

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW HAMPSHIRE STATE
MEDICAID FRAUD CONTROL UNIT:
2012 ONSITE REVIEW**



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WHY WE DID THIS STUDY

The Office of Inspector General (OIG) is responsible for overseeing the activities of all Medicaid Fraud Control Units (MFCU or Unit). As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. The reviews describe the Units' caseloads; assess performance in accordance with the 12 MFCU performance standards; identify any opportunities for improvement; and identify any instances of noncompliance with laws, regulations, or policy transmittals.

HOW WE DID THIS STUDY

We based our review on an analysis of data from six sources: (1) a review of policies and procedures and documentation on the Unit's operations, staffing, and caseload; (2) structured interviews with key stakeholders; (3) structured interviews with Unit staff; (4) a review of financial documentation; (5) an onsite review of case files; and (6) an onsite review of Unit operations.

WHAT WE FOUND

From fiscal years (FY) 2009 to 2011, the New Hampshire Unit reported recoveries of \$14 million, filed criminal charges against 25 defendants, and obtained 15 convictions. Although the number of fraud cases opened and closed by the Unit increased during this time, the overall number of cases opened and closed by the Unit decreased. This was due to a decrease in patient abuse and neglect cases. The Unit attributed the overall decrease primarily to staffing limitations; for all 3 years, the Unit's staff levels were below the number of staff that the Unit requested and OIG approved. Additionally, although the Unit reported that its best source of fraud referrals was the State's Surveillance and Utilization Review Subsystem (SURS), the Unit also noted that the number of referrals from SURS was low. Our review also found that the Unit's case files lacked documentation of periodic supervisory review, and the Unit lacked annual training plans for each of the three professional disciplines (i.e., for auditors, investigators, or attorneys). At the same time, our review found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals. The Unit identified as a noteworthy practice its sending a letter to nursing facilities and assisted living facilities explaining that drug diversion is a form of patient abuse and neglect; this letter resulted in facilities making drug diversion-related referrals to the Unit. (Drug diversion is when facility staff members or other individuals divert residents' prescription drugs for their own use or for sale.)

WHAT WE RECOMMEND

We recommend that the New Hampshire Unit: (1) seek to expand staff sizes to reflect the number of staff approved in the Unit's budget, (2) ensure that it maintains an adequate workload through referrals from SURS, (3) ensure that case files contain documented supervisory reviews, and (4) establish annual training plans for each professional discipline. The New Hampshire Unit concurred with all four of our recommendations.

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OBJECTIVE

To conduct an onsite review of the New Hampshire 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 Under the Medicaid statute, each State must maintain a certified Unit unless the Department of Health and Human Services (HHS) determines that operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in that State and that the State has other adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.² Currently 49 States and the District of Columbia have created such Units.³ In fiscal year (FY) 2011, HHS and the States spent a combined total of \$208.6 million on these Units.⁴ Of this amount, \$552,310 was spent on the New Hampshire Unit.⁵

Each Unit must employ sufficient staff consisting of at least an investigator, an auditor, and an attorney to carry out its duties and responsibilities in an effective and efficient manner.⁶ The staff review complaints provided by the State Medicaid agency and other sources and determine their potential for criminal or civil prosecution. Collectively, in FY 2011 the 50 Units obtained 1,230 convictions as well as 906 civil settlements or judgments.⁷ That year, the Units reported recoveries of \$1.7 billion.⁸

Units are required to have either Statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an office with

¹ Social Security Act § 1903(q).

² Social Security Act §§ 1902(a)(61) and 1903(q)(3). Regulations found 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. For the purposes of this study, misappropriation of patient funds is combined with patient abuse and neglect.

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. For the purposes of this review, we refer to the District of Columbia as a State.

⁴ The Federal fiscal year, which starts October 1 and ends September 30, is used throughout this report.

⁵ Office of Inspector General (OIG) analysis of Office of Management and Budget Forms SF-425 for FY 2011.

⁶ Social Security Act § 1903(q)(6); 42 CFR § 1007.13.

⁷ OIG, *State Medicaid Fraud Control Units Fiscal Year 2011 Grant Expenditures and Statistics*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2011.asp on June 14, 2011.

