

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW MEXICO STATE MEDICAID
FRAUD CONTROL UNIT:
2014 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). As part of this oversight, OIG conducts periodic reviews of all Units and prepares public reports based on these reviews. The reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor Unit compliance with Federal grant requirements.

HOW WE DID THIS STUDY

We conducted an onsite review in April 2014. 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 a sample of case files from FYs 2011 through 2013; and (7) an onsite observation of Unit operations.

WHAT WE FOUND

From fiscal years 2011 through 2013, the Unit reported recoveries of \$9 million, 25 convictions, and 71 civil judgments and settlements. A Unit supervisor approved the opening and closing of almost all case files; however, 42 percent of case files lacked documentation of periodic supervisory reviews. In addition, 32 percent of case files had unexplained investigation delays of a year or more. The Unit also did not refer 28 percent of sentenced individuals to OIG for program exclusion within an appropriate timeframe, and it did not report 56 percent of adverse actions to the National Practitioner Data Bank (NPDB) within an appropriate timeframe. The Unit's MOU with the New Mexico Human Services Department had not been updated, and the Unit's policies and procedures manual was incomplete. Finally, the Unit incorrectly reported its program income and inappropriately claimed expenditures for indirect costs.

WHAT WE RECOMMEND

We recommend that the New Mexico Unit (1) ensure that periodic supervisory reviews are documented in Unit case files, (2) ensure that any investigation delays are limited to situations imposed by resource constraints or other exigencies, (3) ensure that it reports all relevant information to OIG and the NPDB within an appropriate timeframe, and (4) revise its policies and procedures manual to reflect current operations. The Unit concurred with all four of our recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.¹ Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.² Currently, 49 States and the District of Columbia (States) have created such Units.³ In fiscal year (FY) 2013, combined Federal and State grant expenditures for the Units totaled \$230 million.^{4,5} That year, the 50 Units employed 1,912 individuals.⁶

To carry out its duties in an effective and efficient manner, each MFCU 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.

¹ Social Security Act (SSA) § 1903(q). Regulations at 42 CFR 1007.11(b)(1) add that the MFCU'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 MFCUs. *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 February 11, 2014.

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

⁵ OIG, *MFCU Statistical Data for Fiscal Year 2013*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on March 10, 2014.

⁶ Ibid.

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

In FY 2013, the 50 Units reported a collective 1,341 convictions and 879 civil judgments and settlements. That year, the Units reported recoveries of approximately \$2.5 billion.⁸

MFCUs 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 New Mexico 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, 11} 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.¹²

Oversight of the MFCU Program

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

⁸ OIG, *MFCU Statistical Data for Fiscal Year 2013*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2013-statistical-chart.htm on March 10, 2014. 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 *Medicaid Fraud Control Units*, OIG Web site. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp> on March 18, 2014.

¹¹ 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 also employ a Medicaid Inspector General who conducts and coordinates activities against fraud, waste, and abuse for the State agency.

¹² SSA § 1903(q)(2) and 42 CFR §§ 1007.5 and 1007.9(d).

¹³ The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is referred to as Federal Financial Participation (FFP).

¹⁴ SSA § 1903(a)(6)(B).

¹⁵ 42 CFR § 1007.15(a).

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.¹⁶

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁷ OIG 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.¹⁸ 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.¹⁹

New Mexico MFCU

Located in Albuquerque, the Unit²⁰ is an autonomous entity within the New Mexico Office of the Attorney General and has the authority to prosecute cases of Medicaid fraud and cases of patient abuse and neglect.²¹ The Unit director serves as the chief attorney and directly supervises all Unit attorneys, the chief investigator, and Unit support staff. The chief investigator directly supervises all Unit investigative staff, including special agents, nurse investigators, information systems specialists, and auditors.

The Unit receives provider fraud referrals primarily from the New Mexico State Medicaid agency—the New Mexico Human Services Department (HSD). The Unit also receives provider fraud referrals from private citizens, local law enforcement, and the New Mexico Department of Aging and Long-Term Services' Adult Protective Services Division. The Unit receives patient abuse and neglect referrals primarily from Adult

¹⁶ 42 CFR § 1007.15(b) and (c).

¹⁷ SSA § 1902(a)(61).

¹⁸ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf> on February 11, 2014.

¹⁹ The performance standards referred to in this report were published in 1994 and were in effect during FYs 2011 and 2012, which constitute most of our review period. In 2012, OIG published a revision of the performance standards (77 Fed. Reg. 32645, June 1, 2012). Our onsite data collection took place in April 2014. When referring to the performance standards, we refer to the 1994 standards, unless otherwise noted. The full text of the 1994 standards is available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf>. The full text of the 2012 standards is available online at <http://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf>.

²⁰ In New Mexico, the Unit is called the Medicaid Fraud and Elder Abuse Division.

²¹ 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.

Protective Services and private citizens. For additional information on Unit referrals, see Appendix A.

