1,229,548 in Federal funds but expended a total of only \$1,150,457 in combined Federal and State funds. Total Medicaid expenditures in Connecticut increased from \$5.7 billion in FY 2010 to \$6.7 billion in FY 2012.

The Unit receives referrals of fraud, abuse, or neglect from the State Medicaid agency, the State Department of Public Health, the Attorney General’s Office, and private citizens. The Unit reports to OIG only those referrals that the Unit accepts.

The Unit director receives complaints and determines whether to consider them as potential cases—in which case the director counts the complaint as a referral—or to decline the complaint. All potential cases are entered into the electronic case-management system, assigned a case number, and

¹⁷ OIG initially published performance standards in 1994 (59 Fed. Reg. 49080) and issued revised standards on June 1, 2012. (See 77 Fed. Reg. 32645.) Although the 1994 Performance Standards were in effect during most of the review period, we apply the 2012 performance standards where appropriate in the findings and report recommendations.

¹⁸ “Global” cases are civil false-claims actions involving the U.S. Department of Justice and other State MFCUs. The National Association of Medicaid Fraud Control Units (NAMFCU) facilitates the settlement of global cases.

assigned a lead investigator, prosecutor, and Forensic Fraud Examiner. The lead investigator may immediately open the case, or conduct a preliminary investigation to determine whether to open the referral as a case. If the referral is not opened as a case, the file will be closed and a letter is sent to the entity that referred the complaint. If the referral is opened as a case, the investigation continues.

Previous Review

In 2008, OIG conducted an onsite review of the Connecticut MFCU and found that prior to December 2007, the Unit did not routinely include interim investigative memorandums in its official case files to reflect the progress made in investigation. At that time, the Unit concurred with OIG's assessment and stated that the Unit would incorporate a more detailed process in the Unit's policies and procedures to ensure that (1) the Unit would routinely include in official Unit case files the interim investigative memorandums documenting the progress of Unit investigations, and (2) Unit investigative cases do "not linger."

METHODOLOGY

We conducted an onsite review in October 2013. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit Director and supervisors; (6) an onsite review of case files; and (7) an onsite observation of Unit operations. Appendix C provides a detailed methodology. Appendix D contains the point estimates and 95-percent confidence intervals for the statistics in this report.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

For FYs 2010 through 2012, the Connecticut Unit reported combined civil and criminal recoveries of nearly \$84 million and 20 criminal convictions

The Unit reported total combined criminal and civil recoveries of nearly \$84 million for FYs 2010 through 2012. The majority of the recoveries were obtained from global settlements, which accounted for 84 percent of the Unit’s recoveries during the period of our review.¹⁹ (See Table 1 for details regarding criminal and civil recoveries.) Although the Unit did not have the authority to prosecute civil cases, the Unit reported to OIG non-“global” civil recoveries that were made up of global settlements obtained for Connecticut-only programs, and recoveries made by the Attorney General’s Office as a result of the Unit’s criminal investigations.

Table 1: Connecticut MFCU Criminal and Civil Recoveries, FYs 2010–2012

Type of Recovery	FY 2010	FY 2011	FY 2012	Total Recoveries
Criminal Recoveries	\$1,127,194	\$258,177	\$174,496	\$1,559,8676
Global Case Recoveries	\$12,238,431	\$38,688,571	\$19,657,365	\$70,584,367
Nonglobal Civil Recoveries	\$3,405,848	\$7,312,920	\$806,862	\$11,525,630
Total Recoveries	\$16,771,473	\$46,259,668	\$20,638,723	\$83,669,863

Source: OIG review of Unit self-reported QSRs and other data, FYs 2010–2012.

The number of opened cases decreased significantly during our review period, from 110 cases in FY 2010 to 44 cases in FY 2012. The Unit director reported that the Unit was significantly understaffed from September 2011 to April 2012 as a result of staff retirements and that this understaffing could have contributed to the decline in opened cases. Referrals to the Unit also decreased by more than half during our review period, from 89 in FY 2010 to 38 in FY 2012.

During the period we reviewed, the Unit closed 189 investigations, charged 21 individuals, obtained 20 criminal convictions, and had

¹⁹ “Global” cases are civil false claims actions involving the U.S. Department of Justice and other State MFCUs. The NAMFCU facilitates the settlement of global cases.

4 dismissals.²⁰ See Appendix E for details on investigations opened and closed in FYs 2010 through 2012, broken down by provider category.

The Unit did not always maintain case files in an effective manner

According to the 2012 Performance Standard 7, the Unit must maintain case files in an effective manner and ensure that case files include all relevant facts and information. However, some of the case files we reviewed lacked basic organizational structure and documentation necessary to follow the progression of the case.

Our review identified that certain case files did not contain documentation of relevant facts and information pertaining to the cases. In 14 percent of case files, we were unable to determine when the Unit received the referral. Further, Performance Standard 7(c) requires that significant documents—such as charging documents and settlement agreements—be included in the file. Several case files that we reviewed contained only the initial complaint and opening and closing memoranda, with no other information regarding the investigation.

