

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**RHODE ISLAND STATE
MEDICAID FRAUD CONTROL
UNIT: 2014 ONSITE REVIEW**



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

**September 2015
OEI-02-14-00580**

**EXECUTIVE SUMMARY: RHODE ISLAND STATE MEDICAID FRAUD
CONTROL UNIT: 2014 ONSITE REVIEW
OEI-02-14-00580**

WHY WE DID THIS STUDY

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

HOW WE DID THIS STUDY

We conducted an onsite review in December 2014. We based our review on an analysis from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for fiscal years (FYs) 2012 through 2014; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) an onsite review of a sample of case files; and (7) onsite observation of Unit operations.

WHAT WE FOUND

From FYs 2012 through 2014, the Rhode Island Unit reported 28 criminal convictions, 14 civil judgments and settlements, and combined civil and criminal recoveries of \$8 million. During the same period, however, the overall number of referrals to the Unit decreased significantly. Additionally, our review of the Unit's performance according to OIG standards found that the Unit did not refer convictions to OIG for program exclusion in a timely manner and that it did not report adverse actions to the National Practitioner Data Bank (NPDB). Also, the Unit's internal controls over grant expenditures did not include segregation of duties involving its purchase card. However, we also found that almost all case files contained documentation of supervisory approval to open and close cases as well as of periodic supervisory review. Finally, we noted that the Unit benefits from its relationship with the New England State Police Information Network, which provides support such as surveillance technology to the Unit.

WHAT WE RECOMMEND

We recommend that the Rhode Island Unit (1) work with the State Medicaid agency to increase referrals, (2) refer providers for exclusion to OIG within an appropriate timeframe, (3) report adverse actions to the NPDB, and (4) improve controls over purchase card duties and document purchase requests from Unit staff. The Unit concurred with three of our recommendations and concurred in part with the fourth.

TABLE OF CONTENTS

Objective	1
Background	1
Methodology	4
Findings.....	5
From FYs 2012 through 2014, the Unit reported 28 criminal convictions, 14 civil judgments and settlements, and combined civil and criminal recoveries of \$8 million	5
The Unit did not refer convictions to OIG for program exclusion in a timely manner	7
The Unit did not report adverse actions to the National Practitioner Data Bank	8
The Unit’s internal controls did not include segregation of purchase card duties	9
Almost all case files contained documentation of supervisory approval to open and close cases as well as of periodic supervisory review	9
Other observation.....	10
Conclusion and Recommendations.....	11
Unit Comments and Office of Inspector General Response	12
Appendixes	13
A: Detailed Methodology	13
B: Investigations Opened and Closed by Provider Category From FY 2012 Through FY 2014	16
C: Medicaid Fraud Control Unit Referrals by Source From FY 2012 Through FY 2014	18
D: Point Estimates and 95-Percent Confidence Intervals	19
E: Unit Comments.....	20
Acknowledgments.....	23

OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.¹ Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost effective because (1) minimal Medicaid fraud exists in that State, and (2) the State has other adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.² Currently, 49 States and the District of Columbia (States) have created such Units.³ In Federal fiscal year (FY) 2014, combined Federal and State grant expenditures for the Units totaled \$235 million, and the Units employed 1,957 individuals.

To carry out its duties and responsibilities in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.⁴ Unit staff review complaints provided by the State Medicaid agency and other sources and determine the potential for criminal prosecution and/or civil action. In FY 2014, the 50 Units obtained 1,318 convictions and 874 civil settlements or judgments.⁵ That year, the Units reported recoveries of more than \$2 billion.

The Unit must be in an office of the State Attorney General's office, be in another State government office with statewide prosecutorial authority, or operate under a formal arrangement with the State Attorney General's office.⁶ Units are required to have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an

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

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

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

⁴ SSA § 1903(q)(6) and 42 CFR § 1007.13.

⁵ Office of Inspector General (OIG), *State Medicaid Fraud Control Units Fiscal Year 2014 Statistical Chart*, February 2015.

⁶ SSA § 1903(q)(1).

office with such authority.⁷ In 44 States, including Rhode Island, the Units are located within offices of State Attorneys General; in the remaining 6 States, the Units are located in other State agencies.⁸

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.⁹

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to the Office of Inspector General (OIG) the authority to both annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.¹⁰ All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹¹ To receive Federal reimbursement, each Unit must submit an initial application to OIG.¹² 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.¹³

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁴ OIG developed and issued 12 performance standards to further define the criteria that it applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements. Examples of standards include maintaining an adequate caseload through referrals from various sources, maintaining an annual

⁷ SSA § 1903(q)(1).

⁸ The Units share responsibility for protecting the integrity of the Medicaid program with the division of the State Medicaid agency that functions as the program integrity unit. Some States also employ a Medicaid Inspector General who conducts and coordinates the State Medicaid agency’s activities to combat fraud, waste, and abuse in this area.

