

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**HAWAII 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 a review of the Hawaii Unit in October 2014. We analyzed data from seven sources: (1) a review of any documentation related to the Unit's operations, staffing, and caseload; (2) a review of financial documentation for fiscal years (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 files for cases that were open at any point during FYs 2011 through 2013; and (7) an onsite observation of Unit operations.

WHAT WE FOUND

During the FY 2011 through FY 2013 review period, the Unit expended \$3.9 million and generated 18 patient abuse and neglect convictions, 6 fraud convictions, \$330,000 in criminal fraud recoveries, and \$7,000 of civil recoveries from fraud cases investigated directly by the Unit. We found that the Unit had a number of operational deficiencies. Among other findings, only two of the Unit's seven investigators were hired as long-term employees (as required), the Unit did not have an auditor, it did not have written policies and procedures for its operations, and it did not have a required training plan for its professional employees. Furthermore, the Unit did not regularly communicate with Federal law enforcement agencies, it worked cases outside of its grant authority, and it did not exercise adequate fiscal control of its resources.

WHAT WE RECOMMEND

On the basis of our findings, OIG is concerned about the Unit's ability to carry out its statutory functions and meet program requirements. In addition to reimbursing OIG for Federal financial participation claimed for costs related to investigations of ineligible cases, to misplaced equipment, and to unallowable costs for equipment, the Unit should develop and implement a corrective action plan to address the deficiencies described in this report. That plan should address—among other things—modifying the Unit's hiring practices, including hiring an auditor; establishing written policies and procedures for the Unit's operations; establishing a training plan for the Unit's professional employees; establishing regular communication with Federal agencies; establishing procedures ensuring that Unit staff investigate cases solely within the Unit's grant authority; and establishing fiscal control of the Unit's resources. OIG will take appropriate action to ensure that these deficiencies are addressed; this action may include imposing special conditions on and/or restricting the MFCU grant and conducting a follow-up review to monitor implementation of the plan. The Unit concurred with one of the report's recommendations, concurred in part with four recommendations, and did not indicate whether it concurred with the other recommendation. The Unit's comments included a plan to address all six recommendations.

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OBJECTIVE

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

BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect under State law.¹ Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State; and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.² Currently, 49 States and the District of Columbia (States) have created such Units.³ In fiscal year (FY) 2014, combined Federal and State grant expenditures for the Units totaled \$235 million.^{4,5} That year, the 50 Units employed 1,958 individuals.⁶

To carry out its duties 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 (Medicaid agency) and other sources and determines their potential for criminal prosecution and/or civil action. In FY 2014, the 50 Units reported a collective 1,318 convictions

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 March 17, 2015.

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 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on March 17, 2015.

⁶ Ibid.

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

and 874 civil judgments and settlements. That year, the Units reported recoveries of approximately \$2 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 Hawaii 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 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 OIG reviews the application and notifies the Unit as to 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

⁸ OIG, *MFCU Statistical Data for Fiscal Year 2014*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2014-statistical-chart.htm on March 17, 2015. 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 State and Federal agencies.

⁹ SSA § 1903(q)(1).

¹⁰ OIG, *Medicaid Fraud Control Units*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp> on March 17, 2015.

¹¹ In States with a Unit, the Unit shares responsibility for protecting the integrity of the Medicaid program with the section of the Medicaid agency that functions as the program integrity unit. Some States also employ a Medicaid Inspector General who conducts and coordinates efforts to combat fraud, waste, and abuse for the Medicaid 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).

¹⁶ 42 CFR § 1007.15(b) and (c).

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

Hawaii MFCU

Located in Honolulu, the Unit is an autonomous entity within the Hawaii Office of the Attorney General. The Unit has the authority to investigate and prosecute cases of Medicaid fraud and cases of patient abuse and neglect.²⁰ The Unit had 13 total staff at the time of our October 2014 onsite review. 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 investigators. During our FY 2011–13 review period, the Unit expended \$3.9 million (State and Federal share); the Unit's annual average expenditures for this period were \$1.3 million.

