

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



**Stuart Wright
Deputy Inspector General for
Evaluation and Inspections**

**December 2013
OEI-02-13-00360**

**EXECUTIVE SUMMARY: VERMONT STATE MEDICAID FRAUD CONTROL
UNIT: 2013 ONSITE REVIEW
OEI-02-13-00360**

WHY WE DID THIS STUDY

The Office of Inspector General (OIG) oversees all Medicaid Fraud Control Units (MFCUs or Units) with respect to Federal grant compliance. As part of this oversight, OIG reviews all Units. These reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor Unit compliance with Federal grant requirements, laws, and regulations.

HOW WE DID THIS STUDY

We based our review on an analysis of data from six 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) structured interviews with the Unit's management and staff; (5) an onsite review of case files; and (6) an onsite review of Unit operations.

WHAT WE FOUND

From fiscal year (FY) 2010 through FY 2012, the Unit reported combined civil and criminal recoveries of \$15 million, 18 convictions, and 36 civil settlements and judgments. Although most case files indicated supervisory approval to open and close cases, almost all lacked documentation of periodic supervisory reviews. The Director and staff reported that such reviews occur on a regular basis but are not generally documented in the case files. Also, the Unit did not refer all convictions to OIG appropriately. In addition, large caseloads hinder the Unit's ability to investigate and prosecute fraud and abuse in a timely manner. Lastly, we identified as beneficial (1) the Unit's creation of Provider Focus Teams to collaborate on existing cases with the Program Integrity Unit in the Department of Vermont Health Access; and (2) the development of the Elder Justice Working Group, which has initiated an effort to reduce the use of antipsychotics in nursing homes in Vermont.

WHAT WE RECOMMEND

We recommend that the Unit (1) ensure that case files contain documentation of supervisory reviews; (2) ensure that all convicted individuals are appropriately referred to OIG for program exclusion; and (3) assess the adequacy of existing staffing levels and take appropriate action based on that assessment. The Unit concurred with all three of our recommendations.

TABLE OF CONTENTS

Objective	1
Background	1
Methodology	5
Findings.....	7
From FY 2010 through FY 2012, the Unit reported combined civil and criminal recoveries of \$15 million, 18 convictions, and 36 civil settlements and judgments	7
Although most case files indicated supervisory approval to open and close cases, almost all lacked documentation of periodic supervisory reviews	8
The Unit did not refer all convictions to OIG appropriately	8
Large caseloads hinder the Unit’s ability to investigate and prosecute fraud and abuse in a timely manner.....	9
Other observations: Provider Focus Teams and Elder Abuse Working Group	10
Conclusion and Recommendations.....	12
Unit Comments	13
Appendixes	14
A: Performance Standards for Medicaid Fraud Control Units	14
B: 2012 Revised Performance Standards	18
C: Referrals of Patient Abuse and Neglect, Provider Fraud, and Theft of Patient Funds to the Medicaid Fraud Control Unit by Source, Fiscal Years 2010 through 2012.....	24
D: Cases Opened and Closed by Provider Category and Case Type, Fiscal Years 2010 through 2012.....	25
E: Confidence Intervals for Estimates	28
F: Unit Comments.....	29
Acknowledgments.....	32

OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate fraud and patient abuse and neglect by Medicaid providers and to prosecute it 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 fiscal year (FY) 2012, combined Federal and State grant expenditures for the Units totaled \$217.3 million, with Federal funds representing \$162.9 million of this amount.⁴ In FY 2012, the Vermont Unit was awarded \$913,816 in combined State and Federal funds.⁵

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.⁶ Unit staff review complaints provided by the State Medicaid agency and other sources and determine their potential for criminal prosecution and/or civil action. In FY 2012, the 50 Units collectively obtained 1,337 convictions and 823 civil settlements or judgments.⁷ That year, the Units reported recoveries of approximately \$2.9 billion.

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

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

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

⁴ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures And Statistics*, March 2013. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2012.asp on March 5, 2013. All FY references in this report are based on the Federal FY (October 1 through September 30).

⁵ Office of Inspector General (OIG) analysis of Notice of Award for Vermont for FY 2012.

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

⁷ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures And Statistics*, March 2013. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2012.asp on March 5, 2013.

Units are required to have either Statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.⁸ In Vermont and 43 other States, the Units are located within offices of State Attorneys General; in the remaining six States, the Units are located in other State agencies.⁹ Generally, Units outside of the Attorneys General offices must refer cases to other offices with prosecutorial authority.