⁸ *Ibid.*

such authority.⁹ In New Hampshire and 43 other States, the Units are part of Offices of State Attorneys General; in the remaining 6 States, the Units are part of other State agencies. Generally, Units that are not part of Offices of State Attorneys General must refer cases to other offices that have prosecutorial authority. Additionally, each Unit must be a single identifiable entity of State government, distinct from the single State Medicaid agency, and each Unit must develop a formal agreement, e.g., a memorandum of understanding (MOU), that describes the Unit's relationship with that agency.¹⁰

Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority both to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs in operating a certified Unit.¹¹ All States currently operating Units are reimbursed by the Federal Government on a 75-percent matching basis, with the States required to contribute the remaining 25 percent.¹² In order to receive Federal reimbursement, each Unit must submit an initial application to OIG.¹³ OIG reviews the application and notifies the Unit if the application is approved and the Unit is certified. Approval and certification is for a 1-year period; the Unit must be recertified each year thereafter.¹⁴

Under the Medicaid statute, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁵ To clarify the criteria that OIG applies in assessing whether a Unit is effectively carrying out these functions and meeting program requirements, OIG developed and issued 12 performance standards.¹⁶ Examples include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all three of the professional disciplines (i.e., for auditors, investigators, and attorneys), and establishing policy and procedure manuals to reflect the Unit's operations. See Appendix A for a complete list of these performance standards.

⁹ Social Security Act § 1903(q)(1).

¹⁰ Social Security Act § 1903(q)(2); 42 CFR § 1007.9(d).

¹¹ 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 the Federal Financial Participation (FFP).

¹² Social Security Act § 1903(a)(6)(B).

¹³ 42 CFR § 1007.15(a).

¹⁴ 42 CFR §§ 1007.15(b) and (c).

¹⁵ Social Security Act § 1902(a)(61).

¹⁶ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf> on May 17, 2012. OIG revised these standards on June 1, 2012 (see 77 Fed. Reg. 77106). The standards referred to throughout this report are those from 1994, which were in effect at the time of our review.

New Hampshire State MFCU

The New Hampshire Unit is located within the Office of the New Hampshire Attorney General and has the authority to prosecute Medicaid fraud and patient abuse and neglect cases. At the time of our review, the Unit—one of the smallest Units in the country—had five employees, all of whom were located in Concord, the State’s capital. The Unit receives referrals of provider fraud and patient abuse and neglect from a variety of sources, including the State’s Surveillance and Utilization Review Subsystem (SURS).¹⁷ Other sources of referrals include private citizens, providers, the State Long Term Care Ombudsman, and other State agencies. From FYs 2009 to 2011, the Unit received an average of 151 referrals each year. See Appendix B for a breakdown of the referrals received by the Unit during this period.

When the Unit receives a referral, it determines whether to open it as a criminal case or as a civil case. In addition, the Unit may generate its own cases. Once a case is opened, the Unit may close it through civil action or criminal prosecution. The Unit may also close a case if there is insufficient evidence or by referring it to another agency.

Previous Review

In 2008, OIG conducted an onsite review of the New Hampshire Unit. In that review, OIG found no significant performance issues, but disallowed payments for non-Medicaid activities performed by Unit staff without formal approval from OIG.

METHODOLOGY

We based our review on an analysis of data from six sources: (1) a review of policies and procedures and documentation on the Unit’s operations, staffing, and caseload; (2) structured interviews with key stakeholders; (3) structured interviews with the Unit’s staff; (4) a review of financial documentation; (5) an onsite review of case files; and (6) an onsite review of Unit operations.

We analyzed data from all six sources to describe the caseload and assess the performance of the Unit. We also analyzed the 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

¹⁷ In all States with a MFCU, the Unit shares responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. In New Hampshire, program integrity functions are performed by SURS.

with laws, regulations, and policy transmittals.¹⁸ Lastly, we identified any noteworthy practices observed during the review.

Data Collection and Analysis

Review of Unit documentation. We asked the Unit to provide us with its policies and procedures, as well as documentation on its operations, staffing, and caseload, including its annual reports, quarterly statistical reports, and responses to recertification questionnaires. We also asked the Unit to provide us with data describing how it detects, investigates, and prosecutes Medicaid cases. Data collected included information such as the number of referrals received by the Unit and the number of investigations opened and closed. We requested and reviewed these data for the 3-year period of FYs 2009 to 2011.

Interviews with key stakeholders. We conducted structured interviews with key stakeholders who were familiar with the operations of the Unit. Specifically, we interviewed officials in SURS, the Bureau of Elderly and Adult Services, and the Special Investigations Unit, all of which are part of the State Department of Health and Human Services, which also houses the State Medicaid Agency. Additionally, we interviewed the Associate State Attorney General and the Special Agent in Charge for OIG's Region I, which includes the State of New Hampshire.

