

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



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WHY WE DID THIS STUDY

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

HOW WE DID THIS STUDY

We analyzed data from seven sources: (1) a review of documentation, policies, and procedures related to the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management and selected staff; (6) an onsite review of case files; and (7) an onsite review of Unit operations.

WHAT WE FOUND

From fiscal years 2010 through 2012, the Unit reported recoveries of \$144 million, 64 convictions, and 53 civil judgments and settlements. The Unit maintained proper fiscal control of its resources. Most Unit case files contained documentation of supervisory approval to close cases; however, 21 percent of case files lacked documentation of supervisory approval to open cases, and 67 percent lacked documentation of periodic supervisory reviews. In addition, the Unit did not refer sentenced individuals to OIG for program exclusion within an appropriate timeframe. The Unit's policies and procedures manual was not updated to reflect current Unit operations. Finally, the Unit's memorandum of understanding (MOU) with Michigan's State Medicaid agency—the Department of Community Health (DCH)—did not reflect current law and practice as required.

WHAT WE RECOMMEND

We recommend that the Michigan Unit (1) ensure that supervisory approval to open cases and periodic supervisory reviews are documented in Unit case files, (2) ensure that it refers individuals for exclusion to OIG within an appropriate timeframe, (3) revise its policies and procedures manual, and (4) revise its MOU with DCH. The Unit concurred with all four of our recommendations.

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OBJECTIVE

To conduct an onsite review of the Michigan 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 (HHS) determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State; and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.² Currently, 49 States and the District of Columbia (States) have created such Units.³ In fiscal year (FY) 2012, combined Federal and State grant expenditures for the Units totaled \$217.3 million, of which Federal funds represented \$162.9 million.^{4, 5} That year, the 50 Units employed 1,901 individuals.⁶

To carry out its duties 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 The staff reviews complaints referred by the State Medicaid agency and other sources and determines their potential for criminal prosecution and/or civil action. Collectively, in FY 2012, the 50 Units reported 1,337 convictions and 823 civil judgments and

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

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

³ North Dakota and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units. *Medicaid Fraud Control Units*, Office of Inspector General (OIG) web site. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp> on May 21, 2013.

⁴ All FY references in this report are based on the Federal FY (October 1 through September 30).

⁵ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on May 8, 2013.

⁶ Ibid.

⁷ SSA § 1903(q)(6) and 42 CFR § 1007.13.

settlements. That year, the Units reported recoveries of approximately \$2.9 billion.⁸

Units are required to have either Statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an office with such authority.⁹ In Michigan and 43 other States, the Units are located within offices of State Attorneys General that have this authority. In the remaining six States, the Units are located within other State agencies; generally, such Units must refer cases to offices with prosecutorial authority.¹⁰ Additionally, each Unit must be a single, identifiable entity of State government, distinct from the State Medicaid agency, and each Unit must develop a formal agreement—i.e., a memorandum of understanding (MOU)—that describes the Unit’s relationship with that agency.¹¹

Oversight of the MFCU Program

The Secretary of HHS delegated to OIG the authority both to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating them.¹² All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹³ To receive Federal reimbursement, each Unit must submit an initial application to OIG.¹⁴ OIG reviews the application and notifies the Unit whether it is approved and the Unit is certified. Approval and certification are valid for a 1-year period; the Unit must be recertified each year thereafter.¹⁵

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁶ OIG

⁸ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on May 8, 2013. Pursuant to 42 CFR § 1007.17, Units report the total amount of recovered funds in their annual reports to OIG. “Recoveries” are defined as the amount of money that defendants are required to pay as a result of a judgment or settlement in criminal and civil cases, and may not reflect actual collections. Recoveries may involve cases that include participation by other Federal and State agencies.

⁹ SSA § 1903(q)(1).

¹⁰ In States with a Unit, the Unit shares responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States, including Michigan, also employ a Medicaid Inspector General who conducts and coordinates anti-fraud, waste, and abuse activities for the State agency.

¹¹ SSA § 1903(q)(2) and 42 CFR § 1007.9(d).

¹² 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 referred to as Federal Financial Participation (FFP).

¹³ SSA § 1903(a)(6)(B).

¹⁴ 42 CFR § 1007.15(a).

¹⁵ 42 CFR § 1007.15(b) and (c).

¹⁶ SSA § 1902(a)(61).

developed and issued 12 performance standards to define the criteria that OIG applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements.¹⁷ Examples of standards include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all three of the professional disciplines (i.e., for auditors, investigators, and attorneys), and establishing policy and procedures manuals to reflect the Unit's operations. See Appendix A for a complete list of the performance standards.¹⁸

Michigan Unit

The Unit is an autonomous entity within the Michigan Attorney General's Criminal Justice Bureau and has the authority to prosecute cases of Medicaid fraud and of patient abuse and neglect. At the time of our review, 30 of the Unit's 31 employees were located in East Lansing.¹⁹ The Unit Director served as the Chief Attorney and directly supervised all Unit attorneys, the Chief Investigator, and the Unit auditor.²⁰ The Chief Investigator directly supervised three Investigative Supervisors, each of whom led an investigative team.²¹

The Unit receives referrals of provider fraud from the State Medicaid agency—the Michigan Department of Community Health (DCH)—and from Federal agencies, such as OIG. The Unit receives referrals of patient abuse and neglect²² from the Michigan Long-Term Care Ombudsman and the Michigan Department of Licensing and Regulatory Affairs (LARA). In addition, the Unit receives both types of referrals from other State and local agencies and from the public through a Medicaid Fraud Report hotline and a fraud-reporting form located on the Michigan Attorney General's Web site. For additional information on Unit referrals, see Appendix C.