In July 2013, subsequent to the period of cases we reviewed, the Unit implemented a new policy to standardize its case files. This policy requires that there be a single file for each matter under investigation. Additionally, each file should contain a chronological record, inspector's notes, investigation reports, attachments, correspondence, data files, evidence, miscellaneous documents, warrants, affidavits, and work product.

The Unit did not follow policies and procedures for case management

According to the 1994 Performance Standard 6 and the 2012 Performance Standard 5, the Unit should have a continuous case flow. Further, the 1994 Performance Standard 6(c) and the 2012 Performance Standard 7(a) state that supervisory reviews should be conducted periodically and noted in the case file. These reviews should be conducted in consistence with Unit policies and procedures. During our review period, the Unit had policies and procedures in place to ensure timely opening of cases and periodic supervisory reviews, but supervisors did not always follow these policies.

²⁰ These dismissals occurred upon the defendants' completion of the pretrial diversion program, a condition of which was full restitution.

Sixteen percent of cases were not opened in a period of time consistent with Unit policy

The Unit’s policy requires that no more than 60 days elapse between the receipt of a referral and the opening of either a case or a “preliminary investigation” period.²¹ For the 86 percent of cases for which we could determine when the Unit received the referral, our review found that 16 percent of referrals did not result in the opening of a case or the beginning of a preliminary investigation within that 60-day timeframe. These 16 percent of referrals had a median time of 83 days between when the referral was received and when the case was opened or the preliminary investigation was begun. The Unit director reported that the Unit was significantly understaffed from September 2011 to April 2012 as a result of staff retirements and that this understaffing could have contributed to the delay in opening cases.

Supervisory reviews were not conducted in a timeframe consistent with Unit policy

The Unit’s policy during the period we reviewed was to conduct supervisory case file reviews once every 3 months. The Unit policy states this is to “ensure that cases are progressing at a reasonable pace.” However, for 82 percent of cases that had been open long enough to warrant a supervisory review and that had been determined by the Unit director to be full case investigations, the files lacked documentation of supervisory reviews that should have taken place under Unit policy. The Unit policy from July 2013 increased the frequency of the required supervisory reviews to once a month.

An additional three cases, identified as preliminary investigations by the Unit director, remained open for more than 3 months. There is no policy or procedure for supervisory reviews of such cases because it is the supervisor who conducts preliminary investigations. These three cases remained open for 141, 190, and 439 days.

The Unit did not provide OIG with adequate information to initiate exclusion of convicted individuals

According to the 1994 Performance Standard 8(d) and the 2012 Performance Standard 8(f), the Unit must transmit to OIG, for purposes of program exclusion, all pertinent information on Unit

²¹ After our onsite review, the Unit director informed us that a revised MOU (effective January 17, 2014) with the State Medicaid Agency established a 45-day timeframe between when a referral is received and when a case should be opened or a preliminary investigation should begin.

convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders. During the period we reviewed, the Unit obtained 20 convictions of 19 individuals. However, OIG found that the Unit did not transmit documentation sufficient to exclude 14 of these 19 individuals, and for the remaining 5 individuals, the Unit transmitted no documentation to OIG.

The Unit's protocol is to send to OIG a completed electronic form for each conviction including name; Social Security number; name of the court; docket/court file number; statutory offense(s) and count(s); and a narrative description of the act(s) or omission(s) on which the conviction was based. The 2012 Performance Standard 8(f) also specifies that the MFCU should send OIG copies of Judgment and Sentence or similar court documents. For the 14 cases with incomplete information, OIG found that the Unit did not provide actual court documents showing conviction and sentencing. Also, as of May 2014, the Unit director had provided no documentation to OIG on the five remaining convicted individuals.

Unit staff did not work exclusively on Unit-related matters

According to the 1994 Performance Standard 1 and the 2012 Performance Standard 1, the Unit must conform to all applicable statutes, regulations, and policy directives. Further, according to the Medicaid statute and Federal regulations, the Unit may receive FFP only for fraud investigations that involve allegations of fraud in the administration of the Medicaid program, in the provision of Medicaid services, or in the activities of Medicaid providers.²²

The Unit investigated one case in our sample that was unrelated to Medicaid

We identified an investigation that involved a drug representative who was allegedly forging doctors' signatures and obtaining samples of drugs. The suspect was charged with six counts of forgery. This was not a Medicaid case because no claims were made to the Medicaid program in connection with the activity. Unit staff engaged in investigative activity on the case from May 20, 2007, through December 1, 2009. The Unit director acknowledged that Unit staff should not have worked on this case; the case was opened by the previous director, who left in November 2007.

²² SSA § 1903(q)(3) and 42 CFR §§ 1007.11(a) and 1007.19(d).