⁹ SSA § 1903(q)(2) and 42 CFR § 1007.9(d).

¹⁰ The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called Federal Financial Participation (FFP).

¹¹ SSA §§ 1903(a)(6)(B).

¹² 42 CFR § 1007.15(a).

¹³ 42 CFR § 1007.15(b) and (c).

¹⁴ SSA § 1902(a)(61).

training plan for all professional disciplines, and establishing policy and procedure manuals to reflect the Unit's operations.¹⁵

Rhode Island Unit

The Rhode Island Unit is an autonomous entity within the Rhode Island Office of the Attorney General and has the authority to prosecute cases of Medicaid fraud and cases of patient abuse and neglect. At the time of our review, the Unit's 11 employees were located in the State capital of Providence. In FY 2014, the Rhode Island Unit expended a total of \$1,192,428 in combined Federal and State Funds.¹⁶

The Unit receives referrals of provider fraud and patient abuse and neglect from a variety of sources, including State licensing boards, law enforcement, hotline calls, and the State Long Term Care Ombudsman.¹⁷ The majority of referrals—both for provider fraud and for patient abuse and neglect—come from departments and units located in the Rhode Island Office of Health and Human Services, which is the State Medicaid agency. These are:

- the Program Integrity Unit (PIU);
- the Surveillance and Utilization Review Unit;
- the Department of Health;
- the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals;
- the Department of Children, Youth, and Families, and;
- the Department of Human Services.

When the Unit receives a referral from any source, the Director of Investigations decides whether to open it in consultation with an investigator and with the Unit Director. In some cases, the Unit conducts a preliminary investigation and decides whether to open the case. If the Unit decides to open a case, it gives the case a unique number and enters it into an electronic case management system. The Unit Director then

¹⁵ 77 Fed. Reg. 32645 (June 1, 2012). Accessed at <http://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf> on January 30, 2015. Previous performance standards, established in 1994, are found at 59 Fed. Reg. 49080 (Sept. 26, 1994). The performance standards referred to in this report were published on June 1, 2012, and were in effect for the majority of our review period.

¹⁶ Total Medicaid expenditures in Rhode Island were \$2.6 billion in FY 2014. OIG, *State Medicaid Fraud Control Units Fiscal Year 2014 Grant Expenditures and Statistics*, February 2015. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on February 26, 2015.

¹⁷ In this report, misappropriation of patient funds is included in the category of patient abuse and neglect.

assigns open cases to a lead investigator and assigns supporting staff as needed.

The Unit may approach a case in several ways. The Unit may pursue a case through criminal prosecution or through 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 may also participate in “global”—i.e., multi-State—civil cases, coordinated by the National Association of Medicaid Fraud Control Units (NAMFCU).

Previous Review

A 2007 OIG onsite review of the Rhode Island Unit found that Unit investigators did not regularly prepare interim investigative memoranda for inclusion in the official case file. Additionally, OIG found that the Unit case files did not contain an index identifying the information contained within the file. We address the Unit’s current practices for managing case files in this report.

METHODOLOGY

We conducted an onsite review in December 2014. We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit’s operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit Director and management; (6) an onsite review of case files; and (7) an onsite observation of Unit operations. Appendix A provides a detailed methodology.

Standards

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

FINDINGS

From FYs 2012 through 2014, the Unit reported 28 criminal convictions, 14 civil judgments and settlements, and combined recoveries of \$8 million

The Rhode Island Unit reported 28 criminal convictions, 14 civil judgments and settlements, and combined civil and criminal recoveries of more than \$8 million from FYs 2012 through 2014. Recoveries from “global” civil cases—i.e., multi-State cases coordinated by the NAMFCU—accounted for 96 percent of total recoveries over this 3-year period. (See Table 1.)

Table 1: Rhode Island MFCU Criminal and Civil Recoveries, FYs 2012 Through 2014

Type of Recovery	FY 2012	FY 2013	FY 2014	Total Recoveries
Criminal Recoveries	\$0	\$0	\$7,162	\$7,162
Non-Global Civil Recoveries	\$0	\$122,457	\$210,025	\$332,482
Global Civil Recoveries	\$3,261,105	\$1,882,719	\$2,756,944	\$7,900,768
Total Recoveries	\$3,261,105	\$2,005,176	\$2,974,130	\$8,240,411

Source: OIG analysis of Unit data, 2015.