Upon receiving a referral, a Unit investigative secretary enters the relevant information into the Unit's case file tracking system. An Investigative Supervisor then screens the referral and decides whether to open it as a

¹⁷ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov> on May 8, 2013.

¹⁸ Prior to the time of our onsite data collection (March 2013), OIG published a revision of the performance standards, 77 Fed. Reg. 32645 (June 1, 2012). See Appendix B for a complete list of the revised performance standards. The performance standards referred to in this report were published in 1994 and were in effect during most of our review period (FYs 2010 through 2012). When referring to the performance standards, we refer to the 1994 standards, unless otherwise noted.

¹⁹ One Unit attorney was based in Detroit.

²⁰ Since the time of our onsite review, the Unit has hired a Chief Attorney who directly supervises all Unit attorneys. The Unit Director supervises the Chief Attorney.

²¹ The Unit's three investigative teams focus on fraud, residential care (patient abuse and neglect), and special projects.

²² For the purposes of this report, misappropriation of patients' private funds in residential health care facilities is included in the category of patient abuse and neglect.

case or refer it to another agency.²³ For additional information on the Unit's opened and closed investigations, including a breakdown by case type and provider category, see Appendix D.

After a referral is opened as a case, the Unit Director assigns the case to an investigator, an attorney, and, as appropriate, an auditor; the assigned Unit employees then meet to plan the case strategy. The Unit may open a case and pursue it through a variety of actions, including criminal prosecution, civil action, or a combination of the two. The Unit may close a case for a variety of reasons, including but not limited to resolving it through criminal and/or civil action or referring it to another agency.

METHODOLOGY

We analyzed data from seven sources: (1) Unit documentation, including policies and procedures related to the Unit's operations, staffing, and caseload for FYs 2010 through 2012; (2) financial documentation for FYs 2010 through 2012; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management and selected staff; (6) an onsite review of case files that were open at any point during FYs 2010 through 2012; and (7) an onsite review of Unit operations.

We analyzed data from all seven sources to describe the caseload and assess the performance of the Unit. We also analyzed the data to identify any opportunities for improvement and any instances in which the Unit did not meet the performance standards or was not operating in accordance with laws, regulations, and/or policy transmittals.²⁴ In addition, we noted practices that appeared to benefit the Unit. We based these observations on statements from Unit staff and data analysis. We did not independently verify the effectiveness of these practices, but included the information because it may be useful to other Units in their operations.

We conducted the onsite review in March 2013.

Data Collection and Analysis

Review of Unit Documentation. We collected and reviewed (1) Unit documentation, including policies and procedures related to the Unit's

²³ The Investigative Supervisor of the Fraud investigative team reviews all referrals of provider fraud, and the Investigative Supervisor of the Residential Care investigative team reviews all referrals of patient abuse and neglect. An Investigative Supervisor may also assign a Unit investigator to gather more information on a referral before determining whether to proceed with the investigation or refer it to another agency.

²⁴ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov>.

operations, staffing, and cases; (2) the Unit's annual reports and quarterly statistical reports; and (3) the Unit's responses to recertification questionnaires. We reviewed this documentation to determine how the Unit investigates and prosecutes Medicaid cases. The documentation also included data such as the number of referrals received by the Unit and the number of investigations opened and closed. Additionally, we confirmed with the Unit Director that the information we had was current at the time of our review and, as necessary, requested any additional data or clarification that was needed.

Review of Financial Documentation. To evaluate internal controls of fiscal resources, OIG auditors reviewed policies and procedures related to the Unit's budgeting, accounting systems, cash management, procurement, property, and personnel. We obtained the Unit's claimed grant expenditures for FYs 2010 through 2012 to (1) review final Federal Status Reports²⁵ and supporting documentation, (2) select and review transactions within direct cost categories to determine if costs were allowable, and (3) verify that indirect costs were accurately computed using the approved indirect cost rate. Finally, we reviewed records in the HHS Payment Management System (PMS)²⁶ and revenue accounts to identify any unreported program income.²⁷

Interviews With Key Stakeholders. We conducted structured interviews with eight individual stakeholders among five agencies who were familiar with Unit operations. Specifically, we interviewed the Program Integrity Manager for DCH's Office of Health Services Inspector General; Michigan's Long-Term Care Ombudsman; three Assistant U.S. Attorneys based in Michigan; the Michigan Attorney General's Criminal Justice Bureau Chief;²⁸ an OIG Special Agent based in East Lansing; and the OIG Assistant Special Agent in Charge for the State of Michigan. These interviews focused on the Unit's interaction with external agencies, Unit operations, opportunities for improvement, and any practices that appeared to benefit the Unit and that may be useful to other Units in their operations.

²⁵ The Unit transmits financial status reports to OIG's Office of Management and Policy on a quarterly and annual basis. These reports detail Unit income and expenditures.

²⁶ The PMS is a grant payment system operated and maintained by the HHS Program Support Center, Division of Payment Management. The PMS provides disbursement, grant monitoring, reporting, and cash management services to awarding agencies and grant recipients, such as Units.

²⁷ Program income is defined as "gross income received by the grantee or subgrantee directly generated by a grant supported activity, or earned only as a result of the grant agreement during the grant period." 45 CFR § 92.25(b).

²⁸ The Attorney General's Criminal Justice Bureau Chief supervises the Unit Director.

Survey of Unit Staff. We conducted an online survey of Unit staff.²⁹ We requested and received responses from 27 staff members, for a 100-percent response rate. Our questions focused on Unit operations, opportunities for improvement, and practices that appeared to benefit the Unit and that may be useful to other Units in their operations. The survey also sought information about the Unit's compliance with applicable laws, regulations, and policy transmittals.