The Unit receives referrals of provider fraud primarily from the Hawaii Medicaid agency. The Unit also receives such referrals from private citizens. The Unit receives most of its referrals of patient abuse and neglect from the Adult Protective and Community Services Branch of the Hawaii Department of Human Services, from the Office of Health Care Assurance of the Hawaii State Department of Health, and from private citizens.²¹ For additional information on Unit referrals, see Appendix A.

¹⁷ SSA § 1902(a)(61).

¹⁸ 59 Fed. Reg. 49080 (Sept. 26, 1994). See also footnote 19, below.

¹⁹ In June 2012, OIG published a revision of the original 1994 performance standards (77 Fed. Reg. 32645, June 1, 2012). The performance standards referred to in this report are the revised standards published in 2012, which were in effect during FYs 2012 and 2013. Our onsite data collection took place in October 2014. When referring to the performance standards, we refer to the 2012 standards, unless otherwise noted. Full text of the 2012 standards is available online at <http://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf>. Full text of the 1994 standards is available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/Performance%20Standards.pdf>.

²⁰ For the purposes of this report, the misappropriation or theft of the private funds of patients in residential health care facilities is included in the category of patient abuse and neglect.

²¹ The Office of Health Care Assurance is Hawaii's healthcare facility licensing and certification agency.

Upon receiving a referral of fraud or abuse and neglect, Unit staff enter the referral details as a “matter” into the electronic case tracking system, which assigns a case number to the referral. The Unit director reviews the matter to ensure it is within the Unit’s grant authority and that it warrants further investigation; if not, the Unit closes the matter and possibly refers it to another agency. If the scope is unclear, the director instructs the chief investigator to conduct a preliminary investigation to determine whether the matter is within the Unit’s scope of responsibility. If, after this preliminary investigation, the director determines that the matter warrants a full investigation, the Unit opens the matter as a “case” and the chief investigator assigns an investigator to conduct the full investigation. After the Unit completes the full investigation, a Unit attorney determines whether to prosecute the case or close it.

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

OIG conducted the previous onsite review of the Hawaii Unit in 2009. The final report on that review identified the following concerns: the Unit’s case files were not properly indexed; the Unit’s MOU with the Medicaid agency had expired; and Unit investigators were using private vehicles for investigations, creating a potential safety risk. The report also identified a concern about the fact that the direct supervisor of the Unit’s chief investigator was not the Unit director, but rather the Investigations Division Chief in the Hawaii Attorney General’s Office. In the final report, OIG noted that the Unit had resolved all areas of concern by January 2010 except for investigators’ use of private vehicles for investigations. During the 2014 onsite review, we found no evidence that investigators were still using their private vehicles for investigations.

METHODOLOGY

We based our review on an analysis of data from seven sources: (1) a review of any Unit documentation, policies, and procedures related to the Unit’s operations, staffing, and caseload; (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 files for cases that were open at any point during FYs 2011 through

2013; and (7) 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.²²

²² 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 24 convictions, 26 civil judgments and settlements, and recoveries of \$11.7 million

Of the Unit’s 24 convictions over the 3-year period, 6 convictions—or one quarter—involved cases of Medicaid provider fraud. The other 18 convictions—or three quarters—involved cases of patient abuse and neglect (see Table 1). Furthermore, of the Unit’s 26 civil judgments and settlements over the 3-year period, 1 involved a civil fraud case worked directly by the Unit. The other 25 involved “global” cases, which are civil False Claims Act cases that are brought by the U.S. Department of Justice and involve a group of State MFCUs.²³

Table 1: Hawaii MFCU Convictions and Civil Judgments and Settlements, FYs 2011 through 2013

	FY 2011	FY 2012	FY 2013	3-Year Total	Annual Average*
Total Convictions	3	13	8	24	8.0
Fraud Convictions	1	1	4	6	2.0
Patient Abuse and Neglect Convictions	2	12	4	18	6.0
Total Civil Judgments and Settlements	6	7	13	26	8.7
Global Civil Judgments and Settlements	6	7	12	25	8.3
Nonglobal Civil Judgments and Settlements	0	0	1	1	0.3

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

*The averages in this table are rounded.

From FY 2011 through FY 2013, the Unit reported total criminal and civil recoveries of \$11.7 million—an annual combined average of \$3.9 million (see Table 2). Of the \$11.7 million in total recoveries during this 3-year review period, \$11.4 million were from global civil false claims cases (see Table 2).²⁴ Civil fraud cases worked directly by the Unit accounted for less than 1 percent (\$6,980) of the Unit’s recoveries. The Unit attributed

²³ The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases on behalf of the States.