Upon receiving a complaint of fraud, abuse, or neglect, support staff enter the complaint into the Unit's electronic case tracking system as an "intake." The Unit director and chief investigator review the intakes and present them at biweekly intake meetings, where all Unit staff discuss whether to accept each intake for investigation. After an intake is accepted for investigation, Unit support staff open it as a "referral" in the Unit's electronic case tracking system and a Unit investigator and attorney are assigned to the case. After an initial investigation period of no more than 6 months, the Unit decides whether to open the referral as a "case." The Unit may open a case and pursue it through criminal investigation and prosecution, civil action, or a combination of the two. The Unit may close a case for various reasons, including resolving it through criminal and/or civil action or referring it to another agency. For additional information on the Unit's opened and closed investigations, including a breakdown by case type and provider category, see Appendix B.

Previous Review

The previous onsite review by OIG of the New Mexico Unit was conducted in 2007. That review, conducted while the Unit was under the supervision of a previous director, identified serious financial deficiencies resulting from the Unit's failure to implement adequate financial management systems, reconcile financial status reports, and exercise proper fiscal control. As a result of that review, the Unit was given "high risk" status by OIG and instructed to comply with seven special conditions.²² In 2008, OIG conducted a followup onsite review of the Unit and determined that the Unit complied fully with all seven special conditions. OIG removed the Unit's high-risk status in 2010.

²²A MFCU or other grantee may be considered "high risk" for a variety of reasons. OIG's designation of the New Mexico Unit as high risk was based on the Unit's inadequate financial management system, failure to conform to previous terms and/or conditions of grant awards, and general lack of management responsibility. See 45 CFR §§ 92.12(a)(3),(4), and (5). Regulations authorize the imposition of special conditions or restrictions on high-risk grantees. 45 CFR § 92.12(b).

METHODOLOGY

We conducted the onsite review in April 2014. We based our review on an analysis of data from seven sources: (1) a review of Unit documentation, policies, and procedures related to the Unit's operations, staffing, and caseload for FYs 2011 through 2013; (2) a review of financial documentation for FYs 2011 through 2013; (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 a sample of case files that were open at any point during FYs 2011 through 2013; and (7) an onsite observation of Unit operations. Appendix C contains a detailed methodology. Appendix D contains the point estimates and 95-percent confidence intervals for the statistics in this report.

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.²³

²³ The full text of these standards is available online at <http://www.ignet.gov/pande/standards/oeistds11.pdf>.

FINDINGS

From FY 2011 through FY 2013, the Unit reported recoveries of \$9 million, 25 convictions, and 71 civil judgments and settlements

From FY 2011 through FY 2013, the Unit reported total criminal and civil recoveries of \$9 million—an annual combined average of \$3 million (see Table 1). Of the \$9 million in total recoveries, the Unit attributed \$417,227 to criminal recoveries. The Unit’s criminal recoveries were significantly higher in FYs 2011 and 2012 than in FY 2013. The MFCU reported that this difference was because of cases resolved in FY 2011 and FY 2012 that had large recovery amounts. “Global” cases accounted for 90 of the Unit’s 287 cases over the 3-year period, and judgments and settlements from global cases accounted for \$6.4 million of the total civil recoveries.²⁴ The Unit’s annual average expenditures (State and Federal share) for FYs 2011 through 2013 were \$1.6 million.²⁵

Table 1: Funds Reported Recovered by the New Mexico MFCU, FYs 2011 Through 2013*

	FY 2011	FY 2012	FY 2013	3-Year Total	Annual Average
Criminal Recoveries	\$155,315	\$230,488	\$31,424	\$417,227	\$139,076
Global Civil Recoveries	\$2,069,697	\$3,124,658	\$1,236,360	\$6,430,715	\$2,143,572
Nonglobal Civil Recoveries	\$1,126,899	\$226,512	\$747,102	\$2,100,513	\$700,171
Total Civil Recoveries	\$3,196,596	\$3,351,170	\$1,983,462	\$8,531,228	\$2,843,743
Total Civil and Criminal Recoveries	\$3,351,911	\$3,581,658	\$2,014,886	\$8,948,455	\$2,982,818
Total Expenditures	\$1,238,255	\$1,617,020	\$1,827,905	\$4,683,180	\$1,561,060

Source: OIG review of MFCU self-reported quarterly statistical reports and other data, FYs 2011–2013.

*Figures in this table are rounded.

²⁴ “Global” cases are civil false claims cases that are brought by the U.S. Department of Justice and involve a group of State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the States.

²⁵ The figures presented in this paragraph are rounded.

From FY 2011 through FY 2013, the MFCU Reported 25 Convictions and 71 Civil Judgments and Settlements. From FY 2011 through FY 2013, the Unit’s number of reported convictions was consistent. During this period, the Unit reported a total of 25 convictions and 71 civil judgments and settlements—an annual average of 8.3 convictions and 23.7 civil judgments and settlements (see Table 2). Of the Unit’s 25 convictions over the 3-year period, 23 involved provider fraud and 2 involved patient abuse and neglect.

