

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MAINE STATE MEDICAID
FRAUD CONTROL UNIT:
2015 ONSITE REVIEW**



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

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**EXECUTIVE SUMMARY: MAINE STATE MEDICAID FRAUD CONTROL UNIT:
2015 ONSITE REVIEW
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WHY WE DID THIS STUDY

The Office of Inspector General (OIG) administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies the Units, and oversees the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. These 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 of the Maine Unit in April 2015. We based our review on analysis of data 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 for FYs 2012 through 2014; (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 files for cases that were open in FYs 2012 through 2014; and (7) an onsite observation of Unit operations. We also determined whether the Unit had established policies and procedures as recommended in a previous OIG onsite review report.

WHAT WE FOUND

For FYs 2012 through 2014, the Maine Unit reported 19 criminal convictions, 28 civil judgments and settlements, and combined criminal and civil recoveries of \$32 million. Our review of the Unit's performance identified opportunities for improvement. Specifically, we found that over two-thirds of the case files open longer than 90 days lacked documentation of periodic supervisory reviews. We also found that a few cases had unexplained investigation delays of a year or more. Additionally, we found that the Unit reported convictions to OIG for program exclusion timely, but could improve its reporting of adverse actions to the National Provider Data Bank (NPDB). Further, the Unit did not conduct physical inventories of its property. Finally, we noted that only a small portion of Unit fraud referrals—less than 2 percent—came from the State Medicaid agency's Program Integrity Unit.

WHAT WE RECOMMEND

We recommend that the Maine Unit (1) implement policies and procedures to ensure that case files include documentation of supervisory approval for opening and closing cases and periodic supervisory review, (2) implement policies and procedures to document unexplained investigation delays, (3) implement processes to ensure that the Unit reports all adverse actions to the NPDB and within the required timeframe, and (4) establish policies and procedures for conducting physical inventories of its property. The Unit concurred with all four recommendations.

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OBJECTIVE

To conduct an onsite review of the Maine 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 fiscal year (FY) 2014, combined Federal and State grant expenditures for the Units totaled \$235 million.^{4,5} That year, the 50 Units employed 1,958 individuals.⁶

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.⁷ Unit staff review complaints referred by the State Medicaid agency and other sources and determine their potential for criminal prosecution and/or civil action. In FY 2014, the 50 Units collectively obtained 1,318 convictions and 874 civil settlements or

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

² SSA § 1902(a)(61).

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

⁵ Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on May 5, 2015.

⁶ Ibid.

⁷ SSA § 1903(q)(6); 42 CFR § 1007.13.

judgments.⁸ That year, the Units reported recoveries of approximately \$2 billion.⁹

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.¹⁰ In Maine and 43 other States, the Units are located within offices of State Attorney General's that have this authority. In the remaining six States, the Units are located in other State agencies; generally, such Units refer cases to other offices with prosecutorial authority.¹¹ Additionally, each Unit must be a single, identifiable entity of State government, distinct from the single State Medicaid agency, and each Unit must develop a formal agreement—i.e., a memorandum of understanding (MOU)—that describes the Unit's relationship with that agency.¹²

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to OIG the authority both to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.¹³ All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹⁴ To receive Federal reimbursement, each Unit must submit an initial application to OIG.¹⁵ 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.¹⁶ In addition to annual recertification, OIG performs periodic onsite reviews of the Units.

⁸ OIG, *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on May 5, 2015.

⁹ *Ibid.*

¹⁰ SSA § 1903(q)(1).

¹¹ OIG, *Medicaid Fraud Control Units*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp> on May 5, 2015.

¹² SSA § 1903(q)(2); 42 CFR § 1007.9(d).

¹³ 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.

¹⁴ SSA § 1903(a)(6)(B).

¹⁵ 42 CFR § 1007.15(a).

¹⁶ 42 CFR § 1007.15(b) and (c).

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁷ To clarify the criteria that OIG applies in assessing whether a Unit is effectively carrying out these functions and meeting program requirements, OIG developed and issued 12 performance standards.¹⁸ Examples of the standards include maintaining an adequate caseload through referrals from several sources, maintaining a training plan for all professional disciplines, and establishing policy and procedure manuals. See Appendix A for a description of each of the 12 performance standards.