Interviews with Unit staff. We conducted onsite interviews with all 5 Unit staff, including the Unit director. We asked these staff to provide us with additional information needed to better understand the Unit's operations, as well as to identify opportunities for improvement or practices that contribute to the efficiency and effectiveness of Unit operations and/or performance. We used information obtained from the key stakeholders above to develop questions for the onsite interviews with Unit staff.

Review of financial documentation. We reviewed certain financial documents from the Unit, as well as the Unit's equipment inventory and purchase records, to determine compliance with applicable laws and regulations, as well as to determine whether additional internal controls were needed.

Onsite review of case files. We selected a simple random sample of 70 case files from the Unit's 155 cases that were open at some point during FYs 2009 to 2011. We reviewed all 70 of these case files to check for documentation of supervisory approval for the opening and closing of cases, to check for documented periodic supervisory reviews, and to assess the Unit's processes for monitoring the status and outcomes of cases.

¹⁸ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>.

Onsite review of Unit operations. While onsite, we reviewed the Unit's operations, including its process for receiving referrals, its electronic case management system, its method for case file storage and security, and its general operations.

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

From FYs 2009 to 2011, the New Hampshire Unit reported recoveries of \$14 million, filed criminal charges against 25 defendants, and obtained 15 convictions

From FYs 2009 to 2011, the New Hampshire Unit obtained monetary settlements and court orders requiring the payment of \$14.2 million in civil recoveries and \$100,000 in criminal restitution and fines. (See Table 1.) During this 3-year period, the Unit filed criminal charges against 25 defendants, of which 22 were charged with patient abuse and neglect and 3 were charged with provider fraud. The Unit also obtained 15 convictions.¹⁹ Of these convictions, 13 involved patient abuse and neglect.

Table 1: Criminal and Civil Case Outcomes from FYs 2009 to 2011

Type	FY 2009	FY 2010	FY 2011	TOTAL
Amounts Ordered to Pay Resulting From Criminal Cases	\$47,809.68	\$31,148.17	\$21,104.00	\$100,061.85
Amounts Ordered to Pay Resulting From Civil Cases	\$4,448,009.55	\$6,092,628.75	\$3,687,368.95	\$14,228,007.25
Total Amounts Ordered to Pay	\$4,495,819.23	\$6,123,776.92	\$3,708,472.95	\$14,328,069.10

Source: OIG analysis of New Hampshire MFCU data, 2012.

From FYs 2009 to 2011, the overall number of cases opened and closed by the Unit decreased

According to performance standard 6, the Unit should maintain a continuous case flow. As noted earlier, when the Unit receives a referral, it determines whether to open it as a criminal case or as a civil case. Although the number of fraud cases opened by the Unit increased from FYs 2009 to 2011, the overall number of cases opened by the Unit decreased during this time, from 47 to 31. This overall decrease was due to a decrease in the number of patient abuse and neglect cases opened by the Unit, from 28 in FY 2009 to 5 in FY 2011. (See Table 2.) Within this category of cases, the largest decline occurred among patient funds cases,

¹⁹ These 15 convictions are not necessarily derived from the 25 criminal charges filed during the same period. Some of these convictions may have derived from criminal charges that occurred prior to the 3-year period. Similarly, not all of the criminal charges from this 3-year period may have resulted in convictions during this period.

which involve the misappropriation of patients’ private funds in residential health care facilities and are considered a form of patient abuse and neglect. In FY 2009, the Unit opened 21 patient funds cases, whereas in FY 2011 it opened only 4 such cases.

Table 2: Cases Opened from FYs 2009 to 2011, by Type*

Type of Investigation	FY 2009	FY 2010	FY 2011
Fraud	19	19	26
Patient Abuse and Neglect	28	21	5
Total	47	40	31

*Includes only new cases opened during the FY.
Source: OIG analysis of New Hampshire MFCU data, 2012.

Like the overall number of cases opened by the Unit, the overall number of cases closed by the Unit decreased from FYs 2009 to 2011, from 40 to 35, respectively, despite an increase in the number of fraud cases closed. As with the decline in cases opened, the overall decline in cases closed resulted from a decrease in the number of patient abuse and neglect cases closed. In FY 2009, the Unit closed 24 patient abuse and neglect cases, compared to 9 such cases in FY 2011. (See Table 3.) The largest decline in cases closed during this 3-year period occurred among cases involving patient funds. In FY 2009, the Unit closed 20 patient funds cases, as opposed to 7 such cases in FY 2011. See Appendixes C and D for information about the Unit’s cases by provider category.