Interviews With Unit Management and Selected Staff. We conducted structured interviews with the Unit's Director, Chief Investigator, and auditor. We asked them to provide us with additional information necessary to better understand the Unit's operations, identify opportunities for improvement, identify practices that appeared to benefit the Unit and that may be useful to other Units in their operations, and clarify information obtained from other data sources.

Onsite Review of Case Files. We selected a simple random sample of 100 case files from the 1,068 cases³⁰ that were open at any point from FY 2010 through FY 2012. The design of this sample allowed us to estimate the percentage of all 1,068 cases with various characteristics at the 95-percent confidence level. We reviewed these 100 sampled case files and the Unit's processes for monitoring the status and outcomes of cases. From these 100 case files, we selected another simple random sample of 50 files and conducted a more comprehensive review to identify any other potential issues from a qualitative perspective. For population and sample size counts, as well as confidence interval estimates, see Appendix E.

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

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.³¹

²⁹ We did not survey the Unit Director, Chief Investigator, and Unit auditor because we interviewed these employees onsite. In addition, one Unit attorney was not available to respond to the survey.

³⁰ This figure includes cases opened before FY 2010 that remained open at some point during FYs 2010–2012.

³¹ Full text of these standards is available online at <http://www.ignet.gov/pande/standards/oeistds11.pdf>.

FINDINGS

From FY 2010 through FY 2012, the Unit reported recoveries of \$144 million, 64 convictions, and 53 civil judgments and settlements

From FY 2010 through FY 2012, the Unit reported total criminal and civil recoveries of \$144 million—an annual average of \$48 million (see Table 1). Of the \$144 million in recoveries, the Unit attributed \$139.8 million to civil recoveries and \$4.2 million to criminal recoveries. “Global” case judgments and settlements accounted for \$136.6 million of the total civil recoveries and global cases accounted for 190 of the Unit’s 1,068 cases over the 3-year period.³² The Unit’s annual average expenditures for FYs 2010 through 2012 were \$4.6 million.³³

Table 1: Recovered Funds Reported by the Michigan Unit, FYs 2010 Through 2012

	FY 2010	FY 2011	FY 2012	3-Year Total	Annual Average*
Global Civil Recoveries	\$51,861,436	\$35,088,541	\$49,682,632	\$136,632,609	\$45,544,203
Nonglobal Civil Recoveries	\$2,323,024	\$357,949	\$412,736	\$3,093,709	\$1,031,236
Total Civil Recoveries	\$54,184,460	\$35,446,490	\$50,095,368	\$139,726,318	\$46,575,439
Criminal Recoveries	\$517,736	\$443,359	\$3,264,817	\$4,225,912	\$1,408,637
Total Civil and Criminal Recoveries	\$54,702,196	\$35,889,849	\$53,360,185	\$143,952,230	\$47,984,077
Total Expenditures	\$5,030,100	\$4,065,936	\$4,571,020	\$13,667,056	\$4,555,685

Source: OIG review of Unit self-reported Quarterly Statistical Reports (QSRs) and other data, FYs 2010-2012.

*Averages in this table are rounded.

From FY 2010 through FY 2012, the Unit Reported 64 Convictions and 53 Civil Judgments and Settlements. From FY 2010 through FY 2012, the Unit’s convictions and civil judgments and settlements remained at a consistent level. During this period, the Unit reported 64 convictions and

³² Unit-reported recoveries include funds recovered from multi-State, or “global” civil false claims cases, which consist of both those worked directly by the Unit and those worked by staff from other Units.

³³ The figures presented in this paragraph are rounded.

53 civil judgments and settlements—an annual average of 21 convictions and 18 civil judgments and settlements (see Table 2).³⁴

Table 2: Unit Convictions and Civil Judgments and Settlements, FYs 2010 Through 2012³⁵

	FY 2010	FY 2011	FY 2012	3-Year Total	Annual Average
Convictions	22	21	21	64	21.3
Civil Judgments and Settlements	19	19	15	53	17.7

Source: OIG review of Unit self-reported QSRs and other data, FYs 2010-2012.

From FYs 2010 through 2012, the Unit opened an average of 226 cases annually, with an average of 158 cases of provider fraud and 68 cases of patient abuse and neglect. From FYs 2010 through 2012, the Unit closed an average of 192 cases annually, averaging 114 cases of provider fraud and 78 cases of patient abuse and neglect.³⁶ From FYs 2010 through 2012, the Unit received an average of 5,537 referrals annually, with an average of 956 referrals of provider fraud and 4,581 referrals of patient abuse and neglect.

The Unit maintained proper fiscal control of its resources

According to Performance Standard 11, the Unit Director should exercise proper fiscal control over the Unit’s resources. On the basis of the review conducted by OIG auditors, the Unit’s financial documentation indicated that the Unit’s expenditures claims for FYs 2010 through 2012 represented allowable, allocable, and reasonable costs. In addition, the Unit maintained adequate internal controls relating to accounting, budgeting, personnel, procurement, property, and equipment.

Most Unit case files contained documentation of supervisory approval to close cases; however, 21 percent of case files lacked documentation of supervisory approval to open cases and 67 percent lacked documentation of periodic supervisory reviews

According to Performance Standard 6(b), Unit supervisors should approve the opening and closing of cases to ensure a continuous case flow and the timely completion of cases. Supervisory approval to open and close cases

³⁴ These averages are rounded.

³⁵ Civil Judgments and/or Settlements include those received from global cases.

³⁶ Closures include multiple cases opened before FY 2010.

suggests that Unit supervisors are monitoring the intake and resolutions of cases, thereby facilitating progress in the cases. The Unit documented supervisory approval to close cases in 98 percent of closed case files. Although Unit supervisors reported that they approved the opening of all case files, 21 percent of the case files lacked documentation of supervisory approval to open cases.