The Unit does not maintain sufficient documentation to support that it works exclusively on Unit-related matters

According to Federal regulations and OIG Policy Transmittal 89-1,²³ professional staff from the Unit must be “full-time employees” to receive Federal reimbursement.²⁴ The full-time employee policy requires that a covered employee work exclusively on Unit matters. In addition, pursuant to Federal regulations, a Unit may claim Federal reimbursement only for costs attributable to the establishment and operation of the Unit. During the review period, a review of the Unit’s vehicle usage documentation identified instances of at least one employee performing non-MFCU related work (e.g., traffic stops, motorist assists). The Unit director stated that such non-MFCU work was performed outside the Medicaid work day and at no cost to the MFCU grant. We were unable to determine, however, whether the non-MFCU work was performed during a normal workday or during evening or weekend hours, since (a) the Unit’s vehicle usage documentation did not always identify the time of day these activities occurred and (b) the Unit’s salary accounting records do not list the specific hours or MFCU cases investigated during an employee workday. Because of this lack of documentation, we were unable to determine whether the Unit claimed personnel costs for non-MFCU work performed by Unit professional staff.

The Unit’s vehicle expenditures were not properly allocated, but the Unit maintained proper fiscal control of its resources

According to the 1994 Performance Standard 1 and the 2012 Performance Standard 1, the Unit must conform to all applicable statutes, regulations, and policy directives, including Federal cost principles contained in 2 CFR, part 225.²⁵ For Federal funding to be allocated, costs must be properly chargeable or assignable in accordance with the relative benefits received.²⁶ Contrary to Federal regulations, the Unit did not properly allocate vehicle maintenance and depreciation costs.

²³ OIG Policy Transmittal 89-1 was in effect during our review period. On June 3, 2014, OIG issued State Fraud Policy Transmittal No. 2014-1, which superseded Policy Transmittal 89-1 regarding the employment of full-time and part-time employees by the Units.

²⁴ 42 CFR § 1007.19(e)(4). “Professional staff” includes attorneys, investigators, auditors, and managers. OIG Policy Transmittal 89-1.

²⁵ 2 CFR pt. 225 establishes principles for determining the allowable costs incurred by State, local, and federally recognized Indian tribal governments (governmental units) under grants, cost reimbursement contracts, and other agreements with the Federal Government.

²⁶ 2 CFR pt. 225, Appendix A (C)(3)(a).

The Division of Criminal Justice authorizes police inspectors to use assigned vehicles while off duty. However, the Unit claimed 100 percent of the vehicle maintenance and depreciation expenditures for Federal reimbursement, including the use of the vehicles while off duty.

Therefore, off-duty use occurred for which the Federal government did not receive any relative benefits. As a result, the Unit overclaimed vehicle maintenance and depreciation expenditures.

Further, according to the 1994 Performance Standard 11 and the 2012 Performance Standard 11, the Unit director should exercise proper fiscal control over the Unit's resources. From FYs 2010 through 2012, our review found that the Unit reported program income in accordance with applicable Federal requirements and maintained adequate internal controls related to accounting, budgeting, personnel, procurement, property, and equipment. During the review period, most of the Unit's expenditures that we examined represented allowable costs in accordance with applicable Federal requirements.

During the period we reviewed, the Unit did not regularly communicate and coordinate with OIG to investigate and prosecute health care fraud

42 CFR § 1007.11(e) requires units to cooperate with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud. However, OIG reported having irregular, and in some instances limited, communication with the Unit for extended periods of time during the review period. According to Unit recertification documents, joint OIG-MFCU work on cases declined over the period we reviewed, from 30 cases in 2010 to 13 cases in 2012. Following this period, OIG and Unit staff reported that relations between OIG and the Unit were improving.

Other observation: Referrals from the State Medicaid agency

According to the 1994 Performance Standard 4 and the 2012 Performance Standard 4, the Unit should take steps to ensure that it maintains an adequate volume and quality of referrals from the State Medicaid agency and other sources. During FYs 2010–2012, the Unit received only 22 referrals from the State Medicaid agency and accepted 16 referrals. The Unit director reported a low volume of referrals from the State Medicaid agency. State Medicaid agency staff attributed the low volume of referrals to insufficient staffing. See Appendix F for more information on referrals by referral source.

In an attempt to address the low volume of referrals, the Unit director and Unit staff collaborated with State Medicaid agency staff to develop an “Immediate Advisement” protocol, which allows the State Medicaid agency to informally notify the Unit of a potential fraud case prior to making a formal referral. The Unit integrated this protocol into its policies and procedures effective January 1, 2013. The Unit director reported that the protocol increased the volume of potential cases that the State Medicaid agency identified.

CONCLUSION AND RECOMMENDATIONS

For FYs 2010 through 2012, the Unit reported combined civil and criminal recoveries of nearly \$84 million. During the review period, the Unit closed 189 investigations with 21 individuals charged, obtained 20 criminal convictions, and had 4 dismissals.