Table 2: MFCU Convictions and Civil Judgments and Settlements, FYs 2011 Through 2013²⁶

	FY 2011	FY 2012	FY 2013	3-Year Total	Annual Average
Convictions	8	9	8	25	8.3
Civil Judgments and Settlements	26	15	30	71	23.7

Source: OIG review of MFCU self-reported quarterly statistical reports and other data, FYs 2011–2013.

From FYs 2011 through 2013, the Unit opened an average of 54 cases annually, with an average of 53 cases of provider fraud and 1 case of patient abuse and neglect.²⁷ During this time, the Unit closed an average of 58 cases annually, averaging 51 cases of provider fraud and 7 cases of patient abuse and neglect.²⁸ From FYs 2011 through 2013, the Unit received an average of 356 referrals annually, with an average of 226 referrals of provider fraud and 130 referrals of patient abuse and neglect.²⁹

²⁶ Civil judgments and settlements include those received from global cases.

²⁷ According to Unit management, the Unit opens a relatively low number of cases of patient abuse and neglect because most of the abuse and neglect referrals that the Unit receives do not involve criminal or other serious allegations of abuse or neglect. Unit management reported that most serious allegations of patient abuse and neglect in New Mexico are investigated by local law enforcement.

²⁸ Closures include multiple cases opened before FY 2011.

²⁹ The averages in this paragraph are rounded.

A Unit supervisor approved the opening and closing of almost all case files; however, 42 percent of case files lacked documentation of periodic supervisory reviews

According to Performance Standard 6(b), Unit supervisors should approve the opening and closing of cases.³⁰ Supervisory approval to open and close cases suggests that Unit supervisors are monitoring the intake and resolution of cases, thereby facilitating their progress.

The Unit documented supervisory approval to open cases in 96 percent of the case files. The Unit documented supervisory approval to close cases in 100 percent of the closed case files.

According to Performance Standard 6(c), supervisory reviews should be “conducted periodically and noted in the case file.”³¹ According to the Unit’s policies and procedures, Unit supervisors should have conducted supervisory reviews of case files quarterly prior to October 2011 and bimonthly during and after October 2011. However, 42 percent of the Unit’s case files lacked documentation of periodic supervisory reviews in a timeframe consistent with the then-applicable procedures. Unit management reported that case file reviews are now conducted consistent with the procedures, and that the Unit director and chief investigator presently keep summary logs of all such reviews.³² Of the 42 case files that lacked documentation of periodic supervisory reviews, all but 4 involved cases that were opened during the tenure of a previous MFCU director.

Thirty-two percent of Unit case files had unexplained investigation delays of a year or more

According to 2012 Performance Standard 5, the MFCU should “take steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.” In addition, 2012 Performance Standard 5(c) states that delays in investigation and prosecution should be “limited to situations imposed by resource constraints or other exigencies.” However, 32 percent of Unit case files showed delays of a year or more.

³⁰ 2012 Performance Standard 5(b).

³¹ For the purposes of this report, supervisory approval to open and close a case does not constitute a periodic supervisory review. Periodic supervisory reviews are demonstrated by a supervisor’s reviewing a case more than once between the case’s opening and closing and documenting those reviews in the case file.

³² For the purposes of our case file review, we considered documentation in the summary logs for the MFCU director’s and/or chief investigator’s case file reviews to be sufficient documentation of periodic supervisory reviews.

None of those files contained documentation to explain the delays.³³ Of the 16 case files that did not contain documentation explaining investigation delays, 9 were civil case files and 7 were criminal files.³⁴ Of these 16 case files, 12 had unexplained delays of at least a year, 2 had unexplained delays of at least 18 months, and 2 had unexplained delays of at least 2 years. All 16 case files with unexplained delays involved cases that had been opened during the tenure of a previous MFCU director.

The Unit did not always refer sentenced individuals to OIG or adverse actions to the National Practitioner Data Bank within an appropriate timeframe

According to Performance Standard 8(d), when an individual is sentenced, the MFCU should report the conviction to OIG—with copies of judgment and sentence or other acceptable documentation—“within 30 days or other reasonable time period” for the purpose of program exclusion.^{35, 36} The Unit reported 25 total convictions within the review period, but did not refer 7 (28 percent) of those sentenced individuals to OIG for program exclusion within an appropriate timeframe. Unit management provided documentation that five of these seven individuals were referred to OIG for program exclusion immediately prior to our onsite review and that the remaining two individuals were referred during our onsite review. However, all seven individuals were referred to OIG more than 18 months after their sentencing dates, including five individuals who were referred more than 2 years after their sentencing dates.

Separate from the reporting of convictions to OIG for exclusion purposes, Federal regulations require that all State and Federal government agencies report any final adverse actions, including those resulting from investigations or prosecutions of healthcare providers and suppliers, to the National Practitioner Data Bank (NPDB). The Department of Health and Human Services (HHS) established the NPDB as a national collection

³³ According to 2012 Performance Standard 7(b), case files should include “all relevant facts and information.” For the purposes of this report, we defined a “delay” as a period of at least a year with no documented activity in the case file. During our onsite review, Unit managers reported that they had no knowledge about the reasons for these delays because the delays had occurred under prior management.