Additionally, 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.¹⁰

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to OIG the authority to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs in operating certified Units.¹¹ All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹² 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 are for a 1-year period; the Unit must be recertified each year thereafter.¹⁴

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁵ OIG developed and issued 12 performance standards to define the criteria it applies in assessing whether a Unit is effectively carrying out statutory

⁸ SSA § 1903(q)(1).

⁹ Among those States with a Unit, the Unit shares responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States also employ a Medicaid Inspector General who conducts and coordinates activities combating fraud, waste, and abuse for the State agency.

¹⁰ SSA § 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 Federal Financial Participation.

¹² SSA § 1903(a)(6)(B).

¹³ 42 CFR § 1007.15(a).

¹⁴ 42 CFR § 1007.15(b) and (c).

¹⁵ SSA § 1902(a)(61).

functions and meeting program requirements.¹⁶ Examples 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 a complete list of the 1994 performance standards and Appendix B for a complete list of the 2012 performance standards.

Vermont Unit

In Vermont, the MFCU is known as the Medicaid Fraud and Residential Abuse Unit, and is located in the Vermont Attorney General's Office. The Unit Director reports to the Chief of the Criminal Division, who reports to the Deputy Attorney General. The Unit has the authority to prosecute Medicaid fraud and patient abuse and neglect cases.

As of January 2013, the Unit had eight employees: the Unit Director, who also serves as an attorney; two additional attorneys; two investigators; two auditors (who in the Vermont Unit are known as "fiscal and regulatory analysts," or "analysts"); and a program technician.

The Unit receives referrals of provider fraud from a variety of sources, including the Program Integrity Unit in the Department of Vermont Health Access; the Survey and Certification program, part of the Division of Licensing and Protection in the Vermont Department of Aging and Independent Living; and the Vermont Department of Health. The Unit receives referrals of patient abuse and neglect from a variety of sources, including the Survey and Certification program; Adult Protective Services, which is also part of the Department of Aging and Independent Living; and the Office of Professional Regulation, part of the Office of the Vermont Secretary of State. From FY 2010 through FY 2012, the Unit received a total of 224 referrals of fraud, 241 referrals of patient abuse and neglect, and 69 referrals of theft of patient funds—an average of 75, 80, and 23 referrals, respectively, each year. See Appendix C for a breakdown of referrals by type, year, and source.

When the Unit receives a referral, the Director decides either to accept it after initial review of the complaint, or to defer a decision pending a preliminary investigation. If necessary, the referral is also reviewed by the Unit Case Intake Committee. This committee consists of the Unit Director, an attorney, an investigator, and an analyst. The Director assigns open cases to an investigative team. Investigative teams are led by one of

¹⁶ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov> on November 5, 2012. OIG published a revision of the performance standards, 77 Fed. Reg. 32645 (June 1, 2012). This review applies the previous standards (published on September 26, 1994) for the review period of FY 2010 through May 31, 2012, and the standards published on June 1, 2012, when assessing Unit operations after May 31, 2012.

two Unit attorneys (or the Unit Director), with support from one of two investigators, one of two analysts, and the program technician. See Appendix D for additional information on the Unit's opened and closed cases, including a breakdown by case type and provider category.

The Unit may open a case and pursue it through a variety of actions, including criminal prosecution or civil action. The Unit may close a case through a criminal or civil resolution, through a referral to another agency, or for other reasons. The Unit also participates in "global"—i.e., multi-State—civil cases, coordinated by the National Association of Medicaid Fraud Control Units (NAMFCU).

METHODOLOGY

Our review covered the 3-year period of FYs 2010 through 2012. We analyzed data from six sources: (1) a review of policies, procedures, and documentation relating to the Unit's operations, staffing, and caseload for FYs 2010 through 2012; (2) a review of financial documentation for FYs 2010 through 2012; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's management and staff; (5) an onsite review of case files that were open in FYs 2010 through 2012; and (6) an onsite review of Unit operations conducted in July 2013.

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 meet the performance standards or was not operating in accordance with laws, regulations, and policy transmittals.¹⁷ In addition, we described noteworthy practices that appeared to benefit the Unit, based 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.

Data Collection and Analysis

Review of Unit Documentation. We requested and reviewed documentation, policies, and procedures related to the Unit's operations, staffing, and cases, including its annual reports, quarterly statistical reports, and responses to recertification questionnaires. We also requested and reviewed the Unit's data describing its caseload, prosecutions, and recoveries. Data collected included information such as the number of referrals received by the Unit and the number of investigations opened and closed.