However, our review identified instances in which the Unit did not fully meet performance standards and adhere to Federal regulations. Specifically, the Unit did not always maintain case files in an effective manner. The Unit also lacked policies and procedures sufficient to ensure timely completion of cases. Further, the Unit did not provide OIG with adequate information to initiate exclusion of convicted individuals. Additionally, the Unit worked on a case not related to Medicaid. Our review determined that the Unit maintained proper fiscal control of its resources, but the Unit's vehicle expenditures were not properly allocated. Lastly, during the review period, the Unit did not always communicate and coordinate with OIG on a regular basis to investigate and prosecute health care fraud.

We recommend that the Connecticut Unit:

Ensure that case files are maintained in an effective manner

The Unit should maintain all case files in an effective manner and ensure that case files include all relevant facts and information necessary to follow the progression of the case.

Adhere to Unit policies and procedures for case management

The Unit should ensure that complaints referred to the Unit are opened and investigated, if appropriate, within the 45-day timeframe established in the Unit's new MOU. The Unit should ensure that all case files contain documentation of supervisory reviews in accordance with Unit policy. Additionally, the Unit should develop policies and procedures related to processing cases that are in "preliminary investigation" status.

Refer individuals for exclusion to OIG with the appropriate information for exclusion

The Unit should ensure that individuals convicted of fraud, abuse, and/or neglect are reported to OIG within 30 days of their sentencing, in accordance with 2012 Performance Standard 8(f). This referral should include information necessary for exclusion, including available court documents recording the conviction and sentencing of the defendant.

Ensure Unit professional staff perform only Unit-related duties in accordance with performance standards and Federal regulations

The Unit should not investigate cases outside the scope of the Federal grant and should work with OIG to identify the staff hours and related expenditures that should be repaid. The Unit should develop internal controls to document that professional staff work only on MFCU-related matters while on duty.

Properly allocate vehicle costs

The Unit should institute a policy to ensure that maintenance and depreciation expenditures that are not related to allowable MFCU activities are not allocated to the Federal grant.

Regularly communicate and coordinate with OIG to investigate and prosecute Medicaid fraud

The Unit should continue to improve cooperation with OIG to investigate and prosecute Medicaid fraud.

UNIT RESPONSE AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Connecticut Unit concurred with all six of our recommendations.

The Unit concurred with our recommendation that it ensure that case files are maintained in an effective manner. The Unit stated that in July 2013, it implemented a new policy designed to ensure that 100 percent of the files are dated and organized correctly.

The Unit concurred with our recommendation that it adhere to its policies and procedures for case management. The Unit stated that it has already taken steps to cure lapses in supervisory review documentation by requiring the supervisor who reviews investigations to forward written documentation to the director for approval before filing. Further, the Unit stated that it will adjust policy and procedures for cases in “preliminary investigation” status.

The Unit concurred with our recommendation that it refer individuals for exclusion to OIG with the appropriate information for exclusion. The Unit stated that it provides OIG with adequate information to initiate the exclusion of convicted individuals. We wish to clarify that if the Unit were to provide OIG with a certified copy of the court document called an Information, this would be sufficient to initiate an exclusion.

The Unit concurred with our recommendation that it ensure that its professional staff perform only Unit-related duties in accordance with performance standards and Federal regulations.

The Unit stated that its documentation is adequate to demonstrate when professional staff are working in the Unit and when they are not, and added that the examples we provided involved hours that fell outside of the regular Unit workday. OIG continues to find that documentation of non-Unit work does not contain discernible hours for such incidents; further, Unit timecards do not contain discernible start and end times. Therefore, we advise the Unit to improve its documentation.

The Unit concurred with our recommendation that it properly allocate vehicle costs. The Unit will institute a policy that maintenance and depreciation expenditures related to the night and weekend usage of assigned State vehicles not be allocated to the Federal grant.

The Unit concurred with our recommendation that it regularly communicate and coordinate with OIG to investigate and prosecute Medicaid fraud. The Unit agreed that the working relationship has improved, and said that it will do its part to continue the positive trend.

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

APPENDIX A

2012 Revised Performance Standards²⁷

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

²⁷ 77 Fed. Reg. 32645, June 1, 2012.

staffed, commensurate with the volume of case referrals and workload for each location.

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

- a. The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.
- b. The Unit adheres to current policies and procedures in its operations.
- c. Procedures include a process for referring cases, when appropriate, to Federal and State agencies. Referrals to State agencies, including the State Medicaid agency, should identify whether further investigation or other administrative action is warranted, such as the collection of overpayments or suspension of payments.
- d. Written guidelines and manuals are readily available to all Unit staff, either online or in hard copy.
- e. Policies and procedures address training standards for Unit employees.

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

- a. The Unit takes steps, such as the development of operational protocols, to ensure that the State Medicaid agency, managed care organizations, and other agencies refer to the Unit all suspected provider fraud cases. Consistent with 42 CFR 1007.9(g), the Unit provides timely written notice to the State Medicaid agency when referred cases are accepted or declined for investigation.
- b. The Unit provides periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.
- c. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).