²⁴ Global cases accounted for 28 of the Unit’s 459 cases over the 3-year period.

\$329,437 to criminal recoveries.²⁵ During our FY 2011–2013 review period, the Unit spent \$3.9 million (State and Federal share); the Unit’s annual average expenditures for this period were \$1.3 million.

Table 2: Funds Reported Recovered by the Hawaii MFCU and Total Expenditures, by Year, FYs 2011 Through 2013*

	FY 2011	FY 2012	FY 2013	3-Year Total	Annual Average
Criminal Recoveries	\$52,468	\$228,952	\$48,017	\$329,437	\$109,812
Global Civil Recoveries	\$2,010,249	\$4,892,143	\$4,482,673	\$11,385,065	\$3,795,022
Nonglobal Civil Recoveries	\$0	\$0	\$6,980	\$6,980	\$2,327
Total Civil Recoveries	\$2,010,249	\$4,892,143	\$4,489,653	\$11,392,045	\$3,797,348
Total Civil and Criminal Recoveries	\$2,062,717	\$5,121,095	\$4,537,670	\$11,721,482	\$3,907,161
Total Expenditures	\$1,323,368	\$1,266,733	\$1,288,535	\$3,878,636	\$1,292,879

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

*Figures in this table are rounded.

From FYs 2011 through 2013, the Unit opened an average of 73 cases annually, with an average of 15 cases of provider fraud and 58 cases of patient abuse and neglect.²⁶ During this time, the Unit closed an average of 106 cases annually, with an average of 31 cases of provider fraud and 76 cases of patient abuse and neglect.²⁷ From FYs 2011 through 2013, the Unit received an average of 1,614 referrals annually, with an average of 36 referrals of provider fraud and 1,578 referrals of patient abuse and neglect.²⁸

²⁵ The figures presented in this paragraph are rounded.

²⁶ The averages in this paragraph are rounded.

²⁷ Closures include multiple cases opened before FY 2011.

²⁸ Unit management told us that the Unit receives a relatively large number of referrals of patient abuse and neglect because the Unit is the primary law enforcement agency that investigates and prosecutes patient abuse and neglect in Hawaii.

Aspects of the Unit's hiring, procedures, and training did not comply with Federal regulations or adhere to OIG performance standards

According to Performance Standard 1, a Unit should comply with all Federal regulations, grant administration requirements, OIG policy transmittals, and the terms and conditions of the MFCU grant. However, we determined that four aspects of the Unit's hiring and training practices did not comply with Federal regulations or adhere to OIG performance standards: (1) the Unit did not hire all investigators as long-term employees, (2) the Unit did not have an auditor, (3) the Unit lacked written policies and procedures specific to its operations, and (4) the Unit lacked a training plan. These practices may have limited the Unit's ability to effectively investigate and prosecute Medicaid provider fraud, as evidenced by its low number of fraud convictions.

Although required by Federal regulations, the Unit did not hire all Unit investigators as long-term employees

According to Federal regulations, FFP is not available for any management function, audit, investigation, or prosecution conducted by anyone other than full-time employees.²⁹ With regard to professional employees, Federal regulations define an "employee" as someone who is hired for full-time, long-term duty intended to last for at least a year.³⁰ One purpose of the requirement to hire employees long-term is to ensure that Unit employees gain adequate training and experience to investigate and prosecute Medicaid fraud in an effective manner.³¹ However, rather than hire all of its investigators as long-term employees, the Unit appointed five of its seven investigators (including the chief investigator) to 89-day renewable positions.³² The 89-day non-civil service appointments are used by the Unit to fulfill relatively short-term operational needs.³³ Because the renewable appointments were not guaranteed, the Unit had to request that the Hawaii Attorney General's Office Division Chief and Administrative Services Manager sign agreements to renew each investigator's appointment at the end of the 89-day term. As a result of the continual renewal of these appointments,

²⁹ 42 CFR § 1007.19(e)(4).

³⁰ 42 CFR § 1007.1.