Maine MFCU

Located in Augusta, the Maine Unit is an autonomous entity within the Maine Office of the Attorney General which investigates and prosecutes cases of Medicaid fraud and patient abuse. To investigate and prosecute such cases, the Unit employs four detectives, two attorneys (which includes the Unit director), one auditor, and a legal secretary.

Referrals. The Unit receives referrals from a variety of sources, including the State Medicaid agency, the State survey and certification agency, the State Long-Term Care Ombudsman, and private citizens. Unit referrals by referral source for FYs 2012 through 2014 can be found in Appendix B.

An “incident report” is created each time a referral is received. The incident report includes such information as the date of the report; the name of the provider or facility at which the incident is alleged to have occurred; the type of referral (e.g., fraud, abuse); and a description of the allegations, including the alleged individuals involved and the name of the person making the referral. The Unit director reviews the incident report to determine whether to open a case for investigation or refer the report to another appropriate entity (e.g., licensing board).

Investigations and prosecutions. Referrals that warrant opening as cases are investigated and prosecuted, as appropriate. Once a case is opened, it is assigned to a detective and an attorney. The detective works with the Unit’s auditor to complete an investigation. Upon completion of the investigation, the detective submits the case to the assigned attorney for review. The attorney then makes a recommendation to the Unit director, who determines whether to prosecute the case. After a case is successfully prosecuted, copies of

¹⁷ SSA § 1902(a)(61).

¹⁸ 77 Fed. Reg. 32645 (June 1, 2012).

all necessary court documents are collected and case information is reported to OIG for program exclusion and to the Health Services Resource Administration for reporting to the National Practitioner Data Bank (NPDB).¹⁹ See Appendix C for details on investigations opened and closed.

Previous OIG Onsite Review

In 2009, OIG published a report regarding its onsite review of the Maine Unit. OIG found that the Unit was generally in compliance with all applicable Federal rules and regulations. However, OIG identified that the Unit lacked formal MFCU-specific policies and procedures. A draft policies and procedures manual was under development at the time of the 2009 review. OIG recommended that the Unit complete the policies and procedures manual. As part of this review, we determined that the Unit maintained a completed policies and procedures manual.

METHODOLOGY

We conducted an onsite review of the Maine Unit in April 2015. We based our review on analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload for FYs 2012 through 2014; (2) a review of financial documentation for FYs 2012 through 2014; (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 files for cases that were open in FYs 2012 through 2014; and (7) onsite observation of Unit operations. Appendix D provides a detailed methodology.

Standards

These reviews are conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

¹⁹ The 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 adverse action history.

FINDINGS

For FYs 2012 through 2014, the Maine Unit reported 19 criminal convictions, 28 civil judgments and settlements, and combined criminal and civil recoveries of \$32 million

For FYs 2012 through 2014, the Unit reported 19 criminal convictions and 28 civil judgments and settlements. See Table 1 for yearly convictions and civil judgments and settlements. Of the Unit's 19 convictions over the 3-year period, 11 involved provider fraud, 5 involved patient abuse and neglect, and 3 involved patient funds.

Table 1: Maine MFCU Criminal Convictions and Civil Judgments and Settlements, FYs 2012–2014*

Outcomes	FY 2012	FY 2013	FY 2014	3-Year Total
Criminal Convictions	2	8	9	19
Civil Judgments and Settlements	10	6	12	28

Source: OIG analysis of Unit-submitted documentation, 2015.

For the same period, the Unit reported combined criminal and civil recoveries of \$32 million. See Table 2 for the Unit's yearly recoveries and expenditures. Nearly all of the recoveries were obtained from “global” cases, which accounted for 99 percent of all recoveries during the 3-year review period.²⁰

Table 2: Maine MFCU Recoveries and Expenditures, FYs 2012–2014*

Type of Recovery	FY 2012	FY 2013	FY 2014	3-Year Total
Global Civil	\$17,810,162	\$5,848,924	\$8,156,435	\$31,815,520
Nonglobal Civil	\$0	\$219,533	\$0	\$219,533
Criminal	\$14,857	\$109,607	\$18,968	\$143,432
Total Recoveries	\$17,825,018	\$6,178,064	\$8,175,403	\$32,178,485
Total Expenditures	\$674,779	\$700,451	\$728,262	\$2,103,492

Source: OIG analysis of Unit-submitted documentation, 2015.

