

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MARYLAND STATE MEDICAID
FRAUD CONTROL UNIT:
2016 ONSITE REVIEW**



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**September 2016
OEI-07-16-00140**

**EXECUTIVE SUMMARY: MARYLAND STATE MEDICAID FRAUD CONTROL
UNIT: 2016 ONSITE REVIEW
OEI-07-16-00140**

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 Units' adherence to the 12 MFCU performance standards and compliance with applicable Federal statutes and regulations.

HOW WE DID THIS STUDY

We conducted an onsite review of the Maryland Unit in March 2016. We based our review on analysis of data from seven sources: (1) policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) financial documentation for fiscal years (FYs) 2013 through 2015; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) a sample of files for cases that were open in FYs 2013 through 2015; and (7) observation of Unit operations.

WHAT WE FOUND

For FYs 2013 through 2015, the Maryland Unit reported 42 convictions, 61 civil judgments and settlements, and combined criminal and civil recoveries of over \$70 million. Our review found that the Unit was generally in compliance with applicable laws, regulations, and policy transmittals. The Unit maintained proper fiscal control of its resources and developed an internal "boot camp" training for staff. However, we identified three areas where the Unit should improve its operations. First, 22 percent of the case files lacked documentation of at least one required periodic supervisory review. Second, although the Unit reported all convictions and adverse actions to Federal partners, it did not report some within required timeframes. Finally, the Unit's staff levels were significantly below the number of staff that the Unit requested and OIG approved. Over one-quarter of the Unit's approved positions were vacant, including two supervisory positions.

WHAT WE RECOMMEND

We recommend that the Maryland Unit: (1) ensure it conducts and documents supervisory reviews of Unit case files according to the Unit's policies and procedures, (2) ensure that convictions and adverse actions are consistently reported to Federal partners within required timeframes, and (3) maintain staff levels in accordance with staffing allocations the Unit requested and OIG approved. The Unit concurred with all three recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse or neglect under State law.¹ The SSA requires each State to operate a MFCU, unless the Secretary of Health and Human Services (HHS) determines that operation of a Unit would not be cost-effective because minimal Medicaid fraud exists in a particular State and that the State has other adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.² Currently, 49 States and the District of Columbia (States) have MFCUs.³

Each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.⁴ Unit staff review referrals of provider fraud and patient abuse or neglect to determine their potential for criminal prosecution and/or civil action. In fiscal year (FY) 2015, the 50 Units collectively reported 1,553 convictions, 795 civil settlements or judgments, and approximately \$745 million in recoveries.^{5, 6}

Units must meet a number of requirements established by the SSA and Federal regulations. For example, each Unit must:

- be a single, identifiable entity of State government, distinct from the single State Medicaid agency;⁷
- develop a formal agreement, such as a memorandum of understanding, which describes the Unit's relationship with the State Medicaid agency;⁸ and

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 SSA § 1903(q)(6); 42 CFR § 1007.13.

⁵ Office of Inspector General (OIG), *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on February 17, 2016.

⁶ All FY references in this report are based on the Federal FY (October 1 through September 30).

⁷ SSA § 1903(q)(2); 42 CFR § 1007.5 and 1007.9(a).

⁸ 42 CFR § 1007.9(d).

- have either statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.⁹

MFCU Funding

Each MFCU is funded jointly by its State and the Federal government. Federal funding for the MFCUs is provided as part of the Federal Medicaid appropriation, but it is administered by OIG.¹⁰ Each Unit receives Federal financial participation equivalent to 75 percent of its total expenditures, with State funds contributing the remaining 25 percent.¹¹ In FY 2015, combined Federal and State expenditures for the Units totaled \$251 million, \$188 million of which represented Federal funds.¹²

Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority to administer the MFCU grant program.¹³ To receive Federal reimbursement, each Unit must submit an initial application to OIG for approval and be recertified each year thereafter.