Referrals to the Unit decreased significantly during the review period

During this same period, however, the overall number of referrals to the Unit decreased by 93 percent. Departments in the State Medicaid agency were responsible for the large decrease in referrals of patient abuse and neglect as well as in referrals of fraud. Specifically, from FY 2012 through 2014, patient abuse and neglect referrals from departments in the State Medicaid agency decreased from 1,072 to 60. Similarly, fraud referrals from departments in the State Medicaid agency decreased from 37 to 4 in the same period. See Table 2 for total referrals to the Unit by type and source. See Appendix B for additional information on the Unit’s cases and Appendix C for information on referrals to the Unit by source.

Table 2: Total Referrals to the Rhode Island Unit, FYs 2012 Through 2014, by Type and Source

Referral Type	Referral Source	FY2012	FY2013	FY2014
Referrals of Patient Abuse and Neglect	Departments in the State Medicaid Agency	1,072	85	60
	All Other Sources	2	3	2
	Total Patient Abuse and Neglect Referrals	1,074	88	62
Referrals of Fraud	Departments in the State Medicaid Agency	37	21	4
	All Other Sources	8	3	16
	Total Fraud Referrals	45	24	20
Total All Referrals		1,119	112	82

Note that in FY 2011, the year before the period of our review, the Unit reported slightly higher numbers of referrals than it reported in FY 2012. Specifically, the Unit reported 75 referrals of fraud and 1,385 referrals of patient abuse and neglect in FY 2011.

Source: OIG analysis of Unit data, 2015.

Several factors contributed to the decline in referrals of patient abuse and neglect from the State Medicaid agency. Nationwide policy changes introduced by CMS in 2011 required the departments in the State Medicaid agency, including the Department of Health, to discontinue providing certain personally identifiable information to the Unit.¹⁸ The State Medicaid agency confirmed that it could no longer send as many referrals to the Unit for this reason. The Unit director further noted that the prior referrals allowed the Unit to look for patterns to better determine which ones could be developed into cases and that limiting the information hindered the Unit's efforts.

Other factors affected the decline in fraud referrals. Since the expansion of the PIU in 2013—when it grew from 1 to 5 investigative staff—the Unit reported receiving fewer fraud referrals. The Director of the PIU explained that it now investigates referrals first, and then sends what it

¹⁸ CMS, *Policy Memorandum S&C-11-39*, released September 16, 2011. Accessed at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter11_39.pdf on July 2, 2015. The personally identifiable information referred to in the policy memorandum is associated with nursing home complaints that are maintained in a CMS database. Other MFCUs have expressed similar issues about receiving this information.

considers to be viable cases to the Unit.¹⁹ However, Unit management stated that it would be better if the PIU sent more referrals to the Unit, as it did in the past, so that the Unit could be more involved in deciding which ones to pursue.

The Unit did not refer all convictions to OIG for program exclusion in a timely manner

According to Performance Standard 8(f), when a convicted individual is sentenced, the Unit should send a referral letter to OIG “within 30 days of sentencing” for the purpose of program exclusion.²⁰ OIG excludes 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.²¹ If a Unit fails to ensure that convicted providers are referred for exclusion, those providers may be able to continue to submit claims and receive payments from the Medicaid program.

From FYs 2012 through 2014, the Unit reported the sentencing of 33 individuals for health care fraud or for abuse, neglect, or financial exploitation of patients. Of these individuals, only two were referred to OIG for exclusion within 30 days of sentencing. Another 10 were referred within 31 to 50 days, and 6 were referred within 51 and 100 days. Fifteen were referred more than 100 days after sentencing. (See Figure 1.)

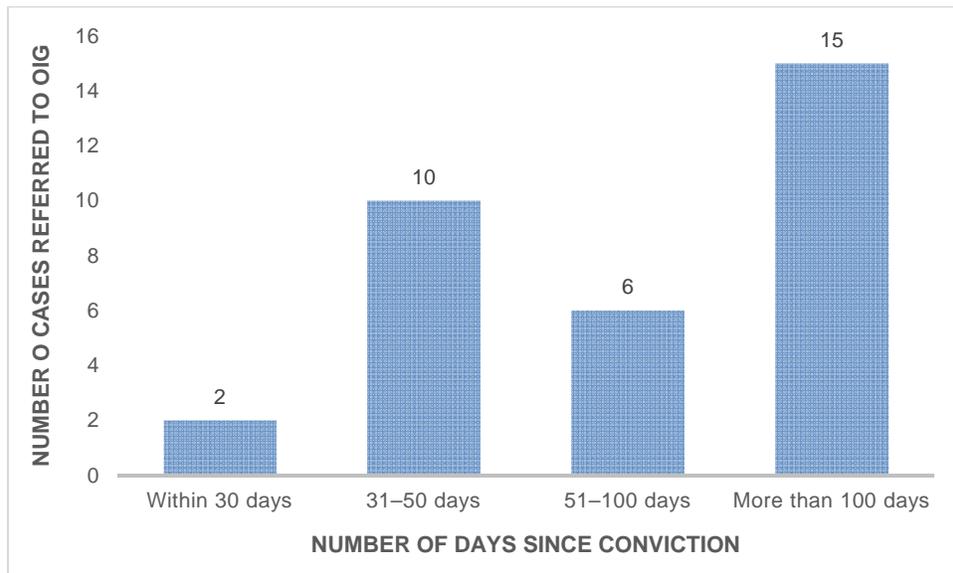
In these cases, the Unit delayed sending referral letters to OIG until it received the judgment of conviction which, according to the Unit Director, could take several months. Since the time of the review, however, the Unit changed this practice and now sends the conviction information to OIG within 30 days of sentencing; the Unit then provides the official judgments to OIG when they are issued.