¹⁷ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov>.

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. We conducted structured interviews with seven individual stakeholders who were familiar with Unit operations. We interviewed key stakeholders in (1) the Program Integrity Unit; (2) Adult Protective Services; (3) the Survey and Certification Program; (4) the Office of Professional Regulation; and (5) the Administrator of Children's Personal Care Services, an agency within the Vermont Department of Health. We also interviewed (6) a Special Agent in OIG's Region I (the region that includes Vermont) who was familiar with the Unit and (7) the Chief of the Criminal Division of the Attorney General of Vermont. These interviews focused on the Unit's interaction with external agencies, Unit operations, opportunities for improvement, and any practices that appeared to benefit the Unit and that may be useful to other Units in their operations.

Interviews With Unit Management and Staff. We conducted structured interviews with the Unit's Director and staff. We asked the Director for additional information to better understand the Unit's operations, to identify opportunities for improvement, to identify practices that appeared to benefit the Unit and that may be useful to other Units, and to clarify information obtained from other data sources. We also interviewed the Unit's two analysts, two attorneys, two investigators, and the program technician. We asked similar questions of these staff.

Onsite Review of Case Files. We selected a simple random sample of 100 case files from the 286 cases that were open at any point from FY 2010 through FY 2012. The design of this sample allowed us to estimate the proportion of all 286 case files with certain characteristics at the 95-percent confidence level. We reviewed these 100 sampled case files and the Unit's processes for monitoring the status and outcomes of cases. From these 100 case files, we selected another simple random sample of 50 cases for a more in-depth review.

Onsite Review of Unit Operations. While onsite, we reviewed the Unit's operations. Specifically, we reviewed the Unit's process for intake of referrals, security of data and case files, and the general functioning of the Unit.

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 FY 2010 through FY 2012, the Unit reported combined civil and criminal recoveries of \$15 million, 18 convictions, and 36 civil settlements and judgments

Unit recoveries more than doubled from \$3.7 million in FY 2010 to \$8.7 million in FY 2012. State-only—i.e., non-“global”—civil case recoveries had the largest increase during this period, to \$328,866. Additionally, recoveries from “global” civil cases—i.e., multi-State NAMFCU cases—more than doubled, accounting for 96 percent of total recoveries in FY 2012. Over the 3-year period, the Unit reported recoveries of \$15 million—an average of \$5 million annually. (See Table 1.) The Unit also reported 18 convictions and 36 civil settlements and judgments from FY 2010 through FY 2012.

Table 1: Unit Recoveries, FYs 2010 through 2012

	FY 2010	FY 2011	FY 2012	Total	Annual Average
Reported Criminal Recoveries	\$7,598	\$6,658	\$10,230	\$24,486	\$8,162
Reported Civil Recoveries – State Only	\$14,125	\$200,990	\$328,866	\$543,981	\$181,327
Reported Civil Recoveries – Global	\$3,708,149	\$2,454,715	\$8,393,446	\$14,556,309	\$4,852,103
Total Reported Recoveries	\$3,729,872	\$2,662,362	\$8,732,541	\$15,124,775	\$5,041,592

Source: OIG analysis of Unit data, 2013.

From FY 2010 through FY 2012, the overall number of referrals received by the Unit decreased slightly, from 222 to 192. Additionally, the breakdown of referrals changed, resulting in a decrease in the number of patient abuse referrals and an increase in the number of fraud referrals. This was primarily driven by a decrease in patient abuse referrals—from 92 to 64—from the State Survey and Certification program and an increase in fraud referrals—from 5 to 15—from the State Program Integrity Unit. See Appendix B for more detailed information on the number of referrals by source.

Although most case files indicated supervisory approval to open and close cases, almost all lacked documentation of periodic supervisory reviews

According to Performance Standard 6, the Unit should complete cases within a reasonable timeframe.¹⁸ As a part of this standard, supervisors should approve the opening and closing of cases and supervisory reviews should be “conducted periodically and noted in the case file” to ensure timely case completion. In our review, we found that most case files contained documentation indicating supervisory approval to open and close the case. Specifically, 89 percent of case files had an opening memorandum approved by the Director and 96 percent had a closing memorandum approved by the Director. However, 96 percent of Unit case files contained no documentation indicating periodic reviews, or at least one supervisory review beyond opening and closing approval.¹⁹ See Appendix E for confidence intervals.