In annually recertifying the Units, OIG evaluates Unit compliance with Federal requirements and adherence to performance standards. The Federal requirements for Units are contained in the SSA, regulations, and policy guidance.¹⁴ In addition, OIG has published 12 performance standards that it uses to assess whether a Unit is effectively performing its responsibilities.¹⁵ The standards address topics such as staffing, maintaining adequate referrals, and cooperation with Federal authorities. Appendix A contains the performance standards.

OIG also performs periodic onsite reviews of the Units, such as this review of the Maryland MFCU. During these onsite reviews, OIG evaluates Units' compliance with laws, regulations, and policies, as well as adherence to the 12 performance standards. OIG also makes observations about best practices, provides recommendations to the Units, and monitors the implementation of the recommendations. These evaluations differ from

⁹ SSA § 1903(q)(1).

¹⁰ SSA § 1903(a)(6)(B).

¹¹ Ibid.

¹² OIG, *MFCU Statistical Data for Fiscal Year 2015*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm on February 17, 2016.

¹³ The SSA authorizes the Secretary of HHS to award grants to the Units (SSA § 1903(a)(6)(B)); the Secretary delegated this authority to OIG.

¹⁴ On occasion, OIG issues policy transmittals to provide guidance and instructions to MFCUs.

¹⁵ 77 Fed. Reg. 32645 (June 1, 2012). Accessed at <http://www.oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf> on April 7, 2016.

other OIG evaluations as they support OIG's direct administration of the MFCU grant program. These evaluations are subject to the same internal quality controls as other OIG evaluations, including internal peer review.

OIG provides additional oversight including the collection and dissemination of performance data, training, and technical assistance.

Maryland MFCU

The Unit, a division of the Maryland Office of the Attorney General, investigates and prosecutes cases of Medicaid fraud and patient abuse or neglect. At the time of our March 2016 onsite review, the Unit employed 28 staff members—1 director, 1 senior civil attorney, 1 chief of investigations, 1 chief auditor, 11 investigators, 4 attorneys, 4 auditors, and 5 support staff. The Unit director supervises the attorneys, the chief of investigations, and the chief auditor. The chief of investigations supervises the investigators and the chief auditor supervises the auditors. The deputy director supervises the support staff.¹⁶ The Maryland Unit had total expenditures of approximately \$3.7 million in combined State and Federal funds in FY 2015.¹⁷

Referrals. The Unit receives referrals from a variety of sources, including the State Medicaid Agency, other law enforcement agencies (e.g., county and city police departments), and private citizens. Appendix B depicts Unit referrals by referral source for FYs 2013 through 2015. An intake committee comprising the director, deputy director, senior civil attorney, senior criminal attorney, chief of investigations, and chief auditor meets monthly to review fraud referrals. The intake committee decides whether the Unit will accept a fraud referral to be opened as a case. The senior criminal attorney reviews each patient abuse and neglect referral to determine whether the matter is within the Unit's jurisdiction.

Investigations and Prosecutions. Opened fraud cases are assigned to criminal or civil teams, as appropriate. Criminal teams include an attorney and three investigators, with assistance from an auditor as needed. Civil teams include an attorney, an auditor, and an investigator. The team develops an investigative plan and documents investigative and prosecutorial activities in case logs. The attorney assigned to a fraud case is responsible for leading and directing the team's investigative activity and approving and finalizing an investigative plan. The supervising

¹⁶ The deputy director and senior criminal attorney positions were vacant at the time of our onsite review.

¹⁷ OIG, MFCU Statistical Data for Fiscal Year 2015. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.pdf on February 18, 2016.

attorney assigns opened patient abuse and neglect cases to an investigator with instructions outlining the initial case plan.

Unit attorneys prosecute both criminal and civil cases. Unit attorneys have the authority to prosecute civil cases in State court under the Maryland State False Claims Act.¹⁸ Unit attorneys may prosecute civil cases in Federal court in concert with the United States Attorney's Office, and may be designated as Special Assistant United States Attorneys.