Table 3: Cases Closed from FYs 2009 to 2011, by Type

Type of Investigation	FY 2009	FY 2010	FY 2011
Fraud	16	27	26
Patient Abuse and Neglect	24	30	9
Total	40	57	35

Source: OIG analysis of New Hampshire MFCU data, 2012.

The Unit director explained that in mid-2010, the Unit became more selective in opening certain patient funds cases because of staffing limitations. Historically, in instances of suspected misuse of patient funds, the Unit had investigated persons not employed at nursing facilities or assisted living facilities—such as family members serving as fiduciaries—when facilities referred such cases. These cases were often resolved civilly. The Unit director explained that State law gives facilities the same civil enforcement powers as the Unit to investigate fiduciary conduct, adding, “[W]e wanted to preserve our resources for investigating criminal allegations of abuse, neglect and financial exploitation.” He also noted

that before 2010, patient funds cases represented a disproportionately large share of the Unit’s caseload mix; to provide more balance, the director decided to shift the Unit’s focus to fraud referrals.

From FYs 2009 to 2011, the Unit’s staff levels were below the number of staff that the Unit requested and OIG approved

According to performance standard 2, the Unit should maintain staff levels in accordance with staffing allocations approved in its budget. As a part of its oversight role, OIG approves the number of staff requested by the State in its annual budget. At the time of our review, the Unit—one of the smallest in the country—had only five employees: two attorneys (one of whom was the director), one auditor, one investigator, and one legal assistant. For each year during the review period, the Unit’s staff level was below the number of staff that the Unit requested and OIG approved. From FYs 2009 to 2011, OIG approved eight staff members, but the Unit employed only six in FY 2009 and five in FYs 2010 and 2011. According to one staff member, “We’ve lost some senior staff over the last few years. We’re really down on staff now and it’s very difficult.” Another staff member agreed, “Our biggest limitation is our staff size.”

The Unit reported that its best source of fraud referrals was SURS; however, the Unit noted that the number of referrals from this source was low

According to performance standard 4, the Unit should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources. As noted earlier, the Unit receives fraud referrals from a variety of sources, including the State Medicaid Agency, which houses the SURS unit. Identifying potential fraud through analysis of Medicaid data is a statutory responsibility of SURS, and the Unit is highly dependent on SURS for referrals generated by this data analysis.²⁰

Although the Unit director reported that the Unit’s best source of high-quality fraud referrals was SURS, he acknowledged that the number of fraud referrals from SURS was lower than he would have liked. The Unit received seven fraud referrals from SURS in FY 2009, two in FY 2010, and four in FY 2011. Data provided by SURS showed that of these 13 referrals, only 2 came from analysis of claims data. One Unit staff member noted that the State legislature’s aggressive move to managed care—and the need to adapt the State’s computer system to meet

²⁰ According to 42 CFR § 1007.19(e)(2), Units do not have the authority to claim FFP for analysis of patterns of practice to identify situations in which a question of fraud may exist; they are therefore limited to relying on referrals from SURS’ analysis of data.

different needs—has affected SURS’ ability to generate referrals through analysis of Medicaid data, adding: “[W]e would like for them to have a good system so we can have better referrals.”

The Unit’s cases files lacked documentation of periodic supervisory review

According to performance standard 6, the Unit should complete cases within a reasonable timeframe, and as a part of this effort, supervisors should approve the opening and closing of cases and document any supervisory case reviews in the case file. All but one of the case files we reviewed included an opening memorandum signed by the Unit director, and all of the closed case files we reviewed included a closing memorandum signed by the Unit director. However, most files—94 percent—lacked documentation of periodic supervisory review between the case’s opening and closing.²¹ Although staff reported that supervisory case reviews occur on a regular basis, they acknowledged that these reviews were not always documented in the case files. See Appendix E for confidence intervals.

The Unit lacked annual training plans for each of the three professional disciplines

According to performance standard 12, the Unit should establish an annual training plan for each of the three professional disciplines. While all of the Unit’s professional staff members reported being allowed to attend one out-of-state training event per year, the Unit had not established an annual training plan for each professional discipline. Although staff members reported attending training when possible and maintaining their licensure through continuing professional education, they highlighted several obstacles to attending training, including the lack of relevant local training opportunities, the need for State approval of costs, and the cost of time spent away from work to attend trainings. For example, one staff member noted, “In such a small unit, it becomes such a burden to attend some trainings and to be out of the office for that long, so the training you attend has to be really worth it.”