- d. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.
 - e. The Unit provides timely information, when requested, to those agencies identified in (d) above regarding the status of referrals.
 - f. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.
- 5. A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.**
- a. Each stage of an investigation and prosecution is completed in an appropriate timeframe.
 - b. Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.
 - c. Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.
- 6. A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.**
- a. The Unit seeks to have a mix of cases from all significant provider types in the State.
 - b. For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.
 - c. The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.
 - d. As part of its case mix, the Unit maintains a balance of fraud and patient abuse and neglect cases for those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases.

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

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

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

recoveries and the types of relief obtained through civil judgments or pre-filing settlements.

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

- a. The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.
- b. The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, cases involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.
- c. The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.
- d. For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.
- e. For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.
- f. The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.
- g. The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.

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

- a. The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.

- b. The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.

10. A Unit periodically reviews its 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

1994 Performance Standards²⁸

1. **A Unit will be in conformance with all applicable statutes, regulations and policy transmittals.** In meeting this standard, the Unit must meet, but is not limited to, the following requirements:
 - a. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.
 - b. The Unit must be separate and distinct from the State Medicaid agency.
 - c. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.
 - d. The Unit must submit annual reports, with appropriate certifications, on a timely basis.
 - e. The Unit must submit quarterly reports on a timely basis.
 - f. The Unit must comply with the Americans with Disabilities Act, the Equal Employment opportunity requirements, the Drug Free workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.
2. **A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.** In meeting this standard, the following performance indicators will be considered:
 - a. Does the Unit employ the number of staff that was included in the Unit's budget as approved by the OIG?
 - b. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?
 - c. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?
 - d. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?
3. **A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.** In meeting this standard, the following performance indicators will be considered:
 - a. Does the Unit have policy and procedure manuals?

²⁸ 59 Fed. Reg. 49080, Sept. 26, 1994.

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

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

- a. Does the Unit work with the State Medicaid agency to ensure adequate fraud referrals?
- b. Does the Unit work with other agencies to encourage fraud referrals?
- c. Does the Unit generate any of its own fraud cases?
- d. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?

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

- a. Does the Unit seek to have a mix of cases among all types of providers in the State?
- b. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?
- c. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?
- d. Are there any special Unit initiatives targeting specific provider types that affect case mix?
- e. Does the Unit consider civil and administrative remedies when appropriate?

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

- a. Is each stage of an investigation and prosecution completed in an appropriate time frame?
- b. Are supervisors approving the opening and closing of investigations?
- c. Are supervisory reviews conducted periodically and noted in the case file?

7. A Unit should have a process for monitoring the outcome of cases.

In meeting this standard, the following performance indicators will be considered:

- a. The number, age, and type of cases in inventory.
- b. The number of referrals to other agencies for prosecution.
- c. The number of arrests and indictments.
- d. The number of convictions.
- e. The amount of overpayments identified.
- f. The amount of fines and restitution ordered.
- g. The amount of civil recoveries.
- h. The numbers of administrative sanctions imposed.

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

- a. Does the Unit communicate effectively with the OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?
- b. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?
- c. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?
- d. Does the Unit transmit to the OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

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

- a. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?
- b. Does the Unit provide program recommendations to State Medicaid agency when appropriate?

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

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

- a. Is the MOU more than 5 years old?
- b. Does the MOU meet Federal legal requirements?
- c. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?
- d. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?

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

- a. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?
- b. Does the Unit maintain an equipment inventory?
- c. Does the Unit apply generally accepted accounting principles in its control of Unit funding?

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

- a. Does the Unit have a training plan in place and funds available to fully implement the plan?
- b. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?
- c. Are continuing education standards met for professional staff?
- d. Does the training undertaken by staff add to the mission of the Unit?

APPENDIX C

Methodology

Data collected from the seven sources below was used to describe the caseload and assess the performance of the Unit.

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information from several sources regarding how the Unit investigated Medicaid cases and referred them for prosecution. Specifically, we collected and analyzed 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 QSRs, its annual reports, its recertification questionnaire, its policy and procedures manuals, its MOU with the State Medicaid agency, and the 2008 OIG report on the previous onsite review. Additionally, we confirmed with the Unit director that the information we had was current as of October 2013, and as necessary, we requested any additional data or clarification.

Review of Fiscal Control. We reviewed the Unit's control over its fiscal resources to identify any internal control issues or other issues involving use of resources. Prior to the onsite review, we reviewed the Unit's financial policies and procedures; its response to an internal control questionnaire; and documents (such as financial status reports) related to MFCU grants. During the onsite review, we reviewed a sample of the Unit's purchase and travel transactions. In addition, we reviewed vehicle records, the equipment inventory, and a sample of time and effort records.