Previous Onsite Review

In 2010, OIG published a report regarding its onsite review of the Maryland Unit. OIG found that the Maryland Unit was in general compliance with all applicable Federal rules and regulations and the 12 performance standards.

METHODOLOGY

Data Collection and Analysis

We conducted the onsite review in March 2016. We based our review on an analysis of data from seven sources: (1) policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) financial documentation for FYs 2013 through 2015; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) a sample of files for cases that were open in FYs 2013 through 2015; and (7) observation of Unit operations. Appendix C provides details of our 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.

¹⁸ Md. Code, Health General, §§ 2-601 through 2-611.

FINDINGS

Our review of the Maryland Unit found that it was generally in compliance with applicable laws, regulations, and policy transmittals. However, 22 percent of case files lacked documentation of at least one required periodic supervisory review, and the Unit did not report some convictions and adverse actions to Federal partners within required timeframes. In addition, the Unit did not maintain staff levels consistent with its approved budget.

For FYs 2013 through 2015, the Unit reported 42 criminal convictions, 61 civil judgments and settlements, and combined criminal and civil recoveries of over \$70 million

For FYs 2013 through 2015, the Unit reported 42 criminal convictions and 61 civil judgments and settlements. Table 1 provides details of the Unit’s yearly convictions and civil judgments and settlements. Of the Unit’s 42 convictions over the 3-year period, 29 involved provider fraud, and 13 involved patient abuse or neglect.

Table 1: Maryland MFCU Criminal Convictions and Civil Judgments and Settlements, FYs 2013–2015

Outcomes	FY 2013	FY 2014	FY 2015	3-Year Total
Criminal Convictions	21	9	12	42
Civil Judgments and Settlements	29	22	10	61

Source: OIG analysis of Unit-submitted documentation, 2016.

The Unit reported criminal and civil recoveries of over \$70 million for FYs 2013 through 2015—ranging from nearly \$7 million to almost \$41.5 million annually over the 3 years (shown in Table 2). During the 3-year review period, “global cases” accounted for approximately 63 percent of the Unit’s recoveries.¹⁹

¹⁹ “Global” cases are civil false claims actions involving the U.S. Department of Justice and a group of State MFCUs. The National Association of Medicaid Fraud Control Units (NAMFCU) facilitates the settlement of global cases.

Table 2: Maryland MFCU Recoveries and Expenditures, FYs 2013–2015

Type of Recovery	FY 2013	FY 2014	FY 2015	3-Year Total
Global Civil	\$20,799,249	\$23,105,238	\$526,035	\$44,430,521
Nonglobal Civil	\$1,333,851	\$18,340,654	\$1,246,923	\$20,921,428
Criminal	\$289,086	\$48,049	\$4,996,364	\$5,333,499
Total Recoveries**	\$22,422,185	\$41,493,941	\$6,769,321	\$70,685,448
Total Expenditures	\$2,839,746	\$3,510,342	\$3,697,014	\$10,047,102

Source: OIG analysis of Unit-submitted documentation, 2016.

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

** Recovery amounts vary from year to year due to particular settlements. For example, \$15 million of the Unit's nonglobal civil recoveries in FY 2014 came from the settlement of one pharmaceutical case. Similarly, \$4.7 million of the Unit's criminal recoveries in FY 2015 came from one criminal case.

Maryland's global recoveries declined from more than \$23 million in FY 2014 to less than \$1 million in FY 2015. This is consistent with a national trend of declining civil health care fraud complaints and settlements, especially those involving pharmaceutical companies.²⁰

Twenty-two percent of the case files lacked documentation of at least one required periodic supervisory review; however, supervisors documented the opening and closing of cases

Twenty-two percent of the Unit's case files lacked documentation of at least one periodic supervisory review required by Unit policy.²¹ Performance Standards 5(b) and 7(a) state that supervisors should periodically review the progress of cases, consistent with Unit policies and procedures, ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe, and note in the case file that the reviews take place. Unit policy states that the director, deputy director, chief of investigations, chief auditor, and appropriate supervising attorney

²⁰ From the 1990s through the early 2000s, a significant number of pharmaceutical companies were the subject of large monetary settlements in civil fraud actions. As a condition of those settlements, pharmaceutical companies were required to adopt corporate integrity agreements that were designed to prevent future abusive practices. Other corporations have adopted voluntary compliance programs, promoted by OIG, which may have further reduced the incidence of fraud allegations. See OIG Compliance Program Guidance for Pharmaceutical Manufacturers, 68 Fed. Reg. 23731 (May 5, 2003), available at <http://www.oig.hhs.gov/authorities/docs/03/050503FRCPGPharmac.pdf>.