³¹ *OIG State Fraud Transmittal 89-1, Clarification of the Hiring of Full-Time and Part-Time Employees* (Jan. 13, 1989); 43 Fed. Reg. 320789 (July 24, 1978).

³² *State of Hawaii, Department of Human Resources Development Policies and Procedures*, "Types of Appointments" (Policy 300.001) § V5(B).

³³ *Ibid.*

four of the five investigators under the short-term renewable appointments each performed Unit duties for a cumulative period of at least 1 year.

According to Unit management, the Unit assigned cases of patient abuse and neglect primarily to the five nonpermanent investigators because these investigators had training and experience conducive to investigating this type of case. Unit management reported that the Unit assigned provider fraud cases primarily to the two permanent investigators, which resulted in a relatively high workload for these individuals. According to Unit management, hiring investigators on a permanent basis is difficult because of union rules, because the Unit's pay scale for investigators is not competitive, and because there is not a sufficient pool of qualified applicants from which to choose.

Although required by Federal regulations, the Unit did not have an auditor

According to Federal regulations, a Unit's staff must include at least one experienced auditor.³⁴ Unit auditors provide services such as conducting financial record reviews and assisting fraud investigations and prosecutions. As of our onsite review in October 2014, the Unit had not employed an auditor for approximately 10 months, despite having approval to hire two auditors under its MFCU grant. According to Unit management, hiring auditors is difficult because of union rules and because the Unit's pay scale for auditors is not competitive.

The Unit lacked written policies and procedures specific to its operations

According to Performance Standard 3, a Unit should have written policies and procedures for its operations and should ensure that staff are familiar with, and adhere to, these policies and procedures. Written policies and procedures help to ensure that a Unit conducts its operations, case file reviews, and training consistently. Unit policies and procedures should address the investigation and prosecution of Medicaid fraud and patient abuse and neglect, should include a process for referring cases to Federal and State agencies, and should include a training plan for the Unit's professional employees.³⁵ However, the Unit did not have written policies and procedures during our review period. According to Unit management, the Unit relies on the Criminal Justice Division's policies and procedures; therefore, it does not have written policies and procedures specific to Unit

³⁴ 42 CFR § 1007.13(a)(2).

³⁵ Performance Standard 3(e) states that training standards should be included in the Unit's written policies and procedures manual.

operations. During our onsite review, Unit management reported that it was developing policies and procedures specific to Unit operations.

The Unit lacked a training plan

According to Performance Standard 12(a), a Unit should have a training plan that includes an annual number of required training hours for each professional discipline. However, the Unit did not have a training plan during our review period. Unit management reported that all Unit staff undergo some level of training, but that staff are not required to complete any specific training other than what is necessary to maintain professional credentials.³⁶ During our onsite visit, Unit management reported that the Unit was developing a written training plan.

The Unit's MOU with the Medicaid agency did not reflect current law and practice

According to Performance Standard 10, a Unit should periodically review its MOU with the Medicaid agency to ensure that the MOU reflects current law and practice. Although the Unit and the Medicaid agency had an MOU, the MOU did not include procedures regarding how the Unit and the Medicaid agency should handle providers that are subject to a payment suspension on the basis of a credible allegation of fraud (implemented by regulation in March 2011, as required by the Affordable Care Act). During our onsite review, Unit management provided us with a draft of a revised MOU that was intended to incorporate such procedures.

The Unit lacked adequate safeguards to secure case files and the personally identifiable information (PII) associated with those case files

According to Federal regulations, a Unit must “safeguard the privacy rights of all individuals and will provide safeguards to prevent the misuse of information” under the Unit’s control.³⁷ This includes securing case files containing potentially sensitive PII about witnesses, victims, suspects, and informants. However, the Unit could not locate 5 of the 100 case files (from FYs 2011–13) that we requested for our sample and had no explanation about what happened to these files. In addition, Unit case files containing PII were not secured from access by non-Unit individuals. Although Unit staff use a coded access system to enter the general office space, the Unit also grants non-Unit individuals access to

³⁶ Performance Standard 12(b) states that the Unit should maintain records of staff compliance with the Unit’s training plan.