Although the Director and staff reported that supervisory case reviews occur on a regular basis, they acknowledged that these reviews were more informal and not generally documented in the case files. The Director noted, and Unit staff confirmed, that case supervision is conducted at several points during the investigation and prosecution stages. For example, case discussions are held during the complaint intake; the opening of a complaint for full investigation; the development of a case investigation plan; the case investigation; and the preparation of a prosecution memorandum, charging recommendation, and decision. Case supervision also occurs during weekly administrative meetings with the Director, at quarterly staff meetings and individual team meetings, and on an ad hoc basis with the Chief of the Criminal Division. The Unit’s policies and procedures manual describes procedures for several of these supervisory reviews.

The Unit did not refer all convictions to OIG appropriately

According to Performance Standard 8(d), the Unit must send reports of convictions to OIG “within 30 days or other reasonable time period” for the purpose of excluding individuals and entities from participation in

¹⁸ Performance standards cited in this report are found at 59 Fed. Reg. 49080 and dated Sept. 26, 1994, unless otherwise noted.

¹⁹ Of the 100 case files we reviewed, 25 were for multi-State cases that—because they involved NAMFCU—were worked on primarily by the Unit Director. Because the Unit Director was the only supervisor of these cases in the Unit, we excluded these 25 case files from our analysis of documented periodic supervisory review. Of the remaining 75 case files, only 3 included documentation of periodic supervisory reviews.

Federally funded healthcare programs, including Medicare and Medicaid.²⁰ If a Unit fails to properly ensure that convicted providers are referred for exclusion, those providers may be able to continue to submit fraudulent claims and receive payments.

From FY 2010 through FY 2012, the Vermont Unit's investigations resulted in the sentencing of 18 individuals for health care fraud or for abuse, neglect, or financial exploitation of patients. Of these, 8 were referred to OIG for exclusion within 30 days. Another 5 were referred within 31 to 50 days, and 2 were referred more than 100 days after sentencing. The Director explained that in these two cases, the referrals were delayed because the Unit was awaiting resolution of restitution hearings. In addition, the Unit did not refer 3 of the 18 cases for exclusion. These three cases were prosecuted in conjunction with an OIG agent and the U.S. Attorney's Office in the District of Vermont. The Unit Director explained that the Unit played a secondary role and did not ensure that the paperwork was submitted.

Large caseloads hinder the Unit's ability to investigate and prosecute fraud and abuse in a timely manner

According to current Performance Standard 2(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."

Although the Unit was at the staffing level approved by OIG at the time of our review, the Unit Director and almost all staff reported that limited staff size and large caseloads make it difficult to investigate and prosecute cases in a timely manner. Unit investigators reported having caseloads of between 36 and 40 cases each, whereas they said that the ideal caseload would be between 10 and 20 cases each. The national average is 18 cases per investigator.²¹

²⁰ Under 42 U.S.C. § 1320a-7(a), OIG is required to exclude from participation in Federal health care programs any person or entity convicted of a criminal offense related to the delivery of an item or service under the Medicaid program or to the neglect or abuse of patients in residential health care facilities. See also 42 CFR § 1001.1901. For individuals and entities convicted of program-related crimes, patient abuse, felony health care fraud, and felonies relating to controlled substances, a mandatory exclusion is required.

²¹ For FY 2012, the number of investigators Nationwide was 841 and the number of cases was 15,534. The number of cases can be accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2012-statistical-chart.htm.

Additionally, the Director identified the size of the Unit’s caseload as the main obstacle preventing the Unit from meeting timeliness goals. He noted that in addition to cases being deferred pending his decisions on how to proceed with them; cases are occasionally closed due to lack of resources and then must be returned to the referring agency. He said that the Unit has a “critical need” for staff, adding: “[W]e place an enormous burden on our investigators.” According to the Unit Director, when the Unit was created in 1979, it had six positions to investigate and prosecute fraud and the Vermont Medicaid program had a budget of \$800,000. In 2012, the budget of the Vermont Medicaid program had increased to more than \$1 billion—more than a tenfold increase since 1979—yet the Unit’s staff had increased to just eight permanent positions.²²

Unit staff also indicated that large caseloads hinder their efforts. According to one staff member, “[I]t is difficult because [the investigators] have so much work ... we get backlogged sometimes.” He added that the Unit’s policy to conduct biannual case reviews is affected, noting “the cases that are languishing may or may not get a 6 month review.” Other staff members expressed similar concerns about the amount of cases and the delays created by caseload size. One staff member noted that to improve the Unit’s performance, “[W]e need to get ourselves to the point where we have a manageable caseload.”