²¹ Appendix D contains the point estimates and 95-percent confidence intervals for all estimates derived from our case file review.

are to meet quarterly to review progress of cases and document the outcomes of these quarterly reviews in the case logs.²²

We found that nearly all files contained documentation of supervisory approval to open and close cases. Performance Standard 5(b) states that Unit supervisors should approve the opening and closing of cases. The Unit's policy also requires that case opening and case closing documentation be maintained in case files. Specifically, we found that 97 percent of the Unit's case files included documentation of supervisory approval to open the cases. Supervisory approval to open cases indicates that Unit supervisors are monitoring the intake of cases, thereby facilitating progress in the investigation. All 88 closed case files in the sample included documentation of supervisory approval to close the cases.²³ Supervisory approval of the closing of cases helps ensure the timely completion and resolution of cases.

Although the Unit reported all convictions to OIG and all adverse actions to the National Practitioner Data Bank (NPDB), it did not report some convictions and adverse actions within required timeframes

Performance Standard 8(f) states that the Unit should transmit to OIG reports of all convictions for the purpose of exclusion from Federal health care programs within 30 days of sentencing. Federal regulations require that Units report any adverse actions resulting from investigations or prosecutions of healthcare providers to the NPDB within 30 calendar days of the date of the final adverse action.²⁴ Performance Standard 8(g) also states that the Unit should report qualifying cases to NPDB.²⁵

²² Maryland Attorney General, Criminal Division, Medicaid Fraud Control Unit, "Policies and Procedures Manual," B. Case Updates, p. 33.

²³ All closed case files in our sample included documentation of supervisory approval to close the cases. However, we cannot be certain—because of sampling error—that all of the Unit's closed case files in the review period included this documentation. As a statistical matter, we are 95-percent confident that at least 96.0 percent of the closed cases in the population had documentation of supervisory approval to close the case.

²⁴ SSA § 1128E(g)(1) and 45 CFR § 60.5.

²⁵ 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." The HIPDB and the NPDB were merged during our review period (FYs 2013 through 2015); therefore, we reviewed the reporting of adverse actions under NPDB requirements. See 78 Fed. Reg. 20473 (April 5, 2013). Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. See 45 CFR § 60.3.

The Unit did not report one-third of its convictions to OIG within the required timeframe

The Unit did not report 15 of its 42 convictions (36 percent) to OIG within 30 days of sentencing. On average, the Unit reported these convictions 50 days after the sentencing dates; 2 convictions were reported more than 90 days after the sentencing dates.

The Unit director explained that the late reporting of convictions to OIG was due to staff delays in submitting the necessary paperwork to OIG. The director provided a copy of an email she sent to all Unit staff on September 30, 2014, stating that all convictions must be reported to OIG within 30 days of sentencing. This action improved the Unit’s timeliness in reporting convictions to OIG. Of the 12 convictions with dates of sentencing after September 30, 2014, in the review period, only 1 was reported late.

Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in improper payments to providers by Medicare or other Federal health care programs or possible harm to beneficiaries. However, our analysis found that no Medicare or Medicaid claims were paid to the late-reported providers.

The Unit did not report two-thirds of its adverse actions to NPDB within the required timeframe

The Unit did not report 28 of 42 adverse actions (67 percent) to NPDB within 30 days of the adverse action. On average, the Unit reported adverse actions 84 days after the action. Table 3 shows the number of adverse actions that the Unit reported to NPDB after the required timeframe.