According to Performance Standard 6(c), supervisory reviews should be “conducted periodically and noted in the case file” to ensure timely case completion.³⁷ Although Unit supervisors reported that they consistently conducted periodic supervisory reviews, 67 percent of the files lacked documentation of periodic supervisory reviews. During our onsite review, Unit management provided a “case status form” that was introduced toward the end of FY 2011 to ensure that periodic supervisory reviews are documented in Unit case files. After the introduction of the case status form, the percentage of closed case files that lacked documentation of periodic supervisory reviews decreased in FY 2012, from 84 percent of case files closed in FYs 2010–2011 to 39 percent of case files closed in FY 2012. Similarly, the percentage of case files that lacked documentation of periodic supervisory reviews decreased in FY 2012, from 71 percent of case files opened in FYs 2010–2011 to 43 percent of case files opened in FY 2012. The case status form is now included with each case file and contains columns for the supervisory review date, the case status, and the reviewing supervisor’s initials.

The Unit did not refer 69 percent of sentenced individuals to OIG for program exclusion within an appropriate timeframe

According to Performance Standard 8(d), when a convicted individual is sentenced, the Unit should send a referral letter to OIG “within 30 days or other reasonable time period” for the purpose of program exclusion.^{38, 39} The Unit reported 64 total convictions within the review period, but had not

³⁷ For the purposes of this report, supervisory approval to open and close a case does not constitute a periodic supervisory review. “Periodic supervisory reviews” indicate that a supervisor reviewed a case more than once between the case’s opening and closing and documented those reviews in the case file.

³⁸ Pursuant to section 1128(a) of the SSA, OIG excludes from participation in Federal health care programs any person or entity convicted of a criminal offense related to the delivery of an item or service under the Medicaid program or to the neglect or abuse of patients in connection with the delivery of a health care item or service. No payment may be made by Medicaid, Medicare, or other Federal health care programs for an item or service provided, ordered, or prescribed by an excluded individual or entity. 42 CFR § 1001.1901.

³⁹ According to Standard 8(f) of the 2012 Performance Standards, all referrals for exclusion should be transmitted to OIG “within 30 days.”

referred 44 (69 percent)⁴⁰ of those sentenced individuals to OIG for program exclusion as of our onsite review. Of these 44 individuals, 7 had not been referred to OIG as of 6 months from the sentencing date, 12 had not been referred as of a year from the sentencing date, 19 had not been referred as of 2 years from the sentencing date, and 6 had not been referred as of 3 years from the sentencing date.

During our onsite review, Unit management reported that it was unaware that the Unit was required to refer 30 of these 44 individuals, who were sentenced for financial exploitation of residential health care facility patients. Unit management also reported that it was unaware that it should have referred an additional 8 of the 44 sentenced individuals who were jointly investigated by the Unit and external agencies, as the Unit was not the lead investigative agency in these cases.⁴¹ Finally, Unit management reported that it was unaware that it should have referred 4 of the 44 sentenced individuals because they were beneficiaries who were sentenced for conspiring with providers to commit Medicaid fraud.⁴² The Unit has provided documentation to OIG demonstrating that 27 of these 44 sentenced individuals have been referred to OIG for program exclusion since the time of our onsite review. According to the Unit, the remaining 17 sentenced individuals will be referred to OIG for program exclusion.

The Unit's policies and procedures manual was not updated, and the Unit's MOU with DCH did not reflect current law and practice

According to Unit management, the Unit's policies and procedures manual had not been updated since the 1990s.⁴³ As a result, it did not reflect any subsequent changes to Unit policies or procedures. In addition, the Unit's October 2010 MOU with DCH had not been updated to include the payment suspension referral process.

⁴⁰ This percentage is rounded.

⁴¹ The Unit reported that it did not have a tracking mechanism to ensure that these sentenced providers were referred to OIG for program exclusion by the external investigating agency. In seven of the eight cases, the providers were not referred to OIG for program exclusion by the external investigating agency.

⁴² The Unit had no explanation for why the remaining 2 of the 44 sentenced individuals were not referred to OIG for program exclusion.

⁴³ Unit management did not know precisely when the Unit's policies and procedures manual had last been updated.

The Unit's policies and procedures manual was not updated to reflect current Unit operations

According to Performance Standard 3, the Unit should establish policies and procedures for its operations, which should be included in a manual. However, the Unit's manual had not been updated to include changes to the Unit's policies and procedures, such as the case file review policy that was introduced in FY 2011. This policy includes the use of the case status form to ensure that periodic supervisory reviews are documented in Unit case files.

The Unit's MOU with DCH did not reflect current law and practice

According to Performance Standard 10, a Unit should periodically review its MOU with the State Medicaid agency to ensure that the MOU reflects current law and practice. As required by Federal regulations, the Unit had an MOU with DCH.⁴⁴ However, the Unit's MOU with DCH had not been updated to include a provision describing the referral process between the Unit and DCH for providers who are subject to a payment suspension on the basis of a credible allegation of fraud.⁴⁵ Unit management reported that it is working with DCH to issue a revised MOU that incorporates the payment-suspension provision.

Other Observations

During our onsite review, we noted two practices that may have been beneficial to Unit operations: (1) an OIG workstation within the Unit that promoted cooperation between the Unit and OIG, and (2) the Unit's streamlined patient abuse and neglect referral process.

According to the Unit, having an OIG workstation within the Unit promoted cooperation between the Unit and OIG

According to Performance Standard 8, the Unit "will cooperate with the OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud." Performance Standard 8(a-c) specifies that "cooperation" includes

⁴⁴ 42 CFR § 1007.9(d).