Interviews With Key Stakeholders. In September 2013, we interviewed key stakeholders, such as officials in the United States Attorneys' Offices, the Attorney General's Office, and other agencies that interacted with the Unit (i.e., the State Department of Public Health, the State Department of Social Services, the Office of the State Long Term Care Ombudsman, and the State Bureau of Aging). 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 September 2013, we conducted an online survey of all nonmanagerial Unit staff within each professional discipline (i.e., investigators, auditors, and attorneys) as well as support staff. The response rate was 100 percent. Our questions focused on operations of the Unit, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Onsite Interviews With Unit Management. We conducted structured interviews with the Unit's management in October 2013. We interviewed the Unit director (who also served as the Unit's lead attorney) and the supervisory investigator. We asked these individuals to provide additional information to better understand the Unit's operations and clarify information obtained from other data sources. Finally, we discussed the status of their actions with respect to recommendations from the 2008 report.

Onsite Review of Case Files and Other Documentation. The Unit provided a list of 246 cases that were open at any point during FYs 2010 through 2012. We excluded from our analysis 68 of these cases that the Unit had categorized as "global." We then selected a simple random sample of 100 cases from the remaining 178 cases. We reviewed all sampled case files for documentation of supervisory reviews for the opening and closing (as appropriate) of cases, as well as to see whether supervisors conducted periodic case file reviews. From these 100 case files, we selected a further simple random sample of 50 files for a more in-depth review of selected issues, such as the timeliness of investigations and case development. Subsequent to our review, we removed one case from our sample because it was a case that had been assigned a new number when it was reopened following a parole violation. We projected the results of our review of the 99 case files to the population of Unit cases.

Onsite Review of Unit Operations. During our October 2013 site visit, we reviewed the Unit's workspace and operations. Specifically, we visited the Unit headquarters in the State capital. While onsite, 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.

Data Analysis

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

transmittals.²⁹ In addition, we noted practices that appeared to be beneficial to the Unit. We based these observations on statements from Unit staff, data analysis, and our own judgment. We did not independently verify the effectiveness of these practices, but included the information because it may be useful to other Units in their operations.

²⁹ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu>.

APPENDIX D

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

We calculated confidence intervals for key data points for our reviews of case files. The sample sizes, point estimates, and 95-percent confidence intervals are given for the each of the following:

Table D-1: Confidence Intervals for Case File Review Data

Data Element Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Case files lacking documentation of when the referrals were received by the Unit	99	14.1%	10.1%–19.5%
Case files were not opened within 60 days from receipt of a referral	85	16.5%*	11.8%–22.5%
Case files lacking documentation of supervisory reviews consistent with Unit policy	51**	82.4%	74.1%–88.4%

*The actual percentage of files for cases not opened within 60 days of receipt is 16.47 percent. The number 16.47 rounds to 16.5. As a whole number, however, this percentage rounds to 16 percent.

**We reviewed only the files for cases that were open for longer than 3 months. The review of one case file did not indicate whether the periodic supervisory reviews were consistent with Unit policy, so that case file was excluded.

Source: OIG analysis of Connecticut's MFCU case files, 2014.

APPENDIX E

Investigations Opened and Closed By Provider Category for FYs 2010 Through 2012

Table E-1: Fraud Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Facilities						
Hospitals	3	3	0	0	0	0
Nursing Facilities	3	4	3	2	0	1
Other Long-Term Care Facilities	0	0	0	0	0	0
Substance Abuse Treatment Centers	0	0	0	0	0	0
Other	0	0	0	0	0	0
Subtotal	6	7	3	2	0	1
Practitioners						
Doctors of Medicine or Osteopathy	8	5	7	6	6	5
Dentists	3	3	3	2	4	1
Podiatrists	0	0	0	0	0	0
Optometrists/Opticians	1	1	1	1	0	0
Counselors/Psychologists	3	3	1	2	1	0
Chiropractors	0	0	1	0	0	1
Other	1	1	1	0	1	1
Subtotal	16	13	14	11	12	8
Medical Support						
Pharmacies	0	2	4	3	2	2
Pharmaceutical Manufacturers	17	11	11	19	3	4
Suppliers of Durable Medical Equipment and/or Supplies	8	5	5	4	2	4
Labs	1	1	0	3	0	0
Transportation Services	1	1	0	0	0	0
Home Health Care Agencies	3	1	3	3	1	2
Home Health Care Aides	2	7	2	5	1	1
Nurses, Physician's Assistants, Nurse Practitioners, Certified Nurse Aides	1	1	0	1	3	4
Radiologists	0	0	0	0	0	0
Medical Support—Other	1	1	1	0	2	4
Subtotal	34	30	26	38	14	21

Table E-1 (Continued): Fraud Investigations

Program Related	Opened	Closed	Opened	Closed	Opened	Closed
Managed Care	0	0	1	0	0	0
Medicaid Program Administration	0	0	0	0	0	0
Billing Company	0	0	0	0	0	0
Other	6	7	3	4	0	1
Subtotal	6	7	4	4	0	1
Total Provider Categories	62	57	47	55	26	31

Source: OIG analysis of Unit-submitted documentation, FYs 2010–2012.