Table 3: Number of Adverse Actions Reported to NPDB After Required Timeframe

Federal Partner Reported To	Adverse Actions Reported Within 31 to 60 Days After the Action	Adverse Actions Reported Within 61 to 90 Days After the Action	Adverse Actions Reported More Than 90 Days After the Action	Total Adverse Actions Reported More Than 30 Days After the Action
NPDB	15	7	6	28

Source: OIG analysis of Unit adverse actions and dates reported to NPDB, 2016.

The Unit director explained that the late reporting of adverse actions to NPDB was due to staff error. The NPDB is intended 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 and adverse actions. If a Unit fails to report adverse actions to

the NPDB, individuals may be able to find new healthcare employment with an organization that is not aware of their adverse actions.

At the time of our review, the Unit's staff levels were significantly below the number of staff that the Unit requested and OIG approved

According to Performance Standard 2, the Unit should maintain staff levels in accordance with the staffing levels approved in its budget. As part of its oversight role, OIG approves the number of staff requested by the State in its annual budget. For FY 2016, OIG approved 39 staff members. At the time of our onsite review in March 2016, the Unit employed 28 staff members. Over one-quarter of the Unit's approved positions were vacant, including two supervisory positions.

Performance Standard 2 also states that a Unit must employ an appropriate number of staff to effectively investigate and prosecute an appropriate volume of case referrals and workload. In the staff survey, 20 of 25 staff (80 percent) responded that the Unit did not have adequate staff and resources, given its caseload. Specifically, two staff commented that when staff members left, cases were reassigned to remaining staff and that their increased workload impeded case progress. Moreover, in October 2015, an official from the State Medicaid program integrity unit expressed concern with the Unit's responsiveness to referrals, and noted that the Unit had multiple vacancies.²⁶

The Unit maintained proper fiscal control of its resources

The Unit maintained proper fiscal control of its resources during the review period, in accordance with the terms of Performance Standard 11. The Unit's financial documentation indicated that the Unit's requests for reimbursement for FYs 2013 through 2015 represented allowable, allocable, and reasonable costs. In addition, the Unit maintained adequate internal controls relating to accounting, budgeting, personnel, procurement, property, and equipment.

Other observation: The Unit conducted "boot camp" training for new staff

In FY 2014, the Unit developed an internal "boot camp" for all new staff. The training curriculum comprises 12 topics including civil and criminal procedure, interviewing, medical codes, and patient abuse and neglect. The training is conducted in person by experienced Unit staff in the form

²⁶ 2015 Maryland Integrity/SURS Unit Questionnaire for Medicaid Fraud Control Unit recertification. Referrals, p. 1, q. 7.

of 1 to 2 hour lectures per topic. The Unit director considers the topics covered important in helping all new staff, regardless of position, develop a full understanding of the Unit's work. One staff member who had completed the training remarked, "The MFCU boot camp helped me to understand the legal side of the Unit and how my accounting experience would be used to assist with each of my assigned cases."

CONCLUSION AND RECOMMENDATIONS

Our review of the Maryland Unit found that it was generally in compliance with applicable laws, regulations, and policy transmittals. For FYs 2013 through 2015, the Maryland Unit reported 42 criminal convictions and 61 civil judgments and settlements and combined criminal and civil recoveries of over \$70 million. The Unit maintained proper fiscal control of its resources and developed an internal “boot camp” training for staff.

However, we did identify three areas of concern. Specifically, 22 percent of case files lacked documentation of at least one required periodic supervisory review. In addition, the Unit did not report some convictions and adverse actions to Federal partners within required timeframes. Finally, the Unit’s staff levels were significantly below the number of staff that the Unit requested and OIG approved. Over one-quarter of the Unit’s approved positions were vacant, including two supervisory positions.

We recommend that the Maryland Unit:

Ensure it conducts and documents supervisory reviews of Unit case files according to the Unit’s policies and procedures

Although most of the Unit’s case files included documentation of supervisory approval for opening and closing cases, the Unit should take additional steps to ensure that its existing policy to document periodic supervisory reviews is followed in all case files.