³⁷ 42 CFR § 1007.11(f); *OIG State Fraud Transmittal 99-02, Public Disclosure Requests and Safeguarding of Privacy Rights* (December 22, 1999).

the office for various reasons (e.g., case interviews, cleaning, and information technology services). As a result, non-Unit individuals have access to open areas—such as a hallways—where case files are stored, and these case files clearly display the related case file numbers and names of suspects.

Seventy-one percent of Unit case files lacked documentation of periodic supervisory reviews

According to Performance Standard 7(a), supervisors should review Unit cases periodically and note their reviews in the case files.³⁸ According to Unit management, the Unit has no established policy regarding the frequency of supervisory reviews. However, when a supervisory review occurs, Unit managers expect investigators to note this review in the Unit’s electronic case file tracking system.³⁹ Among Unit cases that were open for at least 6 months, 71 percent of the case files lacked documentation of any periodic supervisory reviews.⁴⁰ Unit management reported that a policy for supervisory review of case files will be included in the policies and procedures manual that is under development.

Some Unit case files had unexplained delays of a year or more during the investigation and/or prosecution phases of cases

According to Performance Standard 5, the MFCU should “complete cases in an appropriate timeframe based on the complexity of the cases.” In addition, Performance Standard 5(c) states that investigation and prosecution delays should be “limited to situations imposed by resource constraints or other exigencies.” However, during our case file review and interviews with Unit staff, we determined that 22 percent of the Unit’s cases had unexplained investigation delays of a year or more.⁴¹ In addition, 4 percent of the Unit’s cases were not fully investigated before the statute of limitations expired. None of the files for these cases

³⁸ 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.

³⁹ For the purposes of our case file review, we considered documentation in the Unit’s electronic case file tracking system to be sufficient documentation of periodic supervisory reviews.

⁴⁰ We reviewed the files of 44 cases that were open for at least 6 months for evidence of supervisory reviews.

⁴¹ According to Performance Standard 7(b), case files should include “all relevant facts and information.” For the purposes of this report, we defined a “delay” as a period of at least a year with no documented activity in the case file.

contained documentation to account for the delays, nor could Unit staff explain these delays.

Additionally, of the 11 reviewed cases that had progressed to the prosecution/litigation phase, 6 had unexplained delays of a year or more during that phase of the case. Five of these six cases were criminal and the other was a civil matter. None of these case files contained documentation to explain the delays, nor could Unit staff explain these delays.

The Unit did not notify the Medicaid agency of referral acceptance or declination

According to Federal regulations, when a Unit receives a referral from the Medicaid agency, the Unit must notify the Medicaid agency as to whether it accepts or declines the referral.⁴² In addition, the Unit's MOU with the Medicaid agency states that the Unit will notify the Medicaid agency if the Unit determines that a referral does not warrant criminal prosecution.⁴³ However, Unit management and Medicaid agency staff reported that the Unit does not notify the Medicaid agency of referral decisions. In addition, there was no documentation of such notification in any of the 25 case files we reviewed that were based on referrals from the Medicaid agency. The failure to notify the Medicaid agency of the Unit's decision to accept or decline the referral could limit the Medicaid agency's ability to refer the case to another law enforcement agency, discontinue or not impose a payment suspension in a timely manner, or take administrative action.⁴⁴

The Unit did not regularly communicate with Federal agencies regarding healthcare fraud

According to Performance Standard 8(a), a Unit should communicate with OIG and other Federal agencies on a regular basis about Medicaid fraud in its State. However, Unit management reported that the Unit has no regular contact with OIG's Office of Investigations or any other Federal agencies.

⁴² 42 CFR § 1007.9(g).

⁴³ *Memorandum of Understanding between the Hawaii MFCU and the Medicaid Agency*, Section III(2).

⁴⁴ The Patient Protection and Affordable Care Act, P.L. No. 111-148 § 6402(h)(2) (March 23, 2010), as amended by the Health Care Reconciliation Act of 2010, P.L. No. 111-152 (March 30, 2010), 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 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).

Furthermore, stakeholders at the U.S. Attorney’s Office (USAO) in Hawaii reported that the Unit has not regularly communicated with them in several years, despite efforts by USAO staff to reach out to the Unit. The lack of regular communication with Federal agencies may have limited the Unit’s fraud referrals and, consequently, its convictions.