Table E-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing Facility	19	23	4	2	9	5
Other Long-Term Care	2	2	1	1	0	0
Nurses, Physician's Assistants, Nurse Practitioners, Certified Nurse Aides	0	1	0	0	0	0
Home Health Aides	1	0	0	1	0	0
Other	2	3	4	2	2	3
Total	24	29	9	6	11	8

Source: OIG analysis of Unit-submitted documentation, FYs 2010–2012.

Table E-3: Patient Funds Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Nondirect Care	2	1	0	0	0	1
Nurses, Physician's Assistants, Nurse Practitioners, Certified Nurse Aides	0	0	0	0	0	0
Home Health Aides	0	0	0	0	0	0
Other	0	0	0	0	0	0
Total	2	1	0	0	0	1

Source: OIG analysis of Unit-submitted documentation, FYs 2010–2012.

APPENDIX F

Medicaid Fraud Control Unit Referrals by Referral Source for FYs 2010 Through 2012

Referral Source	FY 2010			FY 2011			FY 2012		
	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Funds
Medicaid Agency – (Office of Quality Assurance) – PI/SURS ³⁰	4	1	0	6	0	0	5	0	0
Medicaid Agency – Attorney General	33	15	1	26	0	0	12	3	1
State Survey & Certification	0	0	0	0	0	0	0	0	0
Other State Agencies	0	0	0	0	0	0	1	0	0
Licensing Board	10	5	1	1	4	0	1	5	0
Law Enforcement	2	1	0	1	0	0	2	0	0
Office of Inspector General	2	0	0	2	0	0	0	0	0
Prosecutors	0	0	0	0	0	0	0	0	0
Providers	3	0	0	2	0	0	0	0	0
Provider Associations	0	0	0	0	0	0	0	0	0
Private Health Insurer	0	0	0	0	0	0	1	0	0
Long Term Care Ombudsman	0	0	0	0	1	0	0	0	0
Adult Protective Services	0	0	0	0	0	0	0	0	0
Private Citizens	9	2	0	8	4	0	4	2	0
MFCU Hotline	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	1	0
Total	63	24	2	46	9	0	26	11	1
Annual Total	89			55			38		

Source: OIG analysis of Unit-submitted documentation, FYs 2010–2012.

³⁰ “PI” = “program integrity”; “SURS” = “Surveillance and Utilization Review Subsystem.”

APPENDIX G
Unit Comments



KEVIN T. KANE
CHIEF STATE'S ATTORNEY

State of Connecticut
Division of Criminal Justice

OFFICE OF
THE CHIEF STATE'S ATTORNEY

300 CORPORATE PLACE
ROCKY HILL, CONNECTICUT 06067
PHONE (860) 258-5800
FAX (860) 258-5858

July 16, 2014

VIA EMAIL AND REGULAR MAIL

Mr. Brian P. Ritchie
Acting Deputy Inspector General
For Evaluation & Inspection
U.S. Department of Health & Human Services
Room 5660, Cohen Building
330 Independence Avenue S.W.
Washington, D.C. 20201

RE: *Connecticut Medicaid Fraud Control Unit 2013 Onsite Review*
OEI-07-13-00540

Dear Mr. Ritchie,

I appreciate the opportunity to respond to the findings and recommendations in the above captioned report of the Onsite Review of our Medicaid Fraud Control Unit, which was transmitted to me on July 10, 2014. I wish to commend you and your staff for the rigorous review process which, by its nature, is focused on exceptions to the hard work of 10 people whose efforts during the review period produced combined civil and criminal recoveries of nearly \$84 million dollars and 20 criminal convictions. I am personally proud of our accomplishments and committed to make corrections and improvements where necessary and appropriate.

After careful examination of the report, I have the following responses and comments for each recommendation.

Recommendation 1: Ensure that case files are maintained in an effective manner.

Response: I concur. We take very seriously our responsibility to maintain all of our case files properly. As noted in the report, 86% of our files were found to be in order and in July 2013, we implemented a new policy that is designed to ensure that in the future we will keep 100% of our files dated and organized correctly, as per the performance standard.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

July 16, 2014
Page 2

Recommendation 2: Adhere to Unit policies and procedures for case management.

Response: I concur. As noted in the report, 84% of our cases were opened within a timeframe consistent with Unit policy. The report also notes that we experienced significant Unit understaffing in 2011 and 2012, due to abrupt retirements and threatened layoffs, which prevented the timely assignment of some cases. The staffing problem has since been ameliorated, and the Unit is currently adhering to its recently revised policy of opening cases within 45 days of receipt.

I also concur with the recommendation to develop (I would say "adjust") policy and procedures for cases under preliminary investigation status. The finding of a lack of documentation of supervisory reviews is based largely on confusion over our local procedure for handling matters before they are (or are not) opened for full investigation. I will revisit and perhaps adjust how we handle them so as to avoid unnecessary confusion in the future. I have already taken appropriate steps to cure lapses in supervisory review documentation, by requiring the supervisor who reviews investigations to forward written documentation of the same to me for approval before filing.