¹⁹ Federal regulations at 45 CFR § 455.23 require that the PIU conduct a preliminary investigation and refer all credible allegations of fraud to the Unit.

²⁰ Until June 2012, performance standards allowed the Unit to submit convictions to OIG within 30 days or “other reasonable time period.” Revised standards implemented in June 2012 require the Unit to submit convictions “within 30 days of sentencing.”

²¹ 42 CFR § 1001.1901.

Figure 1: Number of Days the Unit Took to Refer Convictions to OIG for Exclusion



Source: OIG analysis of Unit data, 2015.

The Unit did not report adverse actions to the National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) is used to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice payment and history of adverse actions.²²

Pursuant to Federal regulations, Units must report to the NPDB any adverse actions generated as a result of investigations or prosecutions of healthcare providers.²³ Examples of adverse actions include criminal convictions; civil judgments (but not civil settlements); exclusions; and other negative actions or findings, including “any action or finding that under the State’s law is publicly available information, and rendered by a licensing or certification authority.”²⁴

However, the Unit’s registration was not current with the NPDB during the review period, and the Unit had not reported adverse actions to the NPDB since FY 2008. Unit management acknowledged that the Unit was

²² National Practitioner Data Bank. Accessed at <http://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp> on 1/14/2015.

²³ Under requirements established in 2012, Units must report adverse actions to the NPDB within 30 calendar days from the date the final adverse action was taken. 45 CFR § 61.5(a). In addition, according to 2012 Performance Standard 8(g), the Unit should report “qualifying cases” to the NPDB.

²⁴ SSA § 1128E(g)(1) and 45 CFR § 61.3 (2012).

not reporting this correctly and stated that they believed that only licensing issues had to be referred to the NPDB. The Unit subsequently referred the required convictions, which we confirmed with the NPDB.

The Unit's internal controls did not include segregation of purchase card duties

Performance Standard 11 (d) requires each Unit to apply generally accepted accounting principles in its control of Unit funding.²⁵ Segregation of duties reduces the risk of erroneous and inappropriate actions or recording of expenditures. However, from FYs 2012 through 2014, the Unit did not achieve segregation of duties related to its purchase card partly because there were only two fiscal staff and a fiscal director carrying out the accounting function. Consequently, accounting staff were assigned to carry out incompatible duties such as ordering, receiving, and paying for purchases, as well as recording and reviewing the related accounting transactions. Additionally, the Unit Director's authorization for purchases was sometimes made verbally and not documented.

Almost all case files contained documentation of supervisory approval to open and close cases as well as of periodic supervisory review

According to Performance Standard 5(b), Unit supervisors should approve the opening and closing of cases to ensure a continuous case flow and the timely completion of cases. Supervisory approval to open and close cases demonstrates that Unit supervisors are monitoring the intake of cases and the timeliness of case resolutions.²⁶ According to our review, the Unit documented supervisory approval to open 95 percent of cases and documented supervisory approval to close 100 percent of cases.

According to Performance Standard 6(c), supervisory reviews should be conducted periodically and noted in the case file to ensure timely case completion. According to our review, 94 percent of cases contained documentation indicating periodic supervisory review. Appendix D

²⁵ According to generally accepted accounting principles, “[K]ey duties and responsibilities need to be divided or segregated among different people to reduce the risk of error or fraud. This should include separating the responsibilities for authorizing transactions, processing and recording them, reviewing the transactions, and handling any related assets. No one individual should control all key aspects of a transaction or event.” United States General Accounting Office, *Standards for Internal Control in the Federal Government*, November 1999. Accessed at <http://www.gao.gov/special.pubs/ai00021p.pdf> on March 9, 2015.

²⁶ For the purposes of this report, supervisory approval to open and close a case does not constitute a supervisory “review.” Periodic supervisory review indicates that a supervisor reviewed a case at least once between the case’s opening and closing.

contains the point estimates and 95-percent confidence intervals for these statistics.