Stakeholders concurred that large caseloads hinder the Unit’s ability to handle cases in a timely manner. The Director of the Program Integrity Unit, whose agency provides an increasing number of referrals to the Unit, noted that “the Unit needs more staff to catch up to the increase in referrals.” He further stated that lack of staffing resources is the Unit’s biggest problem, adding that it “would improve their effectiveness if they had more investigators and attorneys.” Another stakeholder expressed concerns with the Unit’s current caseload, saying that cases are delayed “because [Unit staff] are overloaded and can’t move the cases” and that “they sometimes have too many cases to get to.” Another stakeholder said, “[I]t would be beneficial if they had a larger staff. They have a lot on their plate.”

Other observations: Provider Focus Teams and Elder Justice Working Group

²² Vermont MFCU responses to the Vermont MFCU FY 2012 Recertification Questionnaire. OIG recertifies Units each year. As part of that recertification process, Units submit responses to a questionnaire to describe Unit operations and performance.

In April 2011, the Unit Director created “Provider Focus Teams” in collaboration with the Program Integrity Unit in the Department of Vermont Health Access. These interagency teams were intended to generate an increased number of referrals of new cases, facilitate existing (i.e., already open) cases, develop provider training, and make program recommendations. The teams, which consisted of one to two staff members from the Unit and a similar number from the Program Integrity Unit, met at least every other month. Each team focused on one of four areas: mental health, narcotic prescribers, pharmacies, and durable medical equipment.

Although the provider-focused teams did not meet the goal of increasing the number of referrals and were discontinued, they had a number of merits. According to the MFCU Director, the teams “had many indirect benefits, [including] training, building relationships, [and] program recommendations.” The Program Integrity Unit Director confirmed that the teams were effective in coordinating provider training and in generating program recommendations. The Director of the Program Integrity Unit also said that the provider-focused teams were successful in collaborating on existing cases. The MFCU Director agreed, noting that having these interagency teams meet on a regular basis to discuss open cases fostered discussion, and that as a result, the Unit received more substantive referrals from the Program Integrity Unit.

In addition, in June 2011, the MFCU Unit Director helped create the Vermont Elder Justice Working Group, consisting of representatives from State and Federal advocacy, regulatory, and law enforcement agencies. The group’s mission is to create opportunities for improving quality health care for the elderly in long-term care settings and other caregiving programs by improving communications among stakeholders and law enforcement.

The first initiative of the group focused on reducing prescriptions for, and the administration of, unnecessary antipsychotic medication in elderly residents with dementia. The group targeted Vermont nursing homes that exceeded the national average for antipsychotic use and sent a written educational alert that reported the numbers of residents in the facility who were prescribed antipsychotics and how those numbers compared to the average numbers in nursing homes in Vermont and the Nation. The group plans to provide nursing homes with followup educational alerts on a biannual basis until the facilities reach rates of use that are at or below the national average.

CONCLUSION AND RECOMMENDATIONS

From FY 2010 through 2012, the Unit reported combined civil and criminal recoveries of \$15 million, 18 convictions, and 36 civil settlements and judgments. Although most case files indicated supervisory approval to open and close cases, almost all lacked documentation of periodic supervisory reviews. The Director and staff reported that such reviews occur on a regular basis but are not generally documented in the case files. Also, the Unit did not refer all convictions to OIG appropriately. In addition, large caseloads hinder the Unit's ability to investigate and prosecute fraud and abuse in a timely manner. Lastly, we identified as beneficial the Unit's creation of Provider Focus Teams to collaborate on existing cases with the Program Integrity Unit, and the development of the Elder Justice Working Group, which has initiated an effort to reduce the use of antipsychotics in nursing homes in Vermont.

We recommend that the Unit:

Ensure that case files contain documentation of supervisory reviews

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

Ensure that all convicted individuals are appropriately referred to OIG for program exclusion

The Unit should ensure that all convictions are referred to OIG for purposes of program exclusion within 30 days of sentencing, in accordance with Performance Standard 8(d) of the 2012 performance standards.

Assess the adequacy of existing staff levels and take appropriate action based on that assessment

The Unit should assess whether professional staffing levels are commensurate with the State's total Medicaid program expenditures. Additionally, the Unit should determine whether existing staffing levels are sufficient to respond to the volume of referrals and to investigate and prosecute all the Unit's cases in a timely manner. The Unit should take appropriate action based on that assessment.