⁴⁵ The Affordable Care Act, § 6402(h)(2), requires State Medicaid programs, as a condition of receiving FFP, to suspend payments to providers for whom there is a credible allegation of fraud, unless good cause exists to not suspend payments. One way to establish good cause is for the MFCU to inform the Medicaid agency that the suspension would compromise or jeopardize its investigation of the provider. CMS and OIG implemented this provision in revisions to 42 CFR §§ 455.23 and 1007.9(e) effective March 25, 2011 (76 Fed. Reg. 5862, February 2, 2011).

“communicating effectively” with the OIG and other Federal agencies, providing timely information about Unit case actions to those agencies, and having effective case referral procedures. To facilitate communication about joint Unit-OIG investigations and to increase the number of case referrals between the Unit and OIG, the Unit makes workspace available to an OIG Special Agent within the Unit offices; the

OIG agent uses this workspace once or twice a week.^{46, 47} Unit management, staff, and stakeholders reported that the OIG workspace within the Unit benefitted the Unit’s performance by encouraging fraud referrals, facilitating communication between the agencies, and promoting efficiency through an informal, reciprocal assessment of potential referrals.

The Unit streamlined its patient abuse and neglect referral process

According to Performance Standard 6, a Unit should have a continuous case flow and cases should be completed within a reasonable time period. According to Unit management and staff, before FY 2011, a large proportion of patient abuse and neglect referrals from LARA were related to matters inconsistent with the Unit’s statutory functions.⁴⁸ Those referrals reportedly reduced Unit efficiency by diverting Unit time and resources from ongoing cases. In response, Unit management and LARA developed a streamlined process for referring cases of patient abuse and neglect during FY 2011. This process sets certain minimum criteria for a referral to be sent to the Unit. Unit management and staff reported that this process reduced the total number of referrals from LARA without limiting those referrals that were consistent with the Unit’s statutory functions, thereby promoting Unit efficiency and case flow. As a result of the streamlined referral process, the total number of referrals from LARA of patient abuse and neglect was reduced from 5,446 in FY 2011 to 2,482 in FY 2012.

⁴⁶ The Unit does not pay for the equipment or wireless internet connection used by the OIG agent; these are funded directly by the OIG Office of Investigations.

⁴⁷ The OIG staff to whom the Unit transmits information for the purpose of excluding providers are located in a headquarters office distinct from the office that employs OIG field agents.

⁴⁸ For example, many of the referrals received from LARA before FY 2011 included complaints from family members of long-term care facility residents about incidents that did not rise to the level of criminal abuse or neglect.

CONCLUSION AND RECOMMENDATIONS

From FY 2010 through FY 2012, the Unit reported recoveries of \$144 million, 64 convictions, and 53 civil judgments and settlements. Most Unit case files consistently contained documentation indicating supervisory approval to close cases. The Unit maintained proper fiscal control of its resources. According to the Unit, having an OIG workstation within the Unit promoted cooperation between the Unit and OIG. Finally, the Unit improved its case flow by streamlining its patient abuse and neglect referral process.

Opportunities for Unit improvement exist. Specifically, Unit case files did not consistently contain documentation of supervisory approval to open cases or periodic supervisory reviews. In addition, the Unit did not refer 69 percent of sentenced individuals to OIG for program exclusion within an appropriate timeframe. The Unit's policies and procedures manual also had not been updated to reflect the Unit's periodic case file review policy. Finally, the Unit's MOU with DCH did not reflect current law and practice. We found no evidence of noncompliance with applicable laws, regulations, or policy transmittals.

We recommend that the Michigan Unit:

Ensure that supervisory approval to open cases and periodic supervisory reviews are documented in Unit case files

The Unit should ensure that supervisors are consistently reviewing case files and documenting these reviews on case status forms.

Ensure that letters referring providers for exclusion are submitted to OIG within an appropriate timeframe

The Unit should ensure that letters referring individuals and entities for exclusion are sent within 30 days of defendant sentencing, consistent with Standard 8(f) of the 2012 Performance Standards. The Unit should also ensure that it refers all sentenced individuals for exclusion, regardless of the type of crime or the Unit's specific role in the investigation and/or prosecution of a provider.

Revise its policies and procedures manual to reflect current Unit operations

The Unit should revise its policies and procedures manual to include its periodic case file review policy.

Revise its MOU with DCH to reflect current law and practice

The Unit should revise its MOU with DCH to include a provision describing the referral process between the Unit and DCH for providers who are subject to payment suspension on the basis of a credible allegation of fraud.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with the four report recommendations.

Regarding our first recommendation, the Unit reported that it created and now uses an assignment memo, to be signed by the Unit Director, which is included in the file for each full-scale investigation. The Unit also created a case status form to be kept in each case's file to document periodic supervisory review of the file.

Regarding our second recommendation, the Unit explained that, for a majority of those cases not reported to OIG for exclusion, either (1) the underlying case was not "connected to the delivery of a health care item or service" under the terms of the Federal exclusion law, or (2) the case involved a joint investigation and the Unit was not the primary investigative agency. The Unit also understands and accepts OIG's interpretation that all convictions should be reported to OIG for program exclusion, regardless of the Unit's role in each case or the type of individual convicted.

Regarding our third recommendation, the Unit created a revised draft of its policies and procedures manual, which the Unit expects to formalize and distribute to Unit staff during the first quarter of 2014.

Regarding our fourth recommendation, the Unit created a revised draft of its MOU with DCH that should be in place by the end of January 2014. The full text of the Unit's comments is provided in Appendix F. We did not make any changes to the report as a result of the Unit's comments.