* Due to rounding, dollar figures for each category of recoveries do not always sum to the total recoveries.

²⁰ “Global” cases are civil false claims actions involving the U.S. Department of Justice and other State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases.

A Unit supervisor approved the opening and closing of almost all case files; however, over two-thirds of the case files open longer than 90 days lacked documentation of periodic supervisory reviews

Eighty-eight percent of case files (92 of 105) included documentation of supervisory approval to open the case; case files for 98 percent of closed cases (83 of 85) included documentation of supervisory approval to close the case. According to Performance Standard 5(b), Unit supervisors should approve the opening and closing of all cases. Supervisory approval to open cases indicates that Unit supervisors are monitoring the intake of cases, thereby facilitating progress in the investigation. Further, supervisory approval of the closing of cases helps ensure the timely completion and resolution of cases.

The Unit's policy requires that supervisory reviews occur on a quarterly basis (i.e., every 90 days); however, 70 percent of case files open longer than 90 days (72 of 103) lacked documentation of periodic supervisory review.²¹ According to Performance Standard 7(a), supervisory reviews should be conducted periodically, consistent with the Unit's policies and procedures, and noted in the case file. Periodic supervisory reviews can help to ensure timely completion of cases and may identify potential issues during the investigation.

Prior to December 2013, it was not the Unit's practice to note periodic supervisory reviews in the case file. This practice may have contributed to the lack of documentation of periodic supervisory reviews in the case files. Of the 72 case files lacking documentation of such reviews, all but 4 involved cases opened and investigated prior to December 2013. The Unit director reported that since he became director, the Unit's practice has been to document periodic supervisory reviews in the case file.

A few cases had unexplained investigation delays of a year or more

Nine percent of the Unit's cases (5 of 53) exhibited unexplained investigation delays of a year or more. According to Performance Standard 5, the Unit should "take steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the

²¹ Two of the Unit's 105 cases had not been open longer than 90 days at the time of the onsite review.

complexity of the cases.” Additionally, Performance Standard 5(c) states that delays in investigation and prosecution should be “limited to situations imposed by resource constraints or other exigencies.” None of the five cases included documentation in the file to explain the delays; all five were criminal cases. Of these five cases, one had an unexplained delay of at least 3 years, three had unexplained delays of at least 2 years, and 1 had an unexplained delay of at least a year.²² Further, documentation of periodic supervisory reviews was not present in the case files for any of these five cases. All five files involved cases that had been opened and investigated during the tenure of previous Unit directors.

The Unit reported convictions to OIG for program exclusion timely, but could improve its reporting of adverse actions to the NPDB

The Unit reported its convictions to OIG for program exclusion timely, but did not report all adverse actions to the NPDB as required. Of the 19 adverse actions that should have been reported to the NPDB, three were not reported. These three actions were not reported to the NPDB because the actions involved cases with which the Unit was assisting OIG, and it was not the Unit’s practice to report actions for cases with which it was assisting OIG. Pursuant to Federal regulations, Units must report any adverse actions, generated as a result of investigations or prosecutions of healthcare providers, to the NPDB.²³ Examples of adverse actions include criminal convictions; civil judgments (but not civil settlements); exclusions; and other negative actions or findings.²⁴ Of the 16 adverse actions that were reported, 3 were not reported within 30 days of the action. Specifically, the Unit reported one adverse action 26 days late, one adverse action 12 days late, and one adverse action 6 days late.

²² According to Performance Standard 7(b), case files should include “all relevant facts and information.” For the purposes of this report, we defined a “delay” as a period of at least a year with no documented activity in the case file.

²³ Units must report adverse actions to the NPDB within 30 calendar days from the date the final adverse action was taken. 45 CFR § 60.5. In addition to Federal regulations, the Performance Standards also require Units to report to NPDB. Performance Standard 8(g) states that the Unit should report “qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases.” We reviewed the reporting of adverse actions under NPDB requirements because the HIPDB and the NPDB were merged during our review period (FYs 2012 through 2014). 78 Fed. Reg. 20473 (April 5, 2013).