UNIT COMMENTS

The Vermont Unit concurred with all three of our recommendations and noted that the actions it cited in each of its responses to the recommendations had been implemented or were in the process of being implemented.

The Unit concurred with our recommendation to ensure that case files contain documentation of supervisory reviews. The Unit reported that it has developed a form for this purpose. Going forward, the Unit will complete this form for each complaint opened for full investigation. To the extent possible, the Unit will also complete the form retroactively for significant investigations that are currently open.

The Unit concurred with our recommendation to ensure that all convicted individuals are appropriately referred to OIG for program exclusion. The Unit reported that it updated its policies and procedures to reflect the new, clarified timetable for reporting convictions, and that it has met with the HHS-OIG exclusion officer for New England to discuss the exclusion paperwork process. The Unit will also report convictions to OIG for exclusion even when the Unit has only a secondary role in the prosecution and an OIG agent is the lead investigator.

Finally, the Unit concurred with our recommendation to assess the adequacy of existing staff levels and take appropriate action based on that assessment. The Unit noted that over the next 6 months, it will assess whether staffing levels are (1) commensurate with Vermont's total Medicaid program expenditures and (2) sufficient to respond to the volume of the Unit's referrals and caseload. On the basis of this assessment, the Unit will then make a recommendation to senior management in the Attorney General's Office.

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

APPENDIX A

Performance Standards for Medicaid Fraud Control Units (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

2012 Revised Performance Standards²³

- 1. A unit conforms with all applicable statutes, regulations, and policy directives, including:**
 - a. Section 1903(q) of the Social Security Act, containing the basic requirements for operation of a MFCU;
 - b. Regulations for operation of a MFCU contained in 42 CFR part 1007;
 - c. Grant administration requirements at 45 CFR part 92 and Federal cost principles at 2 CFR part 225;
 - d. OIG policy transmittals as maintained on the OIG Web site; and
 - e. Terms and conditions of the notice of the grant award.
- 2. A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.**
 - a. The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
 - b. The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
 - c. The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
 - d. The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
 - e. To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.

²³ 77 Fed. Reg. 32645, June 1, 2012.

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

- a. The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.
- b. The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR 455.23, "Suspension of payments in cases of fraud."
- c. The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).
- d. Consistent with performance standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.
- e. The MOU incorporates by reference the CMS performance standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit.

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

- a. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.
- b. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.
- c. The Unit maintains an effective time and attendance system and personnel activity records.
- d. The Unit applies generally accepted accounting principles in its control of Unit funding.

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

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

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

APPENDIX C

Referrals of Patient Abuse and Neglect, Provider Fraud, and Theft of Patient Funds to the Vermont Unit by Source, Fiscal Years 2010 through 2012

Table C-1: Total Referrals of Patient Abuse and Neglect, Provider Fraud, and Theft of Patient Funds to the Unit and Annual Average Referrals

Case Type	Fiscal Year (FY) 2010	FY 2011	FY 2012	3-Year Total	Annual Average
Provider Fraud	84	53	87	224	75
Patient Abuse and Neglect	113	53	75	241	80
Theft of Patient Funds	25	14	30	69	23
Total	222	120	192	534	178

Source: OIG analysis of Unit data, 2013.

Table C-2: Unit Referrals, by Referral Source

Referral Source	FY 2010			FY 2011			FY 2012			Total	Percentage of All Referrals
	Fraud	Abuse and Neglect	Theft of Patient Funds	Fraud	Abuse and Neglect	Theft of Patient Funds	Fraud	Abuse and Neglect	Theft of Patient Funds		
Medicaid Agency – Program Integrity Unit	5	0	0	3	0	0	15	0	0	23	4.3%
Medicaid Agency – Other	1	0	0	0	0	0	1	0	0	2	0.4%
State Survey / Certification	13	92	18	5	30	5	6	64	23	256	47.9%
State Agencies – Other	2	1	1	0	0	0	9	2	0	15	2.8%
Licensing Board	7	3	0	3	4	1	1	0	0	19	3.6%
Law Enforcement	1	0	0	1	2	0	0	2	0	6	1.1%
OIG	1	1	1	0	1	0	2	0	0	6	1.1%
Prosecutor	15	1	0	14	1	0	16	0	0	47	8.8%
Provider	2	0	1	4	2	1	9	1	0	20	3.8%
Provider Association	10	0	0	0	0	0	8	0	0	18	3.4%
Private Health Insurer	0	0	0	0	0	0	0	0	0	0	0.0%
Ombudsman	0	1	0	0	0	0	0	0	0	1	0.2%
Adult Protective Services	8	8	1	5	10	3	4	0	2	41	7.7%
Private Citizen	14	4	2	12	2	3	12	5	2	56	10.5%
Unit Hotline	0	0	0	0	0	0	0	0	0	0	0.0%
Other	5	2	1	6	1	1	4	1	3	24	4.5%
Total	84	113	25	53	53	14	87	75	30	534	100.0%
Annual Total	222			120			192				

Source: OIG analysis of Unit data, 2013.