³⁴ We examined the 50 case files in our subsample for timeliness.

³⁵ 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 Medicaid or to the neglect or abuse of patients in residential health care facilities. 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.

³⁶ 2012 Performance Standard 8(f) states simply that all referrals for exclusion should be made to OIG “within 30 days.”

program for data on health care fraud and abuse.^{37, 38} Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions.³⁹ Final adverse actions must be reported to the NPDB “within 30 days following the action.”⁴⁰ Although the Unit reported 25 final adverse actions to the NPDB during the review period, 14 (56 percent) of these were reported more than 30 days after the final adverse action was taken. Specifically, three final adverse actions were reported within 31–60 days after the final adverse action, two were reported within 61–90 days after the final adverse action, and nine were reported more than 91 days after the final adverse action.⁴¹

The Unit’s MOU with HSD did not reflect current law and practice, and the Unit’s policies and procedures manual was incomplete

As of our review period, the Unit’s May 2010 MOU with HSD had not been revised to address the payment-suspension referral process. According to Unit management, the Unit’s policies and procedures manual was created in 2004 and updated twice—in 2011 and 2012. However, the 2012 version of the manual did not include Unit policies or procedures on periodic supervisory case file reviews or training standards for professional staff.⁴²

The Unit’s MOU with HSD 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

³⁷ SSA § 1128E(a) and 45 CFR § 61.1 (2012). During most of our review period, the data bank to which Units were to report conviction information and other final adverse actions was the Healthcare Integrity and Protection Databank (HIPDB). In May 2013, the HIPDB was merged into the NPDB, formerly a separate data bank. The merged product is known as the NPDB. 78 Fed. Reg. 20473 (April 5, 2013).

³⁸ In addition to the Federal Regulations, 2012 Performance Standard 9(g) states that Units should report all “qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.”

³⁹ SSA § 1128E(g)(1) and 45 CFR § 61.3 (2012). We reviewed the reporting of adverse actions under HIPDB requirements because the HIPDB and the NPDB had not yet been merged during most of our review period (FYs 2011 through 2013). Current MFCU requirements for reporting to the merged NPDB are in 45 CFR pt. 60.

⁴⁰ 45 CFR § 60.5. Under the HIPDB reporting requirements, final adverse actions must be reported “within 30 calendar days from the date the final adverse action was taken, or the date when the reporting entity became aware of the final adverse action; or by the close of the entity’s next monthly reporting cycle, whichever is later.” 45 CFR § 61.5(a).

⁴¹ HHS provided this data to OIG on February 21, 2014.

⁴² 2012 Performance Standard 3(e) states that training standards should be included in the Unit’s written policies and procedures manual.

current law and practice. As required by Federal regulations, the Unit had an MOU with HSD.⁴³ However, as of our review period, this MOU had not been updated to include a provision describing the referral process between the Unit and HSD for providers that are subject to a payment suspension on the basis of a credible allegation of fraud.⁴⁴ During our onsite review, Unit management provided us with a revised MOU (dated April 2014) that incorporates the payment-suspension provision.

The Unit's policies and procedures manual did not reflect current Unit operations

According to 2012 Performance Standard 3(a), the Unit should have written guidelines or manuals that contain current policies and procedures for its operations that are consistent with the performance standards. The Unit's policies and procedures manual was last updated in 2012. However, the 2012 revision did not address the Unit's procedures for periodic supervisory reviews or for documenting these reviews in the Unit's case files. In addition, although the Unit had a training plan for professional staff—consistent with 2012 Performance Standard 12(a)—this training plan was not contained in the Unit's policies and procedures manual.

Immediately prior to our onsite review, the Unit provided us with a version of the policies and procedures manual that had been updated in early 2014—after our review period. This version contains the Unit's professional training policies and procedures, but does not contain the Unit's procedures for periodic supervisory reviews or for documenting these reviews in the Unit's case files.

The Unit incorrectly reported program income and inappropriately claimed expenditures for indirect costs

According to 2012 Performance Standard 11, a Unit should exercise proper fiscal control of its resources. "Control" includes properly reporting program income, maintaining an equipment inventory, maintaining personnel activity records, using generally accepted

⁴³ 42 CFR § 1007.9(d).