Other Observation:

During our onsite review, the Unit identified the New England State Police Information Network (NESPIN) as a useful investigative resource. This network is one of six regional centers comprising the Regional Information Sharing Systems Program, which operates nationwide. The U.S. Department of Justice provides funding, oversight, and program management, but each center is managed locally. The program supports the investigation and prosecution efforts of its member agencies by offering information-sharing and communications capabilities, as well as analytical and investigative support services that are available to all MFCUs as well as other law enforcement agencies. Unit management cited examples of NESPIN loaning the Unit pole cameras and other surveillance technology, as well as creating graphics that the Unit used as exhibits in court.

CONCLUSION AND RECOMMENDATIONS

From FYs 2012 through 2014, the Rhode Island Unit reported 28 criminal convictions, 14 civil judgments and settlements, and combined civil and criminal recoveries of \$8 million. During the same period, however, the overall number of referrals to the Unit decreased by 93 percent. Such a decline in referrals may have a substantial impact on the Unit's ability to investigate and prosecute Medicaid fraud and patient abuse or neglect in the State. Additionally, our review of the Unit's performance according to OIG standards found that the Unit did not refer convictions to OIG for program exclusion in a timely manner and did not report adverse actions to the NPDB. Also, the Unit's internal controls over grant expenditures did not include segregation of duties related to its purchase card. However, we also found that almost all case files contained documentation of supervisory approval to open and close cases as well as of periodic supervisory review. Finally, we noted that the Unit benefits from its relationship with the New England State Police Information Network, which provides support such as surveillance technology to the Unit.

We recommend that the Rhode Island Unit:

Work with the State Medicaid agency to increase referrals

The Unit should make increasing the number of referrals it receives a priority, and work with the State Medicaid agency to resolve information-sharing issues and to increase referrals.

Refer providers for exclusion to OIG within an appropriate timeframe

The Unit should ensure that letters referring individuals and entities for exclusion are sent within 30 days of sentencing. The Unit should also work with the courts to ensure that the courts provide conviction information to the Unit in a timely manner.

Report adverse actions to the NPDB

The Unit should ensure that it reports to the NPDB all adverse actions generated as a result of investigations or prosecutions of healthcare providers, as specified in Federal regulations.

Improve controls over purchase card duties and document purchase requests from Unit staff

The Unit should work with Attorney General's fiscal office to segregate the responsibilities for ordering, receiving, and paying for purchases as well as for recording and reviewing purchase card transactions, as staffing allows. Additionally the Unit should develop policies to ensure that all purchase requests are documented.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Rhode Island Unit concurred with three of our recommendations and concurred in part with the fourth.

The Unit concurred with our recommendation to work with the State Medicaid agency to increase referrals. The Unit noted that it is considering undertaking data mining through the appropriate waiver and noted that it will try to obtain more referrals from meetings with the State PIU as well as managed care organizations in the State.

The Unit concurred with our recommendation to refer providers for exclusion to OIG within an appropriate timeframe, adding that it now complies with the 30-day requirement. The Unit also concurred with our recommendation to report adverse actions to the NPDB. It added that its registration has been updated, that all cases that should have been reported are now in the system, and that it will report all future cases immediately, as required.

Finally, the Unit concurred in part with our recommendation to improve controls over purchase card duties and to document purchase requests from Unit staff. The Unit reported implementing a policy where all purchase requests made by the Director will be in writing. However, the Unit indicated that because of the small size of the Unit, it will not be implementing controls to segregate responsibilities related to the purchase card. The Unit further noted that credit cards issued to the Attorney General's Office are independently audited by the State Controller's Office, which ensures proper use of the card. We encourage the Unit to—in keeping with generally accepting accounting principles—segregate the duties related to the purchase card, as staffing allows.

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

APPENDIX A

Detailed Methodology

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

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information from several sources regarding how the Unit investigated Medicaid cases and referred them for prosecution. Specifically, we collected and analyzed information about the number of referrals the Unit received, the number of investigations the Unit opened and closed, and the outcomes of those investigations. We also collected and analyzed information about the number of cases that the Unit referred for prosecution and the outcomes of those prosecutions. We gathered this information from several sources, including the Unit’s Quarterly Statistical Reports, annual reports, recertification questionnaire, policy and procedures manuals, and the Memorandum of Understanding with the State Medicaid agency. Additionally, we confirmed with the Unit Director that the information we had was current as of December 2014, and as necessary, we requested any additional data or clarification.