²¹ Of the 70 case files we reviewed, 18 were for multi-State cases that—because they involved the National Association of Medicaid Fraud Control Units—were worked on primarily by the Unit director. Because the Unit director was the only supervisor in the Unit, we excluded these 18 case files from our analysis of documented periodic supervisory review. Of the remaining 52 case files, only 3 included documentation of periodic supervisory review.

Other Observations: Drug Diversion Letter

The Unit identified as a noteworthy practice its sending a letter to nursing facilities and assisted living facilities explaining that drug diversion²² is a form of patient abuse and neglect; this letter resulted in facilities making drug diversion-related referrals to the Unit. According to the Unit director, “Back in 2005 and 2006, [the Vermont Unit] was getting a lot of drug diversion cases and we were not, so we sent a letter to all facilities [in our State]. We then saw an uptick in the number of drug diversion cases referred to us.” The director explained that over time, however, the number of incoming drug diversion referrals began to wane as facility administrators changed. In response to this, the Unit reported during our onsite review that it was in the process of sending another drug diversion letter to nursing facilities and assisted living facilities throughout the State to ensure that such cases are reported. A supervisor at the Bureau of Elderly and Adult Services, a State agency that works with the Unit, also noted the effectiveness of the letter: “I think this letter is a very good idea and that it will result in more cases of abuse and neglect coming forward.”

²² Drug diversion is when facility staff members or other individuals divert residents’ prescription drugs for their own use or for sale.

CONCLUSION AND RECOMMENDATIONS

From FYs 2009 to 2011, the New Hampshire Unit reported recoveries of \$14 million, filed criminal charges against 25 defendants, and obtained 15 convictions. Although the number of fraud cases opened and closed by the Unit increased during this time, the overall number of cases opened and closed by the Unit decreased. This overall decrease was due to a decrease in patient abuse and neglect cases. The Unit attributed the overall decrease primarily to staffing limitations; for all 3 years, the Unit's staff levels were below the number that the Unit requested and OIG approved. Additionally, although the Unit reported that SURS was its best source of fraud referrals, the Unit also noted that the number of referrals from SURS was low.

Our review also found that the Unit's case files lacked documentation of periodic supervisory review, and that the Unit lacked annual training plans for each of the three professional disciplines. At the same time, our review found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals. The Unit identified as a noteworthy practice its sending a letter to nursing facilities and assisted living facilities explaining that drug diversion is a form of patient abuse and neglect; this letter resulted in facilities making drug diversion-related referrals to the Unit.

We recommend that the New Hampshire Unit:

Seek to expand staff sizes to reflect the number of staff approved in the Unit's budget

The Unit should seek to maintain staff levels in accordance with staffing allocations requested by the Unit and approved by OIG.

Work with SURS to ensure that the Unit maintains an adequate number of referrals

The Unit should work with SURS and, if necessary, request that specific data analysis be undertaken to ensure that the Unit receives an adequate number of fraud referrals from SURS.

Ensure that case files contain documented supervisory reviews

The Unit should develop a means of documenting its regular supervisory case file reviews and ensure that this documentation is included in the case file.

Establish annual training plans for each professional discipline

The Unit should develop formal training plans that indicate the type and duration of training expected each year for employees in each professional discipline.

UNIT COMMENTS

The New Hampshire Unit concurred with all four of our recommendations and noted that each of its responses to the recommendations has been implemented or is in the process of being implemented.

The Unit concurred with our recommendation to expand its staff to reflect the number approved in the Unit's budget. The Unit reported that it is currently exploring the possibility of expanding the Unit's investigative staff by adding a second investigator in the next budget cycle.

The Unit also concurred with our recommendation to work with SURS to ensure that the Unit maintains an adequate number of referrals. The Unit reported that it is committed to building on the successful collaboration with SURS by instituting monthly meeting and providing cross-training opportunities for staff. The Unit is also undertaking a review of the referral form and process.

The Unit concurred with our recommendation to ensure that case files contain documented supervisory reviews. The Unit noted that on the basis of the guidance provided during the onsite review visit, it created and implemented a procedure for documenting supervisory case reviews.