The Unit did not always report adverse actions to the National Practitioner Data Bank (NPDB) within an appropriate timeframe

According to Federal regulations, all State and Federal government agencies must report adverse actions resulting from investigations or prosecutions of healthcare providers to the NPDB.⁴⁵ The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions.⁴⁶ Examples of adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions.⁴⁷ Adverse actions must be reported to the NPDB “within 30 days following the action.”⁴⁸ Although the Unit reported 22 adverse actions to the NPDB during the review period, the Unit reported 15 (68 percent) of these more than 91 days after the final adverse action was taken. The Unit reported

⁴⁵ SSA § 1128E(g)(1) and 45 CFR § 61.3 (2012). In addition to the Federal Regulations, Performance Standard 9(8)(G) states that Units should report “qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.” We reviewed the reporting of adverse actions under HIPDB 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.

⁴⁶ SSA § 1128E(a) and 45 CFR § 61.1 (2012). During most of our review period, the data bank containing conviction information and other adverse actions was designated as the Healthcare Integrity and Protection Databank (HIPDB). In May 2013, the HIPDB was merged with a separate NPDB to create a single data bank that is designated as the NPDB. 78 Fed. Reg. 20473 (April 5, 2013).

⁴⁷ An “adverse action” is any action that involves “reducing, restricting, suspending, revoking, or denying clinical privileges or membership in a health care entity.” 45 CFR § 60.3. For a more detailed list of types of adverse actions, see SSA § 1128E(g)(1)(A) and 45 CFR § 60.5.

⁴⁸ 45 CFR § 60.5. Under the HIPDB reporting requirements, adverse actions must be reported “within 30 calendar days from the date the 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). The date that constitutes when an adverse action occurred may vary depending on the type of adverse action. For criminal matters related to the provision of healthcare, the 30-day obligation to report starts at the time of judgement (i.e., conviction). 45 CFR § 60.5.

one within 61–90 days after the final adverse action and three within 31–60 days after the final adverse action.⁴⁹

The Unit investigated three cases that were outside of its grant authority

According to Federal regulations, the scope of a Unit’s grant authority is the investigation of fraud allegations relating to Medicaid providers and patient abuse and neglect allegations in Medicaid-funded and board-and-care facilities.⁵⁰ A Unit may only receive FFP for activities relating to the investigation and prosecution of these allegations.⁵¹ However, our review of documentation and interviews with Unit staff determined that three Unit investigations did not involve either Medicaid provider fraud or patient abuse and neglect in a Medicaid-funded facility.⁵² Two of these investigations involved allegations of potential abuse of Medicaid recipients. However, neither of these incidents occurred in a Medicaid-funded or board-and-care facility,⁵³ and a third investigation involved an alleged crime unrelated to health care fraud or abuse that was initially thought to be committed by a Medicare recipient.^{54,55} Costs associated with these investigations are not eligible for FFP under the MFCU grant terms and conditions.

The Unit did not maintain adequate internal controls related to staffing and equipment

According to Performance Standard 11, a Unit should exercise proper fiscal control of its resources. “Control” includes maintaining staff activity records, maintaining an accurate equipment inventory, and ensuring that equipment purchased by and for the Unit is used only by Unit staff. From FY 2011 through FY 2013, the Unit did not maintain complete staff records, nor did its equipment inventory accurately reflect what equipment was under the Unit’s control. In addition, the Unit

⁴⁹ HHS provided this data to OIG on July 24, 2014.

⁵⁰ 42 CFR §§ 1007.11(a) and (b)(1); SSA § 1903(q).

⁵¹ 42 CFR § 1007.19(d).

⁵² Three investigations in the sample of case files that we reviewed were outside of the Unit’s grant authority.

⁵³ One incident allegedly occurred on a bus; the other allegedly occurred in a private home.

⁵⁴ The alleged crime was “impersonating a police officer.”

⁵⁵ Unit staff reported that the subjects in these three cases were either Medicaid recipients or potential Medicaid recipients, and that staff believed that the Unit was authorized to investigate abuse and neglect of Medicaid recipients, regardless of where the abuse or neglect allegedly occurred. Unit staff were unable to provide any further documentation to indicate a nexus for investigation by the Unit.

allowed a computer purchased by the MFCU to be routinely used by, and kept in the office of, a non-Unit employee.