Review of Financial Documentation. To evaluate internal control of fiscal resources, OIG auditors reviewed policies and procedures related to the Unit’s budgeting, accounting systems, cash management, procurement, property, and staffing. We obtained the Unit’s claimed grant expenditures for FYs 2012 through 2014 to (1) review final Federal Status Reports²⁷ and supporting documentation, and (2) select and review transactions within direct cost categories to determine if costs were allowable. Finally, we reviewed records in the HHS Payment Management System (PMS)²⁸ and revenue accounts to identify any unreported program income.²⁹

Interviews With Key Stakeholders. In October 2014, we conducted structured interviews with seven individual stakeholders who were familiar with Unit operations. We interviewed key stakeholders in the State Medicaid agency, i.e., the the Rhode Island Office of Health and

²⁷ The Unit transmits Federal Status Reports to OIG’s Office of Management and Policy on a quarterly and annual basis. These financial reports detail Unit income and expenditures.

²⁸ The PMS is a grant payment system operated and maintained by the HHS Program Support Center, Division of Payment Management. The PMS provides disbursement, grant monitoring, reporting, and case management services to awarding agencies and grant recipients, such as MFCUs.

²⁹ Program income is defined as “gross income received by the grantee or subgrantee directly generated by a grant supported activity, or earned only as a result of the grant agreement during the grant period.” 45 CFR § 92.25(b).

Human Services. Specifically, we interviewed officials in the Office of Health and Human Services; the PIU; the Fiscal Intermediary responsible for the Surveillance and Utilization Review Unit; the Department of Health; and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals. We also conducted structured interviews with the Rhode Island Long Term Care Ombudsman, the U.S. Attorney's Office, and other officials of the Office of the Rhode Island Attorney General. We focused these interviews on the Unit's relationship with OIG and other Federal and State authorities. We used the information that we collected from these interviews to develop subsequent interview questions for Unit management. Finally, we conducted a structured interview with the Director of the New England State Police Information Network. We focused this interview on the Unit's relationship with the network.

Survey of Unit Staff. In November 2014, we conducted an online survey of all nonmanagerial Unit staff within each professional discipline (i.e., investigators, auditors, and attorneys) as well as support staff. The response rate was 100 percent. Our questions focused on operations of the Unit, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Onsite Interviews With Unit Management. We conducted structured interviews with the Unit's management in December 2014. We interviewed the Unit Director (who also served as the Unit's lead attorney), the Deputy Director, and the Director of Investigations. We asked these individuals to provide additional information for us to better understand the Unit's operations and clarify information obtained from other data sources. Finally, we asked the Unit management to identify activities that are beneficial to the Unit's overall management, operations, and performance.

Onsite Review of Case Files and Other Documentation. The Unit provided a list of 179 cases that were open at any point during FYs 2012 through 2014. We excluded from our analysis 40 of these cases that the Unit had categorized as "global." We then selected a simple random sample of 100 cases from the remaining 139 cases. We reviewed all sampled case files for documentation of supervisory reviews for the opening and closing of cases (if applicable), as well as to see whether supervisors conducted periodic case file reviews. From these 100 case files, OIG Office of Investigations reviewed a simple random sample of 50 files in more depth, looking at issues such as the timeliness of investigations and case development. The review found no noteworthy concerns.

Onsite Review of Unit Operations. During our December 2014 onsite visit, we reviewed the Unit's workspace and operations. Specifically, we visited the Unit headquarters in the State capital. While onsite, we observed the Unit's offices and meeting spaces, security of data and case files, location of select equipment, and the general functioning of the Unit.

APPENDIX B

Investigations Opened and Closed by Provider Category from FYs 2012 Through 2014

Table B-1: Fraud Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Facilities						
Hospitals	0	0	0	0	0	0
Nursing Facilities	7	5	1	1	0	2
Other Long-Term-Care Facilities	0	0	1	0	0	0
Substance Abuse Treatment Centers	0	0	0	0	0	0
Other Facilities	3	3	1	1	0	1
Subtotal	10	8	3	2	0	3
Practitioners						
Doctors of Medicine or Osteopathy	12	10	2	1	4	5
Dentists	3	3	0	2	2	2
Podiatrists	0	0	0	0	0	0
Optometrist/Opticians	1	0	0	0	0	0
Counselors/Psychologists	0	0	0	0	0	0
Chiropractors	0	0	0	0	0	0
Other Practitioners	3	0	0	1	0	0
Subtotal	19	13	2	4	6	7
Medical Support						
Pharmacies	1	2	1	0	0	1
Pharmaceutical Manufacturers	1	1	1	0	0	3
Suppliers of Durable Medical Equipment	3	0	0	2	0	0
Laboratories	0	0	0	0	0	0
Transportation Services	1	1	0	0	1	0
Home Health Care Agencies	0	0	0	1	0	2
Home Health Care Aides	7	6	8	9	6	6
Nurses/Physician's Assistants/Nurse Practitioners/Certified Nurse Aides	4	1	2	3	2	6
Radiologists	0	0	0	0	0	0
Other Medical Support	0	0	2	3	0	0
Subtotal	17	11	14	18	9	18

continued on next page

Table B-1 (Continued): Fraud Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Managed Care	0	0	0	0	0	0
Facilities	Opened	Closed	Opened	Closed	Opened	Closed
Medicaid Program Administration	0	0	0	0	0	0
Billing Company	0	0	0	0	0	0
Other Program Related	0	0	0	0	0	0
Subtotal	0	0	0	0	0	0
Total	46	32	19	24	15	28

Source: OIG analysis of Unit data, 2015.