The Unit concurred with our recommendation to establish annual training plans for each professional discipline. The Unit agreed that its policy and procedures manual does not include a formal training plan for each discipline but noted that every effort is made to offer all professional staff at least one training course per year. The Unit added that the director has conferred with other MFCU directors to identify best practices in this area and is in the process of developing a formal training policy and plan for each discipline for inclusion in the Unit's policy and procedures manual.

The full text of the Unit's comments is provided in Appendix F. We did not make any changes to the report as a result of the Unit's comments.

APPENDIX A

Performance Standards for Medicaid Fraud Control Units [59 Fed. Reg. 49080, Sept. 26, 1994]

- 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 single 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 Office of Inspector General (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?
 - 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 single State agency and other sources.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit work with the single 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 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 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 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 single State 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 memorandum of understanding (MOU) with the single 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 aid in the mission of the Unit?

APPENDIX B

Referrals Received by the Unit by Source, Fiscal Years 2009 to 2011

<u>Source</u>	Fiscal Year (FY) 2009		FY 2010		FY 2011		FYs 2009 to 2011	
	<u>Fraud</u>	<u>Patient Abuse and Neglect</u>	<u>Fraud</u>	<u>Patient Abuse and Neglect</u>	<u>Fraud</u>	<u>Patient Abuse and Neglect</u>	<u>Fraud</u>	<u>Patient Abuse and Neglect</u>
Surveillance and Utilization Review Subsystem (SURS)	7	0	2	0	4	0	13	0
Medicaid agency (other than SURS)	4	12	0	0	0	0	4	12
State survey and certification	1	3	0	0	1	0	2	3
Other State agencies	2	6	1	6	2	0	5	12
Licensing boards	1	0	1	0	2	0	4	0
Law enforcement agencies	3	1	6	1	4	1	13	3
Health and Human Services Office of Inspector General (OIG)	2	0	4	0	1	0	7	0
Prosecutor	1	0	0	0	0	0	1	0
Providers	1	28	4	26	4	7	9	61
Provider associations	0	9	1	11	0	0	1	20
Private health insurers	0	0	0	0	0	0	0	0
Ombudsman	1	7	2	4	0	0	3	11
Adult Protective Services	2	7	1	4	0	0	3	11
Private citizens	48	3	85	4	91	1	224	8
Medicaid Fraud Control Unit (MFCU) hotline	1	1	0	0	0	0	1	1
Other	6	5	5	1	3	2	14	8
Total referrals received by the Unit	80	82	112	57	112	11	304	150

Source: OIG analysis of New Hampshire MFCU data, 2012.

APPENDIX C

Fraud Investigations Opened and Closed by Provider Category, Fiscal Years 2009 to 2011

Provider Category	Fiscal Year (FY) 2009		FY 2010		FY 2011		FYs 2009 to 2011	
	<u>Opened</u>	<u>Closed</u>	<u>Opened</u>	<u>Closed</u>	<u>Opened</u>	<u>Closed</u>	<u>Opened</u>	<u>Closed</u>
Facilities								
Hospitals	2	1	1	1	1	2	4	4
Nursing facilities	0	0	1	1	0	0	1	1
Other long-term care facilities	0	0	0	0	0	0	0	0
Substance abuse treatment centers	0	0	0	0	0	0	0	0
Other facilities	0	0	0	0	2	1	2	1
Practitioners								
Doctors of medicine or osteopathy	0	1	0	0	2	0	2	1
Dentists	1	1	1	4	1	1	3	6
Podiatrists	0	0	0	0	0	0	0	0
Optometrists and opticians	0	0	0	0	0	0	0	0
Counselors and psychologists	1	3	1	2	1	0	3	5
Chiropractors	0	0	0	0	0	0	0	0
Other practitioners	2	0	1	3	0	0	3	3
Medical Support								
Pharmacies	0	2	1	1	1	1	2	4
Pharmaceutical manufacturers	9	4	9	11	6	11	24	26
Suppliers of durable medical equipment and/or supplies	0	0	0	2	1	0	1	2
Laboratories	1	1	0	0	0	0	1	1
Transportation services	0	0	2	1	4	2	6	3
Home health care agencies	1	1	2	1	6	7	9	9
Home health care aides	0	0	0	0	0	0	0	0
Nurses, physician assistants, nurse practitioners, and certified nurse aides	1	1	0	0	1	1	2	2
Radiologists	0	0	0	0	0	0	0	0
Other medical support	0	0	0	0	0	0	0	0
Program Related								
Managed care	0	0	0	0	0	0	0	0
Medicaid program administration	1	1	0	0	0	0	1	1
Billing company	0	0	0	0	0	0	0	0
Other program related	0	0	0	0	0	0	0	0
Total, All Provider Categories	19	16	19	27	26	26	64	69

Source: Office of Inspector General analysis of New Hampshire Medicaid Fraud Control Unit data, 2012.