The Unit did not maintain complete staff records that documented whether Unit staff worked solely on MFCU-related matters

According to Federal guidelines, charges for salaries and wages of MFCU employees must be supported by periodic certifications that these employees worked solely on MFCU-related matters.⁵⁶ However, the Unit did not maintain annual certifications or timesheets that indicated whether permanent employees worked solely on MFCU-related matters. The Unit also did not maintain certifications that identified the work performed by its nonpermanent investigators. As a result, we could not determine whether Unit employees worked solely on MFCU-related matters.

At the time of our onsite review, the Unit's inventory did not accurately reflect what equipment was under its control

According to Performance Standard 11(b), a Unit should maintain an equipment inventory that “is updated regularly to reflect all property under the Unit’s control.” The Unit did maintain an equipment inventory. However, during our onsite review, the Unit was unable to locate three items listed as part of its inventory. Neither we nor the Unit could determine whether this equipment had been lost, damaged, stolen, and/or used for non-MFCU-related matters. After our onsite review, the Unit located one of the missing items. The Unit also provided documentation to OIG indicating that after our onsite review it updated its inventory to reflect that another of the missing items had been disposed of by the Unit in March 2015. As of the date of this report, one inventory item remained missing. That item had an original purchase cost of \$1,495 (\$1,121 Federal share).

The Unit allowed non-MFCU staff to house and use Unit equipment

According to Federal guidelines, equipment purchased by a Unit must be allocable to the Federal grant.⁵⁷ However, our review determined that the Unit purchased a computer which a non-MFCU employee of the Criminal Justice Division of the Attorney General’s Office housed and used on a

⁵⁶ 2 CFR pt. 225, Appendix B (8)(h)(3) states that “These certifications will be prepared at least semi-annually and signed by the employee or supervisory official having first-hand knowledge of the work performed by the employee.”

⁵⁷ 2 CFR pt. 225, Appendix A, (H)(C)(3)(a) establishes the basic guideline that allowable State agency expenditures must be “allocable,” meaning that they must be charged and assigned to the cost objective “in accordance with the relative benefits received.”

regular basis. Equipment used by a non-MFCU employee is not allocable to the Federal MFCU grant. Therefore, the \$1,347 expenditure (\$1,010 Federal share) claimed by the Unit for this purchase is unallowable. After our onsite review, the Unit reported that the Attorney General's office returned the computer.

The Unit did not report its costs or income correctly

According to Federal regulations, indirect cost rates for MFCUs are reviewed, negotiated, and approved by the appropriate Federal agency.⁵⁸ These indirect cost rates are then included in an agreement between the appropriate Federal agency (generally HHS or another Federal agency, such as the U.S. Department of Justice) and the grantee agency, such as the State Attorney General's Office. From FY 2011 through FY 2013, the Unit overclaimed its indirect costs by a net total of \$14,418 (Federal share).⁵⁹ The Unit overclaimed its indirect costs during this period because it did not use the appropriate approved rates.

According to instructions on the Federal SF-425 form, Units should report on the form 75 percent of their program income earned.⁶⁰ Program income, defined as gross income received by a Unit as the result of a grant activity,⁶¹ should be deducted from a Unit's total allowable costs to determine the net allowable costs.⁶² However, during FYs 2011–2013, the Unit did not report a total of \$2,685 that it received from service fees.⁶³ As a result, the Unit overstated its net allowable costs during the review period by \$2,685 (\$2,014 Federal share).

⁵⁸ 2 CFR pt. 225, Appendix E (1). HHS is the cognizant agency for the Hawaii MFCU's indirect cost rate.

⁵⁹ The Unit overclaimed the Federal share of indirect costs by \$26,642 in FY 2011. The Unit underclaimed the Federal share of indirect costs by \$1,400 in FY 2012 and by \$10,824 in FY 2013. Therefore, the net total over-claim for the 3-year period was \$14,418 (Federal share).

⁶⁰ Unit expenditures, program income, and indirect costs are reported on the SF-425 form; the percentage represents the FFP rate. OIG has provided guidance to MFCUs about what constitutes "program income." *OIG State Fraud Transmittal 10-01, Program Income* (March 22, 2010)

⁶¹ 45 CFR § 92.25(b).