Ensure that convictions and adverse actions are consistently reported to Federal partners within required timeframes

The Unit should ensure that convictions are consistently reported to OIG within 30 days of sentencing and that adverse actions are reported to NPDB within 30 days of the action. The Unit may want to consider whether an automated reminder could be incorporated in the case management system to assist the Unit with timely reporting to Federal partners.

Maintain staff levels in accordance with staffing allocations the Unit requested and OIG approved

The Unit should develop a plan to promptly fill the more than one-quarter of its requested and approved positions that are currently vacant.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Maryland Unit concurred with all three of our recommendations.

Regarding the first recommendation, the Unit stated that it has modified and implemented internal procedures to ensure periodic supervisory reviews are conducted and documented in two ways: (1) supervisors now have case files accessible during the quarterly reviews enabling supervisors to annotate the files with significant investigative recommendations while all team members are present, and (2) the Unit's Computer Information Specialist now attends the quarterly reviews and documents them in the Unit's database.

Regarding the second recommendation, the Unit stated that it has updated procedures to include additional controls so that convictions and adverse actions are consistently reported to Federal partners within required timeframes. Unit procedures now require the chief of investigations to report convictions to OIG and adverse actions to NPDB. Further, procedures require the Unit's management associate to monitor the Unit's litigation schedule and verify that reporting occurred within required timeframes.

Regarding the third recommendation, the Unit stated that it has attempted to fill open positions in accordance with requested and approved staffing allocations. The Unit added that the Office of the Attorney General (OAG), which oversees the hiring of personnel, has committed to filling additional available positions promptly and that hiring for those additional positions is proceeding. We appreciate the OAG's commitment to filling the positions, but recommend that the Unit work with the OIG oversight division to develop an action plan to identify a specific timetable for its hiring plans.

The Unit's comments are provided in Appendix E.

APPENDIX A

2012 Performance Standards²⁷

1. A UNIT CONFORMS WITH ALL APPLICABLE STATUTES, REGULATIONS, AND POLICY DIRECTIVES, INCLUDING:
A. Section 1903(q) of the Social Security Act, containing the basic requirements for operation of a MFCU;
B. Regulations for operation of a MFCU contained in 42 CFR part 1007;
C. Grant administration requirements at 45 CFR part 92 and Federal cost principles at 2 CFR part 225;
D. OIG policy transmittals as maintained on the OIG Web site; and
E. Terms and conditions of the notice of the grant award.
2. A UNIT MAINTAINS REASONABLE STAFF LEVELS AND OFFICE LOCATIONS IN RELATION TO THE STATE'S MEDICAID PROGRAM EXPENDITURES AND IN ACCORDANCE WITH STAFFING ALLOCATIONS APPROVED IN ITS BUDGET.
A. The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
B. The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
C. The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
D. The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
E. To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately 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.

²⁷ 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

Unit Referrals by Referral Source for FYs 2013 Through 2015

Referral Source	FY 2013		FY 2014		FY 2015		Total
	Fraud	Abuse & Neglect ¹	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	
State Medicaid agency – SUR/S or OMIG	24	3	29	3	23	3	85
State Medicaid agency – other	0	1	0	3	2	40	46
Managed care organizations	10	0	1	0	7	0	18
State survey and certification agency	1	23	2	32	3	57	118
Other State agencies	3	3	1	1	0	0	8
Licensing board	0	0	0	0	1	0	1
Law enforcement	1	105	2	83	2	124	317
Office of Inspector General	1	2	1	0	0	2	6
Prosecutors	1	4	3	2	0	1	11
Providers	0	14	2	8	2	2	28
Provider associations	0	0	0	0	0	0	0
Private health insurer	10	0	1	0	0	0	11
Ombudsman	0	2	0	0	0	0	2
Adult protective services	0	0	1	0	0	1	2
Private citizens	82	6	79	9	74	5	255
MFCU hotline ²	0	0	0	0	NA	NA	0
Anonymous ³	NA	NA	NA	NA	3	1	4
Other	4	0	3	2	3	0	12
Total	137	163	125	143	120	236	924
Annual Total		300		268		356	

Source: OIG analysis of Unit Quarterly and Annual Statistical Reports, FYs 2013–2015, 2016.