²⁴ SSA § 1128E(g)(1); 45 CFR § 60.3.

The Unit did not conduct physical inventories of its property

For FYs 2012 through 2014, the Unit did not conduct physical inventories of its property. Federal regulations require equipment to be managed in accordance with State laws and procedures.²⁵ In Maine, the Department of Administrative & Financial Services requires that equipment and inventories be periodically counted. Further, Performance Standard 11(b) requires that the Unit maintain an equipment inventory that is updated regularly to reflect all of the property under the Unit's control. Although the Unit did not conduct any physical inventories of its property, all sampled inventory items were located.

Other observation: only a small portion of Unit fraud referrals—less than 2 percent—came from the State Medicaid agency's Program Integrity Unit

Of the 532 fraud referrals received by the Unit during the 3-year review period, only 8 of those referrals came from the State Medicaid agency's Program Integrity (PI) Unit. These referrals included three fraud referrals in FY 2012, five fraud referrals in FY 2013, and no referrals in FY 2014. Typically, referrals from the PI Unit are an essential component of a Unit's ability to effectively investigate and prosecute Medicaid provider fraud. The Unit director reported that he was concerned about the low number of referrals from the PI Unit. Staff turnover within the PI Unit and the time taken to revise the State Medicaid agency's policies may have affected the PI Unit's ability to provide referrals.

²⁵ 45 CFR § 92.32(b).

CONCLUSION AND RECOMMENDATIONS

For FYs 2012 through 2014, the Maine Unit reported 19 criminal convictions, 28 civil judgments and settlements, and combined criminal and civil recoveries of \$32 million.

Our review of the Unit's performance identified opportunities for improvement. Some of those opportunities for improvement relate to case file documentation and timely case progression. Specifically, we found that over two-thirds of the case files open longer than 90 days lacked documentation of periodic supervisory reviews. Further, a few cases had unexplained investigation delays of a year or more.

Other opportunities for improvement relate to reporting to Federal partners and compliance with other Federal and State requirements. Specifically, we found that the Unit reported convictions to OIG for program exclusion timely, but could improve its reporting of adverse actions to the NPDB. Additionally, the Unit did not conduct physical inventories of its property.

We also noted that only a small portion of Unit fraud referrals—less than 2 percent—came from the State Medicaid agency's Program Integrity Unit.

We recommend that the Maine Unit:

Implement policies and procedures to ensure that case files include documentation of supervisory approval for opening and closing cases and periodic supervisory review

The Unit should implement policies and procedures to ensure that all case files include documented supervisory approval for opening and closing of cases. The Unit should revise its policies and procedures manual to require such documentation in the case files. The Unit could also implement procedures that include automated reminders or other mechanisms to alert Unit staff when cases need approval for opening or closing.

The Unit should implement policies and procedures to ensure that cases are reviewed periodically, consistent with the Unit's policy. The Unit should revise its policies and procedures manual to require that periodic supervisory reviews be documented in case files, consistent with Performance Standard 7(a). The Unit could also develop procedures that include automated reminders or other

mechanisms to alert Unit staff when cases are due for periodic reviews.

Implement policies and procedures to document unexplained investigation delays

The Unit should implement policies and procedures to ensure that explanations of delays are included in case files.

Implement processes to ensure that the Unit reports all adverse actions to the NPDB and within the required timeframe

The Unit should implement a tracking system or other means to ensure that it reports all adverse actions to the NPDB in accordance with Federal regulations.

Establish policies and procedures for conducting physical inventories of its property

The Unit should develop a policy for conducting physical inventories of its property and periodically review the inventory log to ensure all property is within its possession.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Maine Unit concurred with all four of our recommendations.

Regarding the first recommendation, the Unit stated that it updated its policies and procedures manual to require documented supervisory approval for case opening and closing in each case file and will verify that such documentation is maintained in the case file prior to processing the case in the case management system. The Unit also stated that it will require Unit personnel to complete, review, and sign a standardized “Quarterly Case Review” form once every 90 days.

Regarding the second recommendation, the Unit stated that it has updated the standardized “Quarterly Case Review” form to include details about any delays.

Regarding the third recommendation, the Unit stated that it updated its policies and procedures manual to require Unit personnel to schedule a reminder of NPDB reporting deadlines for all adverse actions.

Regarding the fourth recommendation, the Unit stated that it updated its policies and procedures manual to require an annual physical inventory of the Unit’s property.

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

APPENDIX A

2012 Performance Standards²⁶

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.
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.

²⁶ 77 Fed. Reg. 32645 (June 1, 2012).

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.
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.
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.
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 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.
6. The number of criminal convictions and the number of civil judgments.
7. The dollar amount of overpayments identified.
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 <i>CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a Medicaid Fraud Control Unit</i> .
11. A UNIT EXERCISES PROPER FISCAL CONTROL OVER UNIT RESOURCES.

A. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.
B. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.
C. The Unit maintains an effective time and attendance system and personnel activity records.
D. The Unit applies generally accepted accounting principles in its control of Unit funding.
E. The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.
12. A UNIT CONDUCTS TRAINING THAT AIDS IN THE MISSION OF THE UNIT.
A. The Unit maintains a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification.
B. The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.
C. Professional certifications are maintained for all staff, including those that fulfill continuing education requirements.
D. The Unit participates in MFCU-related training, including training offered by OIG and other MFCUs, as such training is available and as funding permits.
E. The Unit participates in cross-training with the fraud detection staff of the State Medicaid agency. As part of such training, Unit staff provide training on the elements of successful fraud referrals and receive training on the role and responsibilities of the State Medicaid agency.

APPENDIX B

Maine State Medicaid Fraud Control Unit Referrals by Referral Source for FYs 2012 Through 2014

Referral Source	FY 2012			FY 2013			FY 2014		
	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Funds	Fraud	Abuse & Neglect	Patient Funds
Medicaid agency – PI/SURS ²⁷	3	0	0	5	0	0	0	0	0
Medicaid agency – other	2	0	0	1	0	0	0	0	0
State survey and certification agency	63	1,072	161	97	674	138	82	703	203
Other State agencies	3	3	0	6	2	0	16	6	2
Licensing board	0	0	0	2	1	0	0	0	0
Law enforcement	7	1	0	5	1	0	5	0	3
Office of Inspector General	7	0	0	3	0	1	1	0	0
Prosecutors	3	0	0	12	0	0	5	0	2
Providers	27	3	3	38	1	5	24	0	0
Provider associations	2	2	0	1	0	0	0	0	0
Private health insurer	0	0	0	0	0	0	0	0	0
Long-term-care ombudsman	1	22	1	0	28	1	1	12	1
Adult protective services	3	1	0	0	0	0	0	0	0
Private citizens	18	3	0	7	1	0	11	3	0
MFCU hotline	12	7	1	19	2	0	16	3	0
Self-generated	0	0	0	0	0	0	0	0	0
Other	10	10	1	4	2	1	10	9	1
Total	161	1,124	167	200	712	146	171	736	212
Annual Total	1,452			1,058			1,119		

Source: OIG analysis of Unit-submitted documentation, 2015.

²⁷ The abbreviation “PI” stands for program integrity; the abbreviation “SURS” stands for Surveillance and Utilization Review Subsystem.

APPENDIX C

Investigations Opened and Closed By Provider Category for FYs 2012 Through 2014

Table C-1: Fraud Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Facilities						
Hospitals	1	0	0	1	0	0
Nursing facilities	0	1	0	0	0	0
Other long-term-care facilities	0	1	2	1	0	1
Substance abuse treatment centers	2	0	0	1	0	0
Other	2	1	3	1	4	1
Subtotal	5	3	5	4	4	2
Practitioners	Opened	Closed	Opened	Closed	Opened	Closed
Doctors of medicine or osteopathy	0	1	0	2	1	0
Dentists	2	2	1	3	1	0
Podiatrists	0	0	0	1	0	0
Optometrists/opticians	0	0	0	0	0	0
Counselors/psychologists	0	1	2	1	4	1
Chiropractors	0	0	0	0	0	0
Other	0	0	0	1	0	0
Subtotal	2	4	3	8	6	1
Medical Support	Opened	Closed	Opened	Closed	Opened	Closed
Pharmacies	1	2	0	1	2	1
Pharmaceutical manufacturers	0	0	0	0	0	0
Suppliers of durable medical equipment and/or supplies	0	0	0	1	0	0
Laboratories	0	0	0	0	0	0
Transportation services	2	0	1	1	0	0
Home health care agencies	1	1	0	2	2	2
Home health care aides	1	3	1	1	2	2
Nurses, physician assistants, nurse practitioners, certified nurse aides	2	3	5	3	0	5
Radiologists	0	0	0	0	0	0
Medical support—other	0	0	1	2	1	1
Subtotal	7	9	8	11	7	11

Table C-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
Medicaid program administration	0	0	2	0	0	2
Billing company	0	0	0	0	0	0
Other	0	0	0	0	2	1
Subtotal	0	0	2	0	2	3
Total Provider Categories	14	16	18	23	19	17

Source: OIG analysis of Unit-submitted documentation, 2015.

Table C-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing facilities	0	0	0	1	1	0
Other long-term-care facilities	0	0	2	1	0	2
Nurses, physician's assistants, nurse practitioners, certified nurse aides	4	4	4	3	3	2
Home health aides	0	0	0	0	0	0
Other	0	0	0	0	2	1
Total	4	4	6	5	6	5

Source: OIG analysis of Unit-submitted documentation, 2015.

Table C-3: Patient Funds Investigations

Provider Category	FY 2012		FY 2013		FY 2014	
	Opened	Closed	Opened	Closed	Opened	Closed
Nondirect care	0	0	0	0	0	0
Nurses, physician's assistants, nurse practitioners, certified nurse aides	1	0	0	1	0	0
Home health aides	0	0	0	0	0	0
Other	0	0	0	0	1	1
Total	1	0	0	1	1	1

Source: OIG analysis of Unit-submitted documentation, 2015.

APPENDIX D

Detailed Methodology

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

Data Collection

Review of Unit Documentation. Prior to the onsite visit, we analyzed information regarding the Unit's investigation of Medicaid cases, including information about the number of referrals the Unit received, the number of investigations the Unit opened and closed, the outcomes of those investigations, and the Unit's case mix. We also collected and analyzed information about the number of cases that the Unit referred for prosecution and the outcomes of those prosecutions.

We gathered this information from several sources, including the Unit's quarterly statistical reports, annual reports, recertification questionnaire, policy and procedures manuals, and MOU with the State Medicaid agency. Additionally, we confirmed with the Unit director that the information we had was current as of March 2015.

Review of Unit Financial Documentation. We reviewed the Unit's control over its fiscal resources to identify any internal control issues or other issues involving use of resources. We also 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 supply inventory, and a sample of time and effort records.

Interviews with Key Stakeholders. In March 2015, we interviewed key stakeholders, including officials in the United States Attorneys' Offices, the State Attorney General's Office, and other State agencies that interacted with the Unit (e.g., the Medicaid Program Integrity Unit, the Office of the State Long-Term Care Ombudsman). We also interviewed supervisors from OIG's Region I offices who work regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with OIG and other Federal and State authorities, and we identified opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management.

Survey of Unit Staff. In March 2015, we conducted an online survey of all six nonmanagerial Unit staff within each professional

discipline (e.g., investigators, auditors, 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 April 2015. We interviewed the Unit director and the Senior Detective. We asked these individuals to provide information related to (1) the Unit's operations, (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance, (3) opportunities for the Unit to improve its operations and/or performance, and (4) clarification regarding information obtained from other data sources.

Onsite Review of Case Files. We requested that the Unit provide us with a list of cases that were open at any point during FYs 2012 through 2014. This list of 111 cases included, but was not limited to, the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened. We selected all 111 cases for review. From the population of 111 cases, we purposively assigned 56 for a more indepth review of selected issues, such as the timeliness of investigations and case development.²⁸ This indepth review was conducted by an OIG investigator.

During our onsite review, we determined that 6 of the 111 cases were not eligible for review. Specifically, we identified that five of the cases were categorized as "global" cases. One additional case was closed prior to the period of review and should not have been included in the case list. We excluded these six ineligible cases from our review, resulting in a total of 105 cases reviewed. Of these 105 cases, 103 were open longer than 90 days and 85 were closed as of the start of the onsite review.

Onsite Review of Unit Operations. During our April 2015 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,

²⁸ During our onsite visit, we identified that 3 of the 56 cases were categorized as "global" cases. As a result, these cases were dropped from our review and the remaining number of cases reviewed for selected issues was 53.

security of data and case files, location of select equipment, and the general functioning of the Unit.

Data Analysis

We analyzed data to identify any opportunities for improvement and any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.²⁹

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

APPENDIX E

Unit Comments

JANET T. MILLS
ATTORNEY GENERAL



REGIONAL OFFICES
84 HARLOW ST. 2ND FLOOR
BANGOR, MAINE 04401
TEL: (207) 941-3070
FAX: (207) 941-3075

TEL: (207) 626-8800
TTY USERS CALL MAINE RELAY 711

STATE OF MAINE
OFFICE OF THE ATTORNEY GENERAL
6 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0006

415 CONGRESS ST. STE. 301
PORTLAND, MAINE 04101
TEL: (207) 822-0260
FAX: (207) 822-0259

14 ACCESS HIGHWAY, STE. 1
CARIBOU, MAINE 04736
TEL: (207) 496-3792
FAX: (207) 496-3291

September 4, 2015

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

Delivered via E-mail to
Jordan R. Clementi, JD

**Re: Draft Report: *Maine State Medicaid Fraud Control Unit 2015 Onsite Review*,
OEI-07-15-00140.**

Dear Ms. Murrin:

Maine's Attorney General and Medicaid Fraud Control Unit appreciate the opportunity to respond to the draft report entitled *Maine State Medicaid Fraud Control Unit 2015 Onsite Review*, OEI-07-15-00140 (hereinafter "Report"). The Unit particularly appreciates the professionalism of the review team throughout the course of the review as well as their recognition within the Report of the improvements the Unit had already self-initiated in the identified areas.

After careful review of the Report and the recommendations within it, the Unit concurs with, and has already implemented, each of the recommendations as follows:

Recommendation #1:

Implement policies and procedures to ensure that case files include documentation of supervisory approval for opening and closing cases and periodic supervisory review.

Response: The Unit concurs. The Unit has updated its Policy and Procedures Manual to require that written supervisory approval to open and close cases be kept with the case file and to require that Unit personnel confirm the presence of the approvals in the file before processing the opening or closing of the case in the computerized case management system.

The Unit has also updated its Policy and Procedures Manual to require that the Unit's standardized "Quarterly Case Review" form be completed, reviewed and signed by the Assistant Attorney General and the Detective no less than once every 90 days. Calendaring requirements for quarterly reviews have also been included in the Policy and Procedures Manual.

Recommendation #2:

Implement policies and procedures to document unexplained investigation delays.

Response: The Unit concurs. The Unit has updated its standardized "Quarterly Case Review" form to specifically require the details of any delays. The Unit has also updated its Policy and Procedures Manual to require that the "Quarterly Case Review" form be completed at least once every 90 days, that the completed form be included in the case file and that the completed form identify and provide details about any delays in the investigation or prosecution of the case.

Recommendation #3:

Implement processes to ensure that the Unit reports all adverse actions to the NPDB and within the required timeframe.

Response: The Unit concurs. The Unit has updated its Policy and Procedures Manual to require both the Assistant Attorney General and the Unit's NPDB Administrator to calendar the NPDB reporting deadline upon the occurrence of every reportable adverse action.

Recommendation #4:

Establish policies and procedures for conducting physical inventories of its property.

Response: The Unit concurs. The Unit has updated its Policy and Procedures Manual to require that a physical inventory of the Unit's property be conducted annually by a member of the Financial Services Division of the Office of the Attorney General.

Thank you for this opportunity to review and respond to the Report. Please let me know if there are any further questions or concerns.

Sincerely,



William R. Savage
Assistant Attorney General
Director, Healthcare Crimes Unit

Cc: Janet T. Mills, Attorney General

ACKNOWLEDGEMENTS

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

Rae Hutchison served as the project leader for this study. Other Office of Evaluation and Inspections staff who conducted the study include Michael P. Barrett. Office of Investigations staff also participated in the review. Central office staff who provided support include Jordan R. Clementi, Kevin Farber, Lonnie Kim, and Jacquelyn Towns.

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