⁴⁴ The Affordable Care Act, § 6402(h)(2), requires that—as a condition of receiving FFP—State Medicaid programs 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. The Centers for Medicare & Medicaid Services and OIG implemented this provision in revisions to 42 CFR §§ 455.23 and 1007.9(e) effective March 25, 2011 (76 Fed. Reg. 5862, Feb. 2, 2011).

accounting principles, and employing a financial system that complies with Federal regulations.⁴⁵ From FY 2011 through FY 2013, the Unit incorrectly reported its program income to OIG. In addition, expenditures for indirect costs were inappropriately claimed by the Unit, although these expenditures were never reimbursed.⁴⁶

The Unit incorrectly reported program income

According to instructions on the Federal SF-425 form, Units should report on the form 75 percent of their program income earned.⁴⁷ However, during the review period, the Unit reported on these forms 100 percent of its program income earned. The New Mexico Attorney General's Office reported that the Unit was informed of this error and that all future SF-425 submissions will reflect the correct 75-percent rate. Financial staff from the New Mexico Attorney General's Office worked with OIG to satisfactorily correct this issue.

The Unit inappropriately claimed expenditures for indirect costs

According to Federal regulations, indirect cost rates for MFCUs are reviewed, negotiated, and approved by HHS.⁴⁸ These indirect cost rates are then included in an agreement between HHS (or the U.S. Department of Justice) and the State Attorney General's Office or other appropriate State agency. In FY 2011, the Unit reported indirect costs of \$18,528.⁴⁹ However, the Unit did not have an agreement in place to claim these costs. We note that the Unit initially reported these indirect costs but later withdrew its claim, and therefore did not receive reimbursement for the indirect costs. Financial staff from the New Mexico Attorney General's office worked with OIG to satisfactorily correct this issue.

Other observation: managed care referrals and program integrity recommendations

Managed care referrals. According to 2012 Performance Standard 4(a), a Unit should take "steps, such as the development of operational protocols, to ensure that the State Medicaid agency, managed care

⁴⁵ According to 2012 Performance Standard 11(e), Units must employ "a financial system in compliance with the standards for financial management systems contained in 45 CFR § 92.20."

⁴⁶ Unit expenditures, program income, and indirect costs are reported on SF-425 forms.

⁴⁷ This percentage represents the FFP rate.

⁴⁸ 2 CFR pt. 225, Appendix E (1).

⁴⁹ Financial officers from the New Mexico Attorney General's Office reported that they could not explain why this claim was filed or how the amount was calculated because the person who had filled out the claim was no longer employed by the Attorney General's Office.

organizations (MCOs), and other agencies” refer all suspected cases of provider fraud to the Unit. Unit management and HSD officials reported that the Unit worked closely with HSD to develop and implement an improved referral process that ensures that the Unit receives all appropriate fraud referrals generated by MCOs. For example, the Unit and HSD meet with MCOs about specific referrals and cases, as well as about general program integrity issues, on a monthly basis. According to Unit management and HSD officials, these monthly meetings help ensure that MCO fraud cases are consistently referred to the Unit and that Unit investigations of MCO cases proceed efficiently.

Program integrity recommendations. According to 2012 Performance Standard 9(b), the Unit should make appropriate program integrity recommendations to the State Medicaid agency. According to HSD officials, the Unit consistently provides program integrity recommendations to HSD during quarterly joint protocol meetings. For example, the Unit provided recommendations regarding provisions in MCO contracts that were adopted by HSD. One such recommendation (formalizing the managed care referral process described above) was that MCOs should refer all suspected fraud to HSD. HSD would then be responsible for screening these referrals and forwarding appropriate cases to the Unit for investigation. This recommendation was incorporated into MCO contracts with HSD as follows: “All confirmed, credible or suspected provider Fraud, Waste and/or Abuse shall be immediately reported to HSD . . . It shall be HSD’s responsibility to report verified cases to [the Unit].”

CONCLUSION AND RECOMMENDATIONS

From FY 2011 through FY 2013, the Unit reported recoveries of \$9 million, 25 convictions, and 71 civil judgments and settlements. A Unit supervisor approved the opening and closing of most case files.

Opportunities for Unit improvement exist. Specifically, Unit case files lacked documentation of periodic supervisory reviews consistent with the Unit's policies for case file review. In addition, Unit case files did not always contain explanations for investigation delays. Also, the Unit did not always refer sentenced individuals to OIG or adverse actions to the NPDB within the appropriate timeframe. The Unit's policies and procedures manual was not complete and the Unit's MOU with HSD did not reflect current law and practice. Finally, the Unit incorrectly reported program income and inappropriately claimed expenditures for indirect costs. However, financial staff from the New Mexico Attorney General's Office worked with OIG to satisfactorily correct these financial issues.

We recommend that the New Mexico Unit:

Ensure that periodic supervisory reviews are documented in Unit case files

The Unit should ensure that periodic supervisory reviews of cases files are conducted consistent with the Unit's case file review policy and that these reviews are documented in the case files.

Ensure that any investigation delays are limited to situations imposed by resource constraints or other exigencies

Except for delays imposed by resource constraints or other exigencies, the Unit should avoid extended delays to investigations. To demonstrate that extended delays were imposed by resource constraints or other exigencies, the Unit could document such occurrences in the case files.