APPENDIX A

Performance Standards for MFCUs (Units)⁴⁹

1. **A Unit will be in conformance with all applicable statutes, regulations and policy transmittals.** In meeting this standard, the Unit must meet, but is not limited to, the following requirements:
 - a. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.
 - b. The Unit must be separate and distinct from the single State Medicaid agency.
 - c. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.
 - d. The Unit must submit annual reports, with appropriate certifications, on a timely basis.
 - e. The Unit must submit quarterly reports on a timely basis.
 - f. The Unit must comply with the Americans with Disabilities Act, the Equal Employment opportunity requirements, the Drug Free workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.
2. **A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.** In meeting this standard, the following performance indicators will be considered:
 - a. Does the Unit employ the number of staff that was included in the Unit's budget as approved by the Office of Inspector General (OIG)?
 - b. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?
 - c. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?
 - d. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?
3. **A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.** In meeting this standard, the following performance indicators will be considered:

⁴⁹ 59 Fed. Reg. 49080 (Sept. 26, 1994). These performance standards were in effect during most of our review period and precede the performance standards published in June 2012.

- a. Does the Unit have policy and procedure manuals?
 - b. Is an adequate, computerized case management and tracking system in place?
- 4. A Unit should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit work with the single State Medicaid agency to ensure adequate fraud referrals?
 - b. Does the Unit work with other agencies to encourage fraud referrals?
 - c. Does the Unit generate any of its own fraud cases?
 - d. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?
- 5. A Unit's case mix, when possible, should cover all significant provider types.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit seek to have a mix of cases among all types of providers in the State?
 - b. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?
 - c. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?
 - d. Are there any special Unit initiatives targeting specific provider types that affect case mix?
 - e. Does the Unit consider civil and administrative remedies when appropriate?
- 6. A Unit should have a continuous case flow, and cases should be completed in a reasonable time.** In meeting this standard, the following performance indicators will be considered:
- a. Is each stage of an investigation and prosecution completed in an appropriate time frame?
 - b. Are supervisors approving the opening and closing of investigations?
 - c. Are supervisory reviews conducted periodically and noted in the case file?

7. A Unit should have a process for monitoring the outcome of cases.

In meeting this standard, the following performance indicators will be considered:

- a. The number, age, and type of cases in inventory.
- b. The number of referrals to other agencies for prosecution.
- c. The number of arrests and indictments.
- d. The number of convictions.
- e. The amount of overpayments identified.
- f. The amount of fines and restitution ordered.
- g. The amount of civil recoveries.
- h. The numbers of administrative sanctions imposed.

8. A Unit will cooperate with the OIG and other federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit communicate effectively with the OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?
- b. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?
- c. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?
- d. Does the Unit transmit to the OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

9. A Unit should make statutory or programmatic recommendations, when necessary, to the State government. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?
- b. Does the Unit provide program recommendations to single State agency when appropriate?

- c. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?

10. A Unit should periodically review its memorandum of understanding (MOU) with the single State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice. In meeting this standard, the following performance indicators will be considered:

- a. Is the MOU more than 5 years old?
- b. Does the MOU meet Federal legal requirements?
- c. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?
- d. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?

11. The Unit director should exercise proper fiscal control over the Unit resources. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?
- b. Does the Unit maintain an equipment inventory?
- c. Does the Unit apply generally accepted accounting principles in its control of Unit funding?

12. A Unit should maintain an annual training plan for all professional disciplines. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit have a training plan in place and funds available to fully implement the plan?
- b. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?
- c. Are continuing education standards met for professional staff?
- d. Does the training undertaken by staff aid to the mission of the Unit?

APPENDIX B

Revised 2012 Performance Standards for MFCUs (Units)⁵⁰

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

⁵⁰ 77 Fed. Reg. 32645 (June 1, 2012).

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.
- c. The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).
- d. For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit

takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.

- e. The Unit provides timely information, when requested, to those agencies identified in (D) above regarding the status of referrals.
- f. The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.

5. A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.

- a. Each stage of an investigation and prosecution is completed in an appropriate timeframe.
- b. Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.
- c. Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.

6. A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

- a. The Unit seeks to have a mix of cases from all significant provider types in the State.
- b. For those States that rely substantially on managed care entities for the provision of Medicaid services, the Unit includes a commensurate number of managed care cases in its mix of cases.
- c. The Unit seeks to allocate resources among provider types based on levels of Medicaid expenditures or other risk factors. Special Unit initiatives may focus on specific provider types.
- d. As part of its case mix, the Unit maintains a balance of fraud and patient abuse and neglect cases for those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases.
- e. As part of its case mix, the Unit seeks to maintain, consistent with its legal authorities, a balance of criminal and civil fraud cases.

7. A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.

- a. Reviews by supervisors are conducted periodically, consistent with MFCU policies and procedures, and are noted in the case file.
- b. Case files include all relevant facts and information and justify the opening and closing of the cases.
- c. Significant documents, such as charging documents and settlement agreements, are included in the file.
- d. Interview summaries are written promptly, as defined by the Unit's policies and procedures.
- e. The Unit has an information management system that manages and tracks case information from initiation to resolution.
- f. The Unit has an information management system that allows for the monitoring and reporting of case information, including the following:
 1. The number of cases opened and closed and the reason that cases are closed.
 2. The length of time taken to determine whether to open a case referred by the State Medicaid agency or other referring source.
 3. The number, age, and types of cases in the Unit's inventory/docket.
 4. The number of referrals received by the Unit and the number of referrals by the Unit to other agencies.
 5. The dollar amount of overpayments identified.
 6. The number of cases criminally prosecuted by the Unit or referred to others for prosecution, the number of individuals or entities charged, and the number of pending prosecutions.
 7. The number of criminal convictions and the number of civil judgments.
 8. The dollar amount of fines, penalties, and restitution ordered in a criminal case and the dollar amount of recoveries and the types of relief obtained through civil judgments or pre-filing settlements.

8. A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.

- a. The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.
- b. The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, cases involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.
- c. The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.
- d. For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.
- e. For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.
- f. The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.
- g. The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.