APPENDIX D

Cases Opened and Closed by Provider Category and Case Type, Fiscal Years 2010 through 2012

Table D-1: Total Annual Opened and Closed Cases, by Case Type

Case Type	Fiscal Year (FY) 2010	FY 2011	FY 2012	3-Year Total	Annual Average
Opened	83	49	59	191	64
Provider Fraud	54	32	45	131	44
Patient Abuse and Neglect	29	17	11	57	19
Theft of Patient Funds	0	0	3	3	1
Closed	76	29	70	175	58
Provider Fraud	54	16	51	121	40
Patient Abuse and Neglect	21	13	18	52	17
Theft of Patient Funds	1	0	1	2	1

Source: OIG analysis of Unit data, 2013.

Table D-2: Outcomes for Closed Cases, by Case Type

Type of Investigations	Closed by Prosecution			Closed by Civil Action			Closed due to Insufficient evidence			Closed by Referral		
	FY 2010	FY 2011	FY 2012	FY 2010	FY 2011	FY 2012	FY 2010	FY 2011	FY 2012	FY 2010	FY 2011	FY 2012
Investigations of Fraud	3	3	7	12	9	17	38	1	24	1	3	3
Investigations of Patient Abuse and Neglect	0	1	2	0	0	0	21	11	16	0	1	1
Investigation of Theft of Patient Funds	1	0	0	0	0	0	0	0	1	0	0	0
Total Investigations	4	4	9	12	9	17	59	12	41	1	4	4

Source: OIG analysis of Unit data, 2013.

Table D-3: Provider Fraud Cases Opened and Closed, by Provider Type

Provider Type	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Facilities						
Hospitals	0	1	3	1	0	3
Nursing Facilities	3	1	0	1	5	2
Other Long-Term Care Facilities	0	0	0	0	0	0
Substance Abuse Treatment Centers	0	0	0	0	0	0
Other Facilities	2	3	0	0	3	0
Practitioners						
Doctors of Medicine or Osteopathy	2	5	2	0	2	0
Dentists	1	1	0	0	0	0
Podiatrists	0	0	0	0	0	0
Optometrist/Opticians	0	0	0	0	0	0
Counselors/Psychologists	3	3	3	0	1	5
Chiropractors	0	0	0	0	0	0
Other Practitioners	1	0	1	0	0	0
Medical Support						
Pharmacies	0	0	4	0	4	2
Pharmaceutical Manufacturers	10	9	8	7	6	11
Durable Medical Equipment and/or Suppliers	2	1	0	1	2	2
Laboratories	1	1	0	0	0	0
Transportation Services	1	0	1	0	2	2
Home Health Care Agencies	0	0	2	0	1	1
Home Health Care Aides	25	22	7	5	17	21
Nurses/Physician Assistants/ Nurse Practitioners/Certified Nurse Aides	2	2	0	1	0	1
Radiologists	0	0	0	0	0	0
Other Medical Support	0	2	0	0	0	0
Program Related						
Managed Care	0	0	0	0	0	0
Medicaid Program Administration	0	0	0	0	0	0
Billing Company	0	0	0	0	0	0
Other Program Related	1	3	1	0	2	1
Total	54	54	32	16	45	51

Source: OIG analysis of Unit data, 2013.