⁶² 45 CFR § 92.25(g)(1).

⁶³ An example of service fees is the fees that the Unit levied against defendants for use of the Unit's copy machine.

CONCLUSION AND RECOMMENDATIONS

As the primary agency to investigate and prosecute Medicaid provider fraud, the Unit expended \$3.9 million during the period of our review. Over the 3-year period, the Unit generated 18 convictions of patient abuse and neglect, 6 convictions of fraud, \$330,000 in criminal fraud recoveries, and \$7,000 in civil recoveries from fraud cases investigated directly by the Unit. Our findings demonstrate that the Unit had a number of operational deficiencies. We found—among other things—that only two of the Unit’s seven investigators were hired as long-term employees, that the Unit did not have an auditor, that it did not have policies and procedures for its operations, that it did not have a required training plan for its professional employees, and that it did not regularly communicate with Federal law enforcement agencies about health care fraud.

On the basis of our findings, OIG is concerned about the Unit’s ability to carry out its statutory functions and meet program requirements. In addition to reimbursing OIG for FFP claimed for costs related to investigating ineligible cases, misplacing equipment, and unallowable equipment costs, the Unit should develop and implement a corrective action plan to address the breadth of deficiencies described in this report and to improve its effectiveness. OIG will take appropriate action to ensure that these deficiencies are addressed, which may include imposing special conditions on and/or restricting the MFCU grant and conducting a follow-up review to monitor implementation of the corrective action plan. We recommend that the corrective action plan address, at a minimum, how the Unit will accomplish the following:

Develop and implement effective hiring and training practices that conform to current laws, regulations, and performance standards

Specifically, the Unit should hire all investigators on a long-term basis; hire an auditor or auditors, as appropriate; develop and implement written policies and procedures specific to its operations; and develop and implement a written training plan for its professional employees. Because FFP is not available for activities conducted by anyone other than full-time professional employees, the Unit should immediately discontinue its practice of appointing investigators to temporary positions and should work with OIG to determine an amount that the Unit should reimburse OIG for costs associated with activities conducted by such staff.

Revise its MOU with the Medicaid agency to reflect current law and practice

The Unit should revise its MOU with the Medicaid agency to include a provision describing the referral process between the Unit and the Medicaid agency for providers that are subject to a payment suspension on the basis of a credible allegation of fraud. The Unit should also develop and implement a procedure to ensure that—per Federal regulations—it notifies the Medicaid agency of all referral decisions, and the Unit should include this procedure in the revised MOU.

Develop and implement policies and procedures that conform to current laws, regulations, and performance standards

At a minimum, these policies and procedures should address the following: notifying the Medicaid agency of the acceptance or declination of all referrals from the Medicaid agency; safeguarding sensitive information; reviewing cases periodically to ensure their timely progress and avoidance of delays, and documenting these reviews in the case files; and ensuring the timely reporting of adverse actions to the NPDB.

Establish regular communication with Federal agencies

The Unit should establish regular communication with OIG's Office of Investigations and other Federal agencies, such as the U.S. Attorney's Office. This communication could address current cases and trends in health care fraud in Hawaii, which could result in mutual referrals and joint investigations.

Develop and implement procedures to ensure Unit staff investigate cases within the grant authority

The Unit should develop and implement procedures to ensure that Unit staff investigate cases solely within the Unit's grant authority. The Unit should also work with OIG to identify the staff hours and expenditures associated with investigating the three ineligible cases and, as appropriate, repay those Federal matching funds.

Establish fiscal controls

The Unit should establish fiscal controls to ensure that (1) it maintains documentation certifying that staff activities are attributable to the grant, (2) it maintains an accurate inventory of equipment under its control, (3) all Unit equipment is housed in the Unit and used solely by Unit staff, and (4) it reports indirect costs and program income correctly. The Unit should work with OIG to reimburse the Federal share of costs for misplaced equipment and unallowable equipment costs, as appropriate. The Unit should also work with OIG to reimburse OIG for indirect costs that were claimed incorrectly during the review period.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments to the draft report, the Unit concurred with one of the