Ensure that all relevant information is reported to OIG and the NPDB within an appropriate timeframe

The Unit should ensure that it sends documentation referring individuals and entities for exclusion within 30 days of sentencing, consistent with 2012 Performance Standard 8(f). Similarly, the Unit should report all adverse actions to the NPDB within 30 days of the action, as specified in Federal regulations and consistent with 2012 Performance Standard 8(g).

Revise its policies and procedures manual to reflect current Unit operations

The Unit should revise its policies and procedures manual to include current procedures for periodic supervisory reviews and for documenting these reviews in the Unit's case files.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Unit concurred with the four report recommendations.

Regarding the first recommendation, the Unit reported that it now includes a supervisory review form in each case file. This form is signed by the Unit director and/or the chief investigator each time they conduct a case file review.

Regarding the second recommendation, the Unit reported that it now documents in the case files the reasons for all investigation and/or prosecution delays.

Regarding the third recommendation, the Unit reported that it had drafted and implemented a process for referring sentenced individuals to OIG and reporting adverse actions to the NPDB within an appropriate timeframe, and that all reporting is now current.

Regarding the fourth recommendation, the Unit reported that it has drafted and implemented policies and procedures for periodic supervisory reviews.

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

APPENDIX A

Referrals of Provider Fraud and Patient Abuse and Neglect to the New Mexico MFCU by Source, FYs 2011 Through 2013

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

Case Type	FY 2011	FY 2012	FY 2013	3-Year Total	Annual Average*
Patient Abuse and Neglect	94	100	196	390	130
Provider Fraud	258	194	226	678	226
Total	352	294	422	1,068	356

Source: MFCU response to OIG data request.

*Averages in this table are rounded.

Table A-2: MFCU Referrals, by Referral Source

Referral Source	FY 2011		FY 2012		FY 2013		Total	Percentage of All Referrals*
	Fraud	Abuse and Neglect	Fraud	Abuse and Neglect	Fraud	Abuse and Neglect		
Private Citizens	50	50	78	65	67	68	378	35.4%
Adult Protective Services	20	31	13	27	21	117	229	21.4%
Other	107	1	36	0	74	2	220	20.6%
State Medicaid Agency	59	3	44	2	41	3	152	14.2%
Law Enforcement	9	4	16	5	11	2	47	4.4%
Providers	6	4	3	0	4	0	17	1.6%
Other State Agencies	4	1	2	1	4	4	16	1.5%
HHS/OIG	2	0	0	0	2	0	4	0.4%
Licensing Board	0	0	0	0	2	0	2	0.2%
Prosecutors	1	0	1	0	0	0	2	0.2%
State Survey and Certification	0	0	1	0	0	0	1	0.1%
Total	258	94	194	100	226	196	1,068	100%
Annual Total	352		294		442			
Annual Average*							356	

Source: MFCU response to OIG data request.

*These figures are rounded.

APPENDIX B

Investigations Opened and Closed by the New Mexico MFCU, by Provider Category and Case Type, FYs 2011 Through 2013

Table B-1: Total Annual Opened and Closed Investigations

Case Type	FY 2011	FY 2012	FY 2013	3-Year Total	Annual Average*
Opened	34	44	86	164	54
Patient Abuse and Neglect	2	0	2	4	1
Provider Fraud	32	44	84	160	53
Closed	44	69	62	175	58
Patient Abuse and Neglect	4	12	5	21	7
Provider Fraud	40	57	57	154	51

Source: MFCU response to OIG data request.

*Averages in this column are rounded.

Table B-2: Patient Abuse and Neglect Investigations

Provider Category	FY 2011		FY 2012		FY 2013	
	Opened	Closed	Opened	Closed	Opened	Closed
Home Health Aides	0	0	0	2	2	1
Nursing Facilities	0	2	0	2	0	1
Other Long-Term Care Facilities	1	0	0	2	0	1
Other	1	2	0	6	0	2
Total	2	4	0	12	2	5

Source: Unit response to OIG data request.

Table B-3: Provider Fraud Investigations

Provider Category	FY 2011		FY 2012		FY 2013	
	Opened	Closed	Opened	Closed	Opened	Closed
Facilities						
Hospitals	1	1	1	0	5	3
Nursing Facilities	0	1	0	2	1	0
Other Long-Term Care Facilities	1	1	0	2	1	2
Substance Abuse Treatment Centers	0	0	0	1	1	0
Other Facilities	0	2	1	1	2	4
Subtotal	2	5	2	6	10	9
Practitioners						
Counselors/Psychologists	1	0	6	1	1	3
Dentists	0	1	1	2	1	0
Doctors of Medicine or Osteopathy	2	4	1	0	6	2
Optometrists/Opticians	0	0	0	1	0	0
Other Practitioners	0	0	3	5	1	0
Subtotal	3	5	11	9	9	5
Medical Support						
Durable Medical Equipment Suppliers	1	0	0	0	5	1
Home Health Care Agencies	9	7	2	11	6	6
Home Health Care Aides	7	5	14	11	9	14
Laboratories	0	0	0	1	1	0
Pharmaceutical Manufacturers	9	12	3	10	27	11
Pharmacies	1	0	3	1	6	1
Transportation Services	0	0	2	0	1	2
Other Medical Support	0	1	2	4	3	2
Subtotal	27	25	26	38	58	37
Program Related						
Billing Company	0	0	1	0	0	0
Managed Care	0	0	1	1	3	0
Other Program Related	0	5	3	3	4	6
Subtotal	0	5	5	4	7	6
Total	32	40	44	57	84	57

Source: Unit response to OIG data request.