APPENDIX D

Patient Abuse and Neglect Investigations Opened and Closed by Provider Category, Fiscal Years 2009 to 2011

Provider Category	Fiscal Year (FY) 2009		FY 2010		FY 2011		FYs 2009 to 2011	
	<u>Opened</u>	<u>Closed</u>	<u>Opened</u>	<u>Closed</u>	<u>Opened</u>	<u>Closed</u>	<u>Opened</u>	<u>Closed</u>
Nursing facility	1	0	1	2	0	0	2	2
Nondirect care	0	0	0	0	0	0	0	0
Other long-term care	1	0	0	1	0	0	1	1
Nurses, physician assistants, nurse practitioners, and certified nurse aides	7	5	2	4	1	2	10	11
Home health care aides	0	0	0	1	0	0	0	1
Other	19	19	18	22	4	7	41	48
Total	28	24	21	30	5	9	54	63

Source: Office of Inspector General analysis of New Hampshire Medicaid Fraud Control Unit data, 2012.

APPENDIX E

Confidence Intervals for Case File Review Data

We estimated the following 3 population values for all 155 case files from the results of our review of the 70 case files selected in our simple random sample. The table below includes the estimate descriptions, sample sizes, point estimates, and 95-percent confidence intervals for these 3 estimates.

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

Data Element Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Case files that included an opening memorandum signed by the Unit director	70	98.6%	92.3%–100%
Case files that included a closing memorandum signed by the Unit director	61	100%	94.8%–100%
Case files that lacked documentation of periodic supervisory review between case opening and closing	52*	94.2%	84.1%–98.8%

*Of the 70 case files reviewed, 18 were for multi-State cases that—because they involved the National Association of Medicaid Fraud Control Units—were worked on primarily by the Unit director. Because the Unit director was the only supervisor in the Unit, we excluded these 18 case files from our analysis of documented periodic supervisory review.

Source: Office of Inspector General analysis of New Hampshire Medicaid Fraud Control Unit case files, 2012.

APPENDIX F

Unit Comments

**ATTORNEY GENERAL
DEPARTMENT OF JUSTICE**

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MICHAEL A. DELANEY
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September 20, 2012

Stuart Wright
Deputy Inspector General for Evaluation and Inspections
Office of Inspector General
Department of Health and Human Services
Room 5660, Cohen Building
330 Independence Avenue, S.W.
Washington, DC 20201

Re: New Hampshire Medicaid Fraud Control Unit (OEI-02-12-00180)

Dear Mr. Wright:

We appreciate the opportunity to respond to the HHS-OIG Onsite Review of the New Hampshire State Medicaid Fraud Control Unit for the review period FFY 2009-2011 and greatly value this review and interaction with HHS-OIG staff as a unique opportunity to review and identify our best practices and opportunities for improvement.

We also appreciate the diligence shown by the HHS-OIG Onsite Review team during this process and their commitment to providing the New Hampshire MFCU with constructive guidance which facilitated our analysis and response to the Onsite Review report.

HHS-OIG has requested that the New Hampshire MFCU respond with comments to the Onsite Review report, including whether we concur with the recommendations and statements of specific actions or alternative actions, with timelines, and reasons for any disagreement with the recommendations.

In the response below, we have set forth each recommendation from the Onsite Review with our concurring response. Each of our responses to the recommendations has been implemented or is in the process of being implemented.

Telephone 603-271-3658 • FAX 603-271-2110 • TDD Access: Relay NH 1-800-735-2964

Seek to expand staff sizes to reflect the number of staff approved in the Unit's budget

The Unit should seek to maintain staff levels in accordance with staffing allocations requested by the Unit and approved by OIG.

Response:

We concur with this recommendation. We also entirely concur with the HHS-OIG finding that the Unit's staff level for each year during the review period was below the number of staff that the Unit requested and OIG approved. As a consequence of budget reductions to all state agencies that became effective during the review period, the Unit had two vacant investigative positions eliminated from the budget. The Unit's director is currently exploring with the front office the possibility of expanding the Unit's present investigative staff by adding back a second investigator position in the next budget cycle. The reinstatement of this position would greatly assist the Unit in fulfilling its mission.