9. A Unit makes statutory or programmatic recommendations, when warranted, to the State government.

- a. The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.
- b. The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies

responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.

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

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

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

- a. The Unit promptly submits to OIG its preliminary budget estimates, proposed budget, and Federal financial expenditure reports.
- b. The Unit maintains an equipment inventory that is updated regularly to reflect all property under the Unit's control.
- c. The Unit maintains an effective time and attendance system and personnel activity records.
- d. The Unit applies generally accepted accounting principles in its control of Unit funding.
- e. The Unit employs a financial system in compliance with the standards for financial management systems contained in 45 CFR 92.20.

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

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

APPENDIX C

Referrals of Provider Fraud and Patient Abuse and Neglect to the Michigan MFCU by Source, FYs 2010 Through 2012

Table C-1: Total MFCU Referrals of Fraud and Abuse and Annual Average

Case Type	FY 2010	FY 2011	FY 2012	3-Year Total	Annual Average*
Patient Abuse and Neglect	5,514	5,581	2,647	13,742	4,581
Provider Fraud	1,016	997	855	2,868	956
Total	6,530	6,578	3,502	16,610	5,537

Source: Unit response to OIG data request.

*Averages in this column are rounded.

Table C-2: Unit Referrals, by Referral Source

Referral Source	FY 2010		FY 2011		FY 2012		Total	Percentage of All Referrals
	Fraud	Abuse and Neglect	Fraud	Abuse and Neglect	Fraud	Abuse and Neglect		
State Survey and Certification Agency	63	5,248	50	5,446	32	2,482	13,321	80.2%
MFCU Hotline	633	31	624	19	532	28	1,867	11.2%
Private Citizens	212	74	216	97	208	128	935	5.6%
Other	34	154	34	13	10	1	246	1.5%
State Medicaid Agency	49	0	40	0	34	0	123	0.7%
Other State Agencies	8	2	14	2	10	3	39	0.2%
Law Enforcement	7	1	8	0	1	0	17	0.1%
OIG	9	1	3	0	4	0	17	0.1%
Licensing Board	0	1	1	1	7	4	14	<0.1%
Private Health Insurers	0	0	4	0	9	0	13	<0.1%
Adult Protective Services	0	2	1	3	3	1	10	<0.1%
Prosecutors	1	0	2	0	5	0	8	<0.1%
Total	1,016	5,514	997	5,581	855	2,647	16,610	100%
Annual Total	6,530		6,578		3,502			
Annual Average*							5,537	

Source: OIG analysis of Unit Quarterly Statistical Reports, FYs 2010 through 2012.

*This average is rounded.

APPENDIX D

Investigations Opened and Closed by the Michigan MFCU, by Provider Category and Case Type, FYs 2010 Through 2012

Table D-1: Total Annual Opened and Closed Investigations

Case Type	FY 2010	FY 2011	FY 2012	3-Year Total	Annual Average*
Opened	268	209	200	677	226
Patient Abuse and Neglect	119	35	49	203	68
Provider Fraud	149	174	151	474	158
Closed	247	162	166	575	192
Patient Abuse and Neglect	140	57	36	233	78
Provider Fraud	107	105	130	342	114

Source: Unit response to OIG data request.

*Averages in this table are rounded.

Table D-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Nondirect Care	3	1	1	1	0	0
Nurses/Doctors' Assistants	7	7	6	2	11	7
Nursing Facilities	5	8	6	6	9	2
Other Long-Term Care Facilities	0	0	0	2	0	1
Other	104	124	22	46	29	26
Total	119	140	35	57	49	36

Source: Unit response to OIG data request.

Table D-3: Provider Fraud Investigations

Provider Category	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Facilities						
Hospitals	1	0	5	3	4	2
Nursing Facilities	4	17	2	0	3	4
Other Long-Term Care Facilities	0	1	1	1	1	0
Substance Abuse Treatment Centers	0	2	0	0	1	0
Other Facilities	5	3	7	3	2	3
Subtotal	10	23	15	7	11	9
Practitioners						
Chiropractors	0	1	1	0	0	0
Counselors/Psychologists	4	1	2	4	6	2
Dentists	5	9	11	1	3	5
Optometrists/Opticians	0	0	1	1	0	0
Physicians	20	12	15	9	24	17
Podiatrists	0	0	0	1	1	0
Other Practitioners	0	0	0	0	1	0
Subtotal	29	23	30	16	35	24
Medical Support						
Durable Medical Equipment Suppliers	13	2	13	7	3	12
Home Health Care Agencies	3	2	5	1	3	3
Home Health Care Aides	5	4	5	5	6	4
Laboratories	6	0	3	4	6	3
Nurses/Doctors' Assistants	1	3	1	1	2	0
Pharmaceutical Manufacturers	55	25	66	39	40	51
Pharmacies	21	16	21	17	23	15
Radiologists	0	1	0	0	0	0
Transportation Services	0	0	2	1	10	2
Other Medical Support	6	7	11	6	10	7
Subtotal	110	60	127	81	103	97
Program Related						
Billing Company	0	0	1	0	2	0
Managed Care	0	1	1	1	0	0
Subtotal	0	1	2	1	2	0
Total	149	107	174	105	151	130

Source: Unit response to OIG data request.

APPENDIX E

Case File Review Population, Sample Size Counts, and Confidence Interval Estimates

Table E-1 shows population and sample counts and percentages by case type. Note that both samples have percentages of case types similar to the general population, though sample counts for some case types are very small. Because of these small sample sizes, we cannot reliably generalize what we found in our sample review to each case type in the population, and only our overall estimates project to the population of all case files. We estimated the 4 population values for all 1,068 case files from the results of our review of the case files selected in our simple random samples. Table E-2 includes the estimate descriptions, sample sizes, point estimates, and 95-percent confidence intervals for these four estimates.