APPENDIX C

Methodology

We analyzed data from seven sources to describe the caseload and assess the performance of the MFCU. We also analyzed the data to identify any opportunities for improvement and any instances in which the MFCU did not meet the performance standards or was not operating in accordance with laws, regulations, and/or policy transmittals.⁵⁰ In addition, we noted practices that appeared to benefit the MFCU. We based these observations on statements from MFCU staff and an analysis of collected data.

Data Collection and Analysis

Review of MFCU Documentation. We collected and reviewed (1) MFCU documentation, including policies and procedures related to the Unit's operations, staffing, and cases; (2) the MFCU's annual reports and quarterly statistical reports; and (3) the MFCU's responses to recertification questionnaires. The documentation also included data such as the number of referrals received by the MFCU and the number of investigations opened and closed. We reviewed the documentation to determine how the MFCU investigates and prosecutes Medicaid cases. Additionally, we confirmed with the MFCU director that the documentation we had was current at the time of our review and requested any additional data or clarification, as needed. The data we collected from the MFCU were current as of April 18, 2014. Subsequent changes to the data would therefore not be included in our analyses.

Review of Financial Documentation. To evaluate internal control of fiscal resources, OIG auditors reviewed policies and procedures related to the MFCU's budgeting, accounting systems, cash management, procurement, property, and personnel. We obtained the MFCU's claimed grant expenditures for FYs 2011 through 2013 to (1) review final Federal Status Reports⁵¹ 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.

⁵⁰ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/>.

⁵¹ The MFCU transmits financial status reports to OIG's Office of Management and Policy on a quarterly and annual basis. These reports detail MFCU income and expenditures.

Finally, we reviewed records in the HHS Payment Management System (PMS)⁵² and revenue accounts to identify any unreported program income.⁵³

Structured Interviews With Key Stakeholders. We conducted structured interviews with eight individual stakeholders among six agencies who were familiar with MFCU operations. Specifically, we interviewed the HSD’s Program Integrity Director; the HSD’s General Counsel; an Assistant U.S. Attorney; a New Mexico Deputy Attorney General;⁵⁴ the OIG Assistant Special Agent in Charge for the State of New Mexico; a New Mexico Adult Protective Services supervisor; and two FBI Special Agents. These interviews focused on the MFCU’s interaction with external agencies, MFCU operations, opportunities for improvement, and any practices that appeared to benefit the MFCU and that may be useful to other MFCUs in their operations.

Survey of MFCU Staff. We conducted an online survey of MFCU staff.⁵⁵ We requested and received responses from 16 staff members, for a 100-percent response rate. Our questions focused on MFCU operations, opportunities for improvement, and practices that appeared to benefit the MFCU and that may be useful to other MFCUs in their operations. The survey also sought information about the MFCU’s compliance with applicable laws, regulations, and policy transmittals.

Structured Interviews With MFCU Management and Selected Staff. We conducted structured interviews with the MFCU’s director, the MFCU’s chief investigator, and a MFCU information systems specialist. We asked them to provide us with additional information to better understand the MFCU’s operations, identify opportunities for improvement, identify practices that appeared to benefit the MFCU and that may be useful to other MFCUs in their operations, and to clarify information obtained from other data sources.

⁵² The PMS is a grant payment system operated and maintained by the HHS Program Support Center, Division of Payment Management. The PMS provides disbursement, grant monitoring, reporting, and case management services to awarding agencies and grant recipients, such as MFCUs.

⁵³ 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).

⁵⁴ The Deputy Attorney General supervises the MFCU director.

⁵⁵ We did not survey the MFCU director or chief investigator.

Onsite Review of Case Files. We selected a simple random sample of 100 case files from the 197 cases⁵⁶ that were open at any point from FY 2011 through FY 2013. The design of this sample allowed us to estimate the percentage of all 197 cases with various characteristics at the 95-percent confidence level. We reviewed these 100 sampled case files and the MFCU's processes for monitoring the status and outcomes of cases. From the 100 case files in the initial sample, we selected another simple random sample of 50 files for a more comprehensive review to identify any potential issues from a qualitative perspective. We consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

Onsite Observation of MFCU Operations. While onsite, we observed the MFCU's operations. Specifically, we observed the intake of referrals; security of data and case files; and the general functioning of the MFCU. We also checked to ensure that the MFCU referred sentenced individuals to OIG for program exclusion and that the MFCU reported adverse actions to the NPDB.