Work with SURS to ensure that the Unit maintains an adequate number of referrals

The Unit should work with SURS and, if necessary, request that specific data analysis be undertaken to ensure that the Unit receives an adequate number of fraud referrals from SURS.

Response:

We concur with this recommendation. We agree that the quantity of referrals that the Unit received from SURS/Program Integrity Unit during the review period was low. This was due in large part to staffing levels within SURS/Program Integrity Unit and the fact that the agency has had long-standing difficulties implementing its state-of-the-art automated utilization review system. The Unit is hopeful that the system will be operational in early 2013. The Unit has a positive and cooperative working relationship with the SURS/Program Integrity Unit. Quarterly meetings are held with the agency's staff to maintain open communication. A Nurse investigator assigned to the agency's program integrity unit has provided our Unit with valuable assistance interpreting and evaluating medical records in several investigations. The Unit is committed to building on the successful collaboration between the Units by instituting monthly meetings and providing cross-training opportunities for SURS/Program Integrity staff. The Unit is also undertaking a review of the referral form and process. At this time there is a State proposed initiative to move Medicaid fee-for-service clients into managed care plans. As this process moves forward, the Unit will work closely with SURS/Program Integrity Unit to ensure that the Unit maintains an adequate workload through referrals from SURS/Program Integrity Unit. Also, as indicated in the Report, while the number of referrals from SURS was low, the Unit receives fraud referrals from a variety of other sources.

As a related matter, the Onsite Review also found that the overall number of cases opened and closed by the Unit had decreased during the review period but that the decrease was solely a function of the Unit opening fewer patient funds cases for investigation. The Unit's reduction in this category of cases was strategically based due to the Unit's limited staffing and concomitant need to prioritize the investigation of patient funds cases involving alleged criminal

conduct. For example, during the review period, the Unit staff successfully completed a high-profile criminal investigation and jury trial involving a defendant's theft of \$500,000 from a facility resident. The completion of that case required a substantial commitment from limited personnel and had a temporary adverse effect on the Unit's capacity to develop other investigations. Following the conclusion of that priority criminal case, which occurred shortly after the close of the time period covered by the Onsite Review, the Unit was able to increase its inventory of open cases by more than 45 percent.

Ensure that case files contain documented supervisory reviews

The Unit should develop a means of documenting its regular supervisory case file reviews and ensure that this documentation is included in the case file.

Response:

We concur with this recommendation. While the Unit director conducts periodic reviews on all open investigations, we agree that the Unit has not consistently documented those reviews in the case files. Based on the guidance the Unit received from the onsite review visit, the Unit created and implemented a procedure for documenting supervisory case file reviews.

Establish annual training plans for each professional discipline

The Unit should develop formal training plans that indicate the type and duration of training expected each year for employees in each professional discipline.

Response:

We concur with this recommendation. While the Unit has established training goals and expectations for all staff, we agree that the Unit's policy and procedures manual does not include a formal training plan for each discipline. The Unit's longstanding training practices have included an expectation that newly-hired professional staff will attend the introductory training course offered through the National Association of Medicaid Fraud Control Units (NAMFCU). For veteran Unit staff, training opportunities emphasize advanced issues and emerging fraud trends. Additionally, certified law enforcement personnel are required to qualify annually with their firearms and the attorneys are afforded the opportunity to meet their annual continuing legal education requirements. Every effort is made to offer all professional staff at least one training course per year. The Unit director has conferred with other state MFCU directors to identify best practices in this area and is in the process of developing a formal training policy and plan for each discipline for inclusion in the Unit's policy and procedures manual.

Conclusion

The New Hampshire MFCU appreciates the efforts of HHS-OIG and the consultations provided by the Onsite Review. We remain committed to meeting and exceeding the standards for Medicaid Fraud Control Units despite noted obstacles. We understand and concur with the recommendations, all of which will be implemented in a manner consistent with our mission.

Respectfully submitted,

/s/

Karin Eckel
Assistant Attorney General
Director, Medicaid Fraud Control Unit

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Vincent Greiber served as the team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Hailey Davis. Central office staff who provided support include Thomas Brannon, Kevin Farber, and Christine Moritz. Office of Investigations staff who contributed to the report include Colleen Fleming. Office of Management and Policy staff who contributed to the report include Alexis Lynady.

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