Table B-2: Investigations of Patient Abuse and Neglect

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing Facilities	8	4	3	3	1	3
Other Long-Term-Care Facilities	0	0	0	0	0	0
Nurses/Physician's Assistants/Nurse Practitioners/Certified Nurse Aides	9	8	6	9	9	14
Home Health Aides	2	0	3	4	6	3
Other	0	1	2	2	5	4
Total	19	13	14	18	21	24

Source: OIG analysis of Unit data, 2015.

Table B-3: Investigations of Misappropriation of Patient Funds

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Non-direct Care	0	0	0	0	0	0
Nurses/Physician's Assistants/Nurse Practitioners/Certified Nurse Aides	0	0	1	0	0	1
Home Health Aides	0	0	0	0	0	0
Other	0	0	5	3	0	0
Total	0	0	6	3	0	1

Source: OIG analysis of Unit data, 2015.

APPENDIX C

Medicaid Fraud Control Unit Referrals by Referral Source from FYs 2012 Through 2014

Referral Source	FY 2012			FY 2013			FY 2014		
	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Fund	Fraud	Abuse & Neglect	Patient Funds
State Medicaid Agency – Program Integrity Unit and Surveillance and Utilization Review Unit	17	0	0	17	0	0	3	0	0
State Medicaid Agency – Department of Health	20	895	0	4	4	1	1	16	0
State Medicaid Agency - Department of Behavioral Healthcare, Developmental Disabilities and Hospitals	0	177	0	0	72	7	0	38	6
State Medicaid Agency – Other	0	0	0	0	0	1	0	0	0
Managed Care Organizations	0	0	0	0	0	0	0	0	0
Licensing Board	0	0	0	0	0	1	0	0	0
Law Enforcement	0	0	0	2	1	0	1	0	0
HHS OIG	0	0	0	0	0	0	11	1	0
Prosecutor	0	0	0	0	0	0	0	0	0
Provider	0	1	0	0	0	0	2	0	0
Provider Association	0	0	0	0	0	0	1	1	0
Private Health Insurer	0	1	0	0	0	0	0	0	0
Ombudsman	0	0	0	0	0	0	1	0	0
Adult Protective Services	0	0	0	0	0	0	0	0	0
Private Citizen	0	0	0	0	0	0	0	0	0
MFCU Hotline	8	0	0	0	0	0	0	0	0
Self-Generated Referrals	0	0	0	1	1	0	0	0	0
Other	0	0	0	0	0	0	0	0	0
Total	45	1074	0	24	78	10	20	56	6

Source: OIG analysis of Unit data, 2015.

APPENDIX D

Point Estimates and 95-Percent Confidence Intervals

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

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

Data Element Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Case files with documented supervisory approval to open a case	100	95.0%	91.4% to 96.4%
Case files with documented supervisory approval to close a case	89*	100.0%	97.6% to 100%
Case files with documented periodic supervisory reviews	70**	94.3%	88.7% to 95.9%

Source: OIG analysis of Unit data, 2015.

* We excluded 11 cases that were open at the time of our review.

** We excluded 22 cases that were not open at least 90 days and 4 cases for which the closing date could not be precisely determined. We also excluded an additional 4 cases that were opened and then referred to another agency for investigation or prosecution.

APPENDIX E

Unit Comments



State of Rhode Island and Providence Plantations

DEPARTMENT OF ATTORNEY GENERAL

150 South Main Street • Providence, RI 02903
(401) 274-4400 - TDD (401) 453-0410

Peter F. Kilmartin, Attorney General

July 30, 2015

Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections
U.S. Department of Health and Human Services
Office of the Inspector General
Room 5660, Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

RE: Rhode Island MFCU 2014 Onsite Review, OEI-02-14-00580

Dear Ms. Murrin:

We appreciate the opportunity to review and comment on the 2014 Onsite Review as well as the exceptional professionalism exhibited by your review staff. In accordance with your request for our comments to the recommendations in your draft report, we offer the following;

Finding and Recommendation

Work with the state Medicaid Agency to increase referrals.

Comments

We concur.

While we strive as a Unit to continue to find and obtain new and more referrals and we concur that more referrals would be desirable, we find it necessary to comment on the conclusions drawn in the Report. The Report states; " From FY 2012 through 2014, the Rhode Island Unit reported 28 criminal convictions, 14 civil judgments and settlements, and combined civil recoveries of \$8 million. During the same period, however, the overall number of referrals to the Unit decreased by 93 percent".