Table E-1: Population and Sample Size Counts for Case Types

Case Type	Population Count and (%) n=1,068	Sample Count* and (%) n=100	Sample Count* and (%) n=50
Closed	621 (58%)	62 (62%)	27 (54%)
Open	447 (42%)	38 (38%)	23 (46%)
Civil	440 (41%)	39 (39%)	19 (38%)
Criminal	628 (59%)	61 (61%)	31 (62%)
Patient Abuse/Neglect	304 (28%)	29 (29%)	12 (24%)
Total Fraud	764 (72%)	71 (71%)	38 (76%)
“Global” Fraud	190 (18%**)	22 (22%**)	13 (26%**)
Non-“Global” Fraud (Provider Fraud)	574 (54%**)	49 (49%**)	25 (50%**)

Source: The Michigan MFCU provided a list of all case files open during FYs 2010 through 2012.

*OIG generated this random sample.

**These percentages refer to the total/sampled number of *all* cases, not to the total/sampled number of fraud cases.

Table E-2: Confidence Intervals for Key Case File Review Data

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Case Files With Documented Supervisory Approval for Closing	62	98.4%	91.6–99.8%
Case Files With No Documented Supervisory Approval for Opening	100	21.0%	13.8–30.0%
Case Files With No Documentation of at Least One Supervisory Review	100	60.0%	50.2–69.3%
Case Files With No Documentation of Periodic Supervisory Review	100	67.0%	57.3–75.8%

APPENDIX F

Unit Comments

STATE OF MICHIGAN
DEPARTMENT OF ATTORNEY GENERAL



P.O. Box 30218
LANSING, MICHIGAN 48909

BILL SCHUETTE
ATTORNEY GENERAL

December 19, 2013

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

Re: Michigan MFCU 2013 Onsite Review (OEI-09-13-00070)

Dear Mr. Wright:

This letter represents the invited comments of the Michigan Medicaid Fraud Control Unit (MFCU) to your report dated November 22, 2013. The report covers the Onsite Review conducted by your agency earlier this year pursuant to your mandate to provide program oversight to the MFCU. I would like to thank you for the opportunity to provide this commentary and for the professionalism of your staff during this review process. The Onsite Review team took care to explain the entire process well in advance and conducted their work with a sincere interest in avoiding disruptions to our normal operations.

Your report made four recommendations. The MFCU concurs with each recommendation, as explained more fully below.

Recommendation #1: Ensure that supervisory approval to open cases and periodic supervisory reviews are documented in Unit case files.

Unit Comment: The MFCU concurs with this recommendation. Unit management recognized this issue prior to the end of the review period and in advance of the Onsite Review. To address the issue, the Unit made two changes in operations. First, the Unit created and now utilizes an assignment memo. This memo is from the Director to the assigned attorney and directs the attorney to pursue the assignment. This is done in every file opened for full-scale investigation. It should be noted that even prior to this process, every full-scale investigation was personally and directly assigned by the Unit Director. It is understood that this recommendation flows from insufficient documentation of this activity.

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Second, and again prior to the conclusion of the review period, the Unit created a case status form to better facilitate the documentation of periodic supervisory review of case files. As reflected in the Onsite Report, the implementation of this form has already enhanced and will continue to improve the documentation of periodic supervisory file reviews.

Recommendation #2: Ensure that the MFCU refers individuals for exclusion to OIG within an appropriate timeframe.

Unit Comment: The MFCU concurs with this recommendation. A large majority of the convictions not originally reported to OIG for exclusion were the result of deliberate good faith decisions and fall into two categories. First, the MFCU did not report convictions for financial abuse of a vulnerable adult in a nursing home when the defendant was not a care provider of any sort. This was based upon our reading of section 1128(a)(2) of the Social Security Act which requires an abuse conviction to be connected to delivery of a health care service or item in order for it to support exclusion. Because the Unit did not view convictions of this nature to involve delivery of a health care service or item, they were not reported. As part of the Onsite Review process, a dialogue on this point was established and Unit management was advised of a broad interpretation of this language by HHS-OIG. Accordingly, the Unit adopted this broad interpretation and immediately embarked upon reporting all convictions, regardless of their nature, to HHS-OIG for exclusion consideration.

The MFCU also did not report convictions where the Unit was not the primary agency. For example, the Unit provided substantial investigative assistance on a case ultimately charged and prosecuted by the Washington State MFCU. Because of the substantial assistance, the Michigan MFCU reported this case as a conviction in our quarterly statistical report to HHS-OIG. However, we did not report this conviction to OIG Exclusions. The MFCU now understands that it is expected that a unit acting as a non-primary agency has an obligation to report that conviction to OIG Exclusions, and this will be done in all cases—both retroactively and going forward, effective immediately.

Recommendation #3: Revise the policies and procedures manual.

Unit Comment: The MFCU concurs with this recommendation. The MFCU operations manual has not kept up with some changes in Unit structure and operations. An overhaul of the Operations Manual is complete in draft form at the time of this comment and is anticipated to be finalized and made available to Unit staff and others within the first quarter of 2014.

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Recommendation #4: Revise the MOU with the Department of Community Health.

Unit Comment: The MFCU concurs with this recommendation. The last operational MOU with the Department of Community Health (DCH) was executed in October of 2010 and is now stale in a number of respects. The MFCU created a new draft MOU and has provided that draft to DCH for review and comment on October 25, 2013. Since then, the two agencies have made adjustments to the language and an updated MOU should be in place by the end of January of 2014.

Once again, I thank you for the opportunity to comment on your report and appreciate how this process has had a positive impact on the Unit.

Sincerely,

/S/

David E. Tanay
Division Chief
Health Care Fraud Division
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DET/jk

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