¹ The category of abuse & neglect referrals includes patient funds referrals.

² The referral source “MFCU hotline” was not a category reported on the FY 2015 Annual Statistical Report.

³ The referral source “Anonymous” was not a category reported on the FY 2013 and FY 2014 Quarterly Statistical Reports.

APPENDIX C

Detailed Methodology

Data collected from the seven sources below was used to describe the caseload and assess the performance of the Maryland 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 and annual statistical reports, its annual reports, its recertification questionnaire, its policy and procedures manual, and its memorandum of understanding with the State Medicaid agency. We requested any additional data or clarification from the Unit as necessary.

Review of Unit Financial Documentation. To evaluate internal control of fiscal resources, we reviewed policies and procedures related to the Unit's budgeting, accounting systems, cash management, procurement, property, and staffing. We reviewed records in the Payment Management System (PMS)²⁸ and revenue accounts to determine the accuracy of the Federal Financial Reports (FFRs) for FYs 2013 through 2015. We also obtained the Unit's claimed grant expenditures from its FFRs and the supporting schedules. From the supporting schedules, we requested and reviewed supporting documentation for the selected items.

We selected three purposive samples to assess the Unit's internal control of fiscal resources. The three samples were structured as follows:

1. To assess the Unit's expenditures, we selected a purposive sample of 72 accounting records. We selected routine and nonroutine transactions representing a variety of budget categories and payment amounts.
2. To assess inventory, we selected and verified a purposive sample of 19 items from the current inventory list of 158 items. To ensure a

²⁸ The PMS is a grant payment system operated and maintained by the Department of Health and Human Services, 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.

variety in our inventory sample, we included items that were portable and high value (e.g., vehicles, communication equipment).

3. To assess employee time and effort, we reviewed time card records from 10 pay periods across the 3 years of the review period for all Unit employees on staff.

Interviews with Key Stakeholders. In February and March 2016, 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 (i.e., the Medicaid Program Integrity Unit, the Office of the State Long-Term Care Ombudsman, and the Office of Health Care Quality). We also interviewed supervisors from OIG's Region III 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 February 2016, we conducted an online survey of all 25 nonmanagerial Unit staff within each professional discipline (i.e., investigators, auditors, attorneys, and analysts) as well as support staff. The response rate was 100 percent. Our questions focused on Unit operations, opportunities for improvement, and practices that contributed to Unit effectiveness, efficiency, and 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 during the onsite review in March 2016. We interviewed the Unit's director, chief of investigations, and chief auditor.²⁹ 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 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 and Other Documentation. We requested that the Unit provide us with a list of cases that were open at any point during FYs 2013 through 2015. We requested data on the 1,193 open cases that included, but was not limited to, the current status of the case; whether the

²⁹ We also interviewed the Unit's former deputy director, who served in this position during the review period. This individual had since taken a position in the Maryland Office of Attorney General.

case was criminal, civil, or global; and the date on which the case was opened. Because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs, we exclude those cases from our review of a Unit's case files. Therefore, we excluded 368 cases that were categorized as "global" from the list of cases. The remaining number of case files was 825.

From the 825 cases, we selected for review a simple random sample of 100 cases. From these 100 case files, we selected a simple random sample of 50 files for a more in-depth review of selected issues, such as the timeliness of investigations and case development.

Based on our review of the sampled case files, we reported: (1) the percentage of all case files that were open longer than 90 days that lacked documentation of periodic supervisory review, (2) the percentage of all case files that included documentation of supervisory approval for opening, and (3) the percentage of all closed case files that included documentation of supervisory approval for closing. Appendix D contains these point estimates and their 95-percent confidence intervals.