Several factors contributed to the decline in patient abuse and neglect referrals from the State Medicaid Agency. The major reason that referrals of patient abuse and neglect cases diminished was the result of an order from CMS in 2012. That order required the Departments of the State Medicaid Agency, specifically, the Rhode Island Department of Health, discontinue providing Incident Reports from facilities to the Unit in the form they had been using in the Aspen/Acts System. This order was not limited to Rhode Island. This was a nationwide change which CMS implemented causing states to stop providing the Incident Reports as was the standard practice

prior to 2012. CMS no longer allows the State Medicaid Agency to share personally identifiable information with the Unit. (Footnote 18)

The “Incident Reports”, not a recognized category for inclusion in the Quarterly Statistical Reports, were counted and inserted by us into the “Referrals” section of those reports.

Limiting this information literally obfuscated the Unit’s efforts to determine whether a case could be made from the Incident Report information. The Incident Reports served as a tool to the Unit wherein the Unit could peruse these reports, even reports of seemingly innocuous incidents, which on their face appeared to be accidental or without fault. A closer look by the Unit sometimes exposed patterns of behavior or lapses of procedures being followed on a regular basis and thereby becoming a “Referral” through that Incident Report. While state agencies then began to provide only the information which they were allowed by CMS, those cases which might have been discovered and might have morphed into a referral were never turned over to the Unit and therefore never scrutinized, as had been the practice in the past. It should be made clear that, while the reduction in Incident Reports was 93 percent, the percentage is really not an accurate reflection of how many cases would have become referrals had the CMS Order not been given.

This Unit’s timeline for correction is immediate. This office has become aware from various sources that CMS will soon have a remedy to assist us in receiving information through Incident Reports which had dwindled as explained above. In addition, this office is considering undertaking “Data Mining” through the appropriate waiver to be applied for through the OIG-OEI. The Data Mining initiative is hoped to provide more valuable referrals. Finally, it is our intention to try to obtain more referrals from meetings with our state Program Integrity Unit as well as from the MCOs in the state.

Finding and Recommendation

The Unit did not refer all convictions to OIG for program exclusion in a timely manner.

We concur.

While all convictions were sent to OIG for program exclusion, most were not done within the thirty day time requirement. The Unit had a practice of waiting for the Court to provide a Judgment of Conviction prior to sending the exclusion referral so that the package would be complete. In many instances, it would take months for the Court Clerk’s Office to provide us with the Judgment of Conviction.

The Unit has now adopted a strict rule of complying with the thirty day requirement and then following up by sending in the Judgment of Conviction separately when received by us, to complete the file sent to OIG.

Finding and Recommendation

The Unit did not report adverse actions to the National Practitioner Data Bank

We concur.

This error of not reporting all adverse actions to the NPDB was the result of a misunderstanding of which types of cases needed to be reported. This error was, in fact, detected prior to the Onsite Team's arrival. The error was also corrected immediately before the Team's arrival and has been resolved. The Unit's registration with the NPDB has now been updated and all cases that should have been reported are now in the system and all future case will be reported immediately, as required.

Finding and Recommendation

The Unit's internal controls did not include segregation of purchase card duties

We do not concur in part and we concur in part.

Due to the small size of this office, the Business Office Director is the only person in control of the purchase card and is solely responsible for its use. An independent audit is done BY THE State Controller's Office on all credit cards issued to every state agency, including the Attorney General's Office. This insures proper usage of the card and its purchases and payments as well as items received. Given that fact, while segregation of duties is not implemented, the independent state audit insures the proper usage of the card. This goes for all office purchases, not just MFCU expenditures.

While the MFCU Director had, on occasion, verbally authorized purchases, we have now implemented a policy where all purchase requests made to the Business Office Director by the MFCU Director are in writing.

Finding and Recommendation

Almost all case files contained documentation indicating supervisory approval to open and close cases as well as periodic supervisory review

We concur.

While the Onsite Team found that 94 percent of the cases included the proper documentation, we strive to have a rate of one hundred percent.

The Rhode Island Medicaid Fraud Control Unit extends its gratitude for the continued guidance of the OIG-OEI and in particular the Onsite Review Team for its professionalism. It is our desire to achieve the highest standards possible in the execution of our duties.

Very truly yours,

James F. Dube
Assistant Attorney General
Director, Rhode Island 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 leaders for this study. Other Office of Evaluation and Inspections staff who conducted the study include Jennifer Karr in the New York regional office and Jordan Clementi in the Kansas City regional office. Central office staff who provided support include Kevin Farber, and Christine Moritz. Office of Audit Services staff who provided support include Beverly Farley. Office of Investigations staff also participated in the review.

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.