Recommendation 3: Refer individuals for exclusion to OIG with the appropriate information for exclusion.

Response: While I concur with the recommendation as a general statement of what the performance standard requires, I cannot agree with the finding that we failed in this regard. The finding is inaccurate and fails to recognize local procedures that I explained to the auditors and many others before and after them. In 14 of the 19 cases in this sample, we provided OIG with the information we had available to us for purposes of exclusion. The documentation we provided to OIG is the same documentation that we have been providing since I became Director in 2007. I have not been informed before now that the documentation is inadequate. Nor, for that matter, has it prevented program exclusions.

For each conviction we provide OIG with a summary fact sheet and a certified copy of a court document called an Information, which is the legal document we use in Connecticut state courts to both charge a defendant and record the particulars of the process and resulting conviction and sentence. We do not indict defendants, and our Superior Court does not prepare criminal judgments in any case that is not appealed. We cannot provide court documents which do not exist.

July 16, 2014
Page 3

As to the finding that we did not provide documentation of conviction in 5 cases, I have taken steps to investigate and, if necessary, rectify this discrepancy. These 5 cases may involve our apparently mistaken belief that only providers should be reported for exclusion. Recent clarification of this point by OIG discloses an interpretation of the applicable rules that is broader than we had thought. Accordingly, we will now report *all* convictions to OIG within 30 days of sentencing.

Recommendation 4: Ensure Unit professional staff performs only Unit-related duties in accordance with performance standards and Federal regulations.

Response: I concur generally with the recommendation and specifically with the finding that in 2007, the then-Director opened one case that was not properly a Medicaid case. The Unit will calculate and repay any staff costs that were improperly claimed.

I do not, however, concur with the finding that the Unit does not maintain sufficient documentation to support that it works exclusively on Unit-related matters. As noted in the report, the basis of this finding is that one professional employee performed "non-MFCU work" when he made traffic stops or assisted disabled motorists. The implication is that these "non-MFCU" events occurred during the federally funded MFCU work day. But, in fact, the employee was not at work when these events occurred, and our documentation adequately demonstrates that.

All of the Inspectors (investigators) in the Medicaid Fraud Control Unit are sworn police officers with statutory authority roughly equivalent to that of state troopers. As part of their employment contract, Inspectors are assigned an unmarked police vehicle and permitted to use it on- and off-duty, 24 hours a day, 7 days a week. Sometimes, while these Inspectors are en route to or from work, or simply driving around on their off time, they might intervene in an emergency or hazardous situation. They are, however, instructed to refrain from any such involvement during the MFCU work day, except in rare cases involving either an emergency or public safety. See OIG Policy Transmittal 14-1.

After the auditors reported this finding to me, I asked them to provide examples of the claimed improper conduct. I was given two examples. One cited incident occurred at 9 p.m. on a weekday, and the other one occurred on a Saturday. Both are outside the regular work day of the Medicaid Fraud Control Unit, which is between the hours of 8 a.m. and 6 p.m. on weekdays. Thus, these examples cannot be the basis for a finding that a Unit employee worked outside the Medicaid grant.

July 16, 2014
Page 4

Contrary to the statement in the report, the Inspectors' employment contract and our employee time sheets, both of which were provided to the auditors, clearly show that Inspectors do not work either at night or on weekends. Accordingly, I conclude that our documentation is adequate to demonstrate when Inspectors are working in the MFCU and when they are not.

Recommendation 5: Properly allocate vehicle costs.

Response: I concur. Proper fiscal control is paramount. I appreciate the comment in the report that the Unit maintained proper fiscal control of its resources. We will continue to ensure that we do so by instituting a policy which provides that maintenance and depreciation expenditures related to the night and weekend usage of assigned state vehicles are not allocated to the federal grant.

Recommendation 6: Regularly communicate and coordinate with OIG to investigate and prosecute Medicaid fraud.

Response: I concur. The Unit's working relationship with OIG, like all such relationships, has had both its good and less-than-good moments. For that reason alone, the relationship should be judged over time, not at a specific point in time. Communication and cooperation is a two-way street. Maintenance of good working relationships is a priority for us. As noted in the report, the working relationship has improved and we will do our part to continue the positive trend.

The Connecticut Medicaid Fraud Control Unit appreciates the professional and courteous efforts of your office during the review process. We look forward to a continued good working relationship.

Very truly yours,

/s/

CHRISTOPHER T. GODIALIS
Supervisory Assistant State's Attorney
Director – Medicaid Fraud Control Unit

ACKNOWLEDGEMENTS

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

Teresa Dailey served as the team leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Thomas Brannon, Jordan R. Clementi, and Rae Hutchison. Office of Investigations staff who conducted the study include Dwight Q. Jackson. Central office staff who provided support include Christine Moritz and Sherri Weinstein.

Office of Inspector General

<http://oig.hhs.gov>

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

Office of Audit Services

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

Office of Evaluation and Inspections

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

Office of Investigations

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

Office of Counsel to the Inspector General

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