⁵⁶ This figure includes cases opened before FY 2011 that remained open at some point during FYs 2011–2013. This figure does not include 90 multi-State (“global”) civil false-claims cases, which consist of both those worked directly by the New Mexico MFCU and those worked by staff from the Federal government or other MFCUs. For the purposes of our case file review, the MFCU's global cases were not included as part of the MFCU's case file population. Including global cases, the total number of MFCU cases open during the review period was 287.

APPENDIX D

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

Table D-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 5 population values for all 197 nonglobal case files from the results of our review of the case files selected in our simple random samples. Table D-2 includes the estimate descriptions, sample sizes, point estimates, and 95-percent confidence intervals for these five estimates.

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

Case Type	Population Count and (%) n=197	Sample Count* and (%) n=100	Sample Count* and (%) n=50
Closed	149 (76%)	78 (78%)	41 (82%)
Open	48 (24%)	22 (22%)	9 (18%)
Civil (Nonglobal)	99 (50%)	50 (50%)	28 (56%)
Criminal	98 (50%)	50 (50%)	22 (44%)
Patient Abuse/Neglect	26 (13%)	18 (18%)	7 (14%)
Provider Fraud (Nonglobal)	171 (87%)	82 (82%)	43 (86%)

Source: The New Mexico MFCU provided a list of all case files open during FYs 2011 through 2013.

* OIG generated this random sample.

Table D-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 Opening	100	96.0%	91.4-98.0%
Case Files With Documented Supervisory Approval for Closing	74	100.0%	96.0-100.0%
Case Files With Documentation of Supervisory Review	100	85.0%	78.7-89.9%
Cases Files With No Documentation of Periodic Supervisory Reviews Consistent With the MFCU's Case File Review Policies	100	42.0%	34.5-49.8%
Cases With No Documentation Explaining Investigation Delays	50	32.0%	20.8-45.2%*

*Because our subsample consisted of only 50 case files, our 95-percent confidence interval is relatively wide for this estimate.

APPENDIX E

Unit Comments



Attorney General of New Mexico

GARY K. KING
Attorney General

ELIZABETH A. GLENN
Chief Deputy Attorney General

December 19, 2014

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

RE: New Mexico MFCU 2014 Onsite Review (OEI-09-14-00240)

Dear Ms. Murrin:

Thank you for your correspondence of November 21, 2014, enclosing the *New Mexico State Medicaid Fraud Control Unit: 2014 Onsite Review, OEI-09-14-00240*, and providing us an opportunity to respond to the recommendations made within the report. We appreciate the opportunity presented by the review and report findings to improve the way in which our Unit functions. We thank your team for the thorough, courteous and professional manner in which the review was conducted.

We offer the following in response to the recommendations:

Recommendation: Ensure that periodic supervisory reviews are documented in Unit case files.

Comments: We concur with this recommendation. While the New Mexico MFCU was conducting supervisory reviews of investigations during the audit period, it was not always clearly indicated in the case files. We continue to conduct supervisory reviews for each investigator, with the director, chief investigator, paralegal and all attorneys present during the reviews. We now use a simple form to clearly indicate in the file that a review has been conducted. The form is located in the same place in each file, and signed during the review by the director and chief investigator.

Recommendation: Ensure that any investigation delays are limited to situations imposed by resource constraints or other exigencies.

Comments: We concur with this recommendation. Based on this recommendation, it has become a standard component of supervisory case reviews to discuss and document in the case files any reasons for delay in the investigation or prosecution of a case.

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Recommendation: Ensure that all relevant information is reported to the OIG and the NPDB within an appropriate timeframe.

Comments: We concur with this recommendation. Based on this recommendation, we have drafted and implemented a policy and procedure outlining who will be responsible for reporting, and guidelines describing how to report both exclusions and adverse actions. This process has been in use since April 2014 and seems to be effective. As of the writing of this letter, all reporting is current.

Recommendation: Revise its policies and procedures manual to reflect current Unit operations.

Comments: We concur with this recommendation. Based on this recommendation, we have drafted and implemented a policy and procedure outlining how supervisory reviews should be conducted and documented. As described above, this process is presently being used and seems to be effective.

The New Mexico MFCU appreciates the efforts of HHS/OIG to ensure the quality and standards of each MFCU, and welcomes the opportunity for improvement. We have made efforts to address each recommendation, and will continue to strive to meet all performance standards. Thank you for your time and effort spent on this review.

Sincerely,

/S/

Patricia Padrino Tucker
Acting Director
New Mexico Medicaid Fraud Control Unit

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy S. Brady, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Michael Henry, Deputy Regional Inspector General.

Matthew DeFraga served as the lead analyst for this study. Other Office of Evaluation and Inspections staff who provided support from the San Francisco regional office include Rosemary Rawlins. Central office staff who provided support include Thomas Brannon, Kevin Farber, Christine Moritz, Andrew VanLandingham, and Sherri Weinstein. Office of Investigations staff who provided support include Timothy DeFrancesca. Office of Audit Services staff who provided support include Matthew Clark and Lisa Lara.

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