Table D-4: Cases of Patient Abuse and Neglect Opened and Closed, by Provider Type

Provider Type	FY 2010		FY 2011		FY 2012	
	Open ed	Closed	Opened	Closed	Opened	Closed
Nursing Facilities	7	3	7	3	3	7
Other Long-Term Care	0	0	0	0	1	1
Nurses/Physician Assistants/ Nurse Practitioners/ Certified Nurse Aides	9	8	4	5	3	5
Home Health Aides	3	2	2	1	3	3
Other	10	8	4	4	1	2
Total	29	21	17	13	11	18

Source: OIG analysis of Unit data, 2013

Table D-5: Cases of Theft of Patient Funds Opened and Closed, by Provider Type

Provider Type	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Non-Direct Care	0	0	0	0	0	0
Nurses/Physician Assistants/ Nurse Practitioners/ Certified Nurse Aides	0	1	0	0	0	0
Home Health Aide	0	0	0	0	0	0
Other	0	0	0	0	3	1
Total	0	1	0	0	3	1

Source: OIG analysis of Unit data, 2013

APPENDIX E

Confidence Intervals for Estimates

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

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Case Files With Opening Documents	100	89.0%	82.9–93.1%
Case Files With Closing Documents	70	95.8%	89.8–98.3%
Case Files With No Documentation Indicating at Least One Supervisory Review (Does Not Include Global Cases)	75	96.0%	90.3–98.4%

APPENDIX F

Unit Comments

WILLIAM H. SORRELL
ATTORNEY GENERAL

SUSANNE R. YOUNG
DEPUTY ATTORNEY GENERAL

WILLIAM E. GRIFFIN
CHIEF ASST. ATTORNEY
GENERAL



STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT
05609-1001

TEL: (802) 828-3171
FAX: (802) 828-3187
TTY: (802) 828-3665

<http://www.atg.state.vt.us>

December 18, 2013

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, D.C. 20201

Re: Vermont State Medicaid Fraud Control Unit Onsite Review (OEI-02-13-00360)

Dear Mr. Wright:

We appreciate the opportunity to respond to the HHS-OIG Onsite Review of the Vermont State Medicaid Fraud Control Unit for the review period FFY 2010-2012 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 Vermont MFCU with constructive guidance which facilitated our analysis and response to the Onsite Review report.

HHS-OIG has requested that the Vermont 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 corresponding response. Each of our responses to the recommendations has been implemented or is in the process of being implemented.

1. HHS-OIG Recommendation: Ensure that case files contain documentation of supervisory reviews.

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

Response: We concur with this recommendation. Although, as noted in the audit report, the Unit's cases are supervised by the assigned attorney, Unit Director, and the Chief of the Criminal Division throughout the intake, investigation, and prosecution/litigation process, it would be helpful for purposes of conducting future audits, and for general case management, to record instances of supervision in each case file. The Unit has developed a form for this purpose. This form will be completed for each complaint opened for full investigation going forward, and, to the extent possible, retroactively for significant investigations that are currently open.

2. HHS-OIG Recommendation: Ensure that all convicted individuals are appropriately referred to OIG for program exclusion.

The Unit should ensure that all convictions are referred to OIG for purposes of program exclusion within 30 days of sentencing, in accordance with Performance Standard 8(d) of the 2012 performance standards.

Response: We concur with this recommendation. The Unit's policies and procedures have been updated to reflect the new, clarified timetable under Performance Standard 8(d) for reporting convictions (i.e., within "30 days" as opposed to "within 30 days or other reasonable time period"), and has met with the HHS-OIG exclusion officer for New England to discuss the exclusion paperwork process. We will also report convictions to OIG for exclusion even when the Unit has only a secondary role in the prosecution and an OIG agent is the lead investigator. We recommend that OIG better educate its own field agents, and federal prosecutors, of the importance of the exclusion process to facilitate this state/federal collaboration.

3. HHS-OIG Recommendation: Assess the adequacy of existing staff levels and take appropriate action based on that assessment.

The Unit should assess whether professional staffing levels are commensurate with the total Medicaid program expenditures. Additionally, the Unit should determine whether existing staffing levels are sufficient to respond to the volume of referrals and to investigate and prosecute all the Unit's cases in a timely manner. The Unit should take appropriate action based on that assessment.

Response: We concur with this recommendation. Over the next six months, the Unit will assess whether staffing levels are commensurate with Vermont's total Medicaid program expenditures, and sufficient to respond to the volume of the Unit's referrals and caseload. The Unit Director will make a recommendation to senior AGO management based on this assessment.

Conclusion

The Vermont MFCU appreciates the efforts of the HHS-OIG and the consultations provided by the Onsite Review. We remain committed to meeting and exceeding the standards for Medicaid Fraud Control Units consistent with our mission, and look forward to implementing the courses of action discussed above.

Sincerely,

/S/

Edward A. Baker
Assistant Attorney General
Director, MFRAU

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 Jennifer Karr. Central office staff who provided support include Susan Burbach, Kevin Farber, Christine Moritz, and Sherri Weinstein. Office of Investigations staff who provided support include Michael Robinson.

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.