Onsite Review of Unit Operations. During our March 2016 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.

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.³⁰

³⁰ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu>.

APPENDIX D

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

Estimate	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of case files that were open longer than 90 days that lacked documentation of periodic supervisory review	41	22.0%	10.8%	37.3%
Percentage of case files that included documentation of supervisory approval for opening	100	97.0%	91.8%	99.4%
Percentage of closed case files that included documentation of supervisory approval for closing	88	100.0%	96.0%	100.0%

Source: OIG analysis of Maryland MFCU case files, 2016.

APPENDIX E

Unit Comments

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September 12, 2016

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

Re: Maryland State Medicaid Fraud Control Unit: 2016 Onsite Review, OEI-07-16-00140

Dear Ms. Murrin:

I have received your letter of August 11, 2016 with the draft report attached. I am responding to your request for comments on behalf of Attorney General Brian E. Frosh.

The first recommendation is that the Maryland Unit ensure it conducts and documents supervisory reviews of Unit case files according to the Unit's policies and procedures. The Office of the Attorney General concurs with this recommendation. As recommended, the Unit has taken additional steps to ensure that periodic supervisory reviews are documented. These additional steps have already been implemented.

Case reviews are scheduled by supervisors quarterly. In the past, supervisors would annotate files after the conclusion of the meetings. Internal procedures have been modified to now mandate documentation in two ways. First, supervisors now have case files accessible during the quarterly reviews; this enables supervisors to annotate the files with significant investigative recommendations while all MFCU team members are present. Second, the Computer Information Specialist now attends the quarterly reviews and subsequently documents them in the Unit's database.

The second recommendation is that the Unit ensure that convictions and adverse actions are consistently reported to Federal partners within the required timeframes. The Office of the Attorney General concurs with this recommendation. The suggested action in the report is an

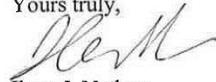
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automated reminder in the case management system. Unfortunately, the MFCU does not have an integrated case management system at this time. What the MFCU has done is update its procedures to have more controls in place to ensure timely filings. First, as already required, the responsibility for collecting the necessary documents for reporting lies with the Assistant Attorney General handling the case. Second, the filings of the exclusion materials and the NPDB submissions will now both be done by the Chief of Investigations. (Previously the databank entry was done by the Computer Information Specialist because he maintains the Unit's statistics). Third, the Unit's Management Associate is monitoring the Unit's litigation schedule and will calendar the reporting dates on the Unit calendar and verify that the reporting was done within the required timeframes.

The third recommendation is that the Unit maintain staff levels in accordance with staffing allocations that have been requested and approved. The Office of the Attorney General concurs with this recommendation. In FY16, the Unit sought additional positions to create a facility failure of care team. The additional positions have required a physical expansion of the Unit's space and that was not completed until April 2016. Hiring for those additional positions has been proceeding although there has been difficulty in filling the nurse investigator position, and the Unit has just issued its third advertisement. The OAG Administration oversees the hiring of personnel and has committed to filling available positions promptly in the future.

The Medicaid Fraud Control Unit is committed to striving for full compliance with the Performance Standards and appreciates the recommendations of the Onsite Review team.

Yours truly,



Ilene J. Nathan
Director, Medicaid Fraud Control Unit

cc: Jordan R. Clementi (via e-mail)
Beverly Pivec (via e-mail)

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian T. Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Jennifer King, Deputy Regional Inspector General; and in consultation with Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Tricia Fields, of the Kansas City regional office, served as project leader for this study. Other Office of Evaluation and Inspections staff who conducted the review include Dana Squires and Michala Walker. Other Medicaid Fraud Policy and Oversight Division staff who participated in the review include Jordan Clementi. Office of Investigations staff also participated in the review. Office of Audit Services staff who conducted a financial review include Mike Jones, Marilyn Carrion, and Valerie Johnson. Central office staff who contributed include Kevin Farber, Lonie Kim, and Joanne Legomsky.

Office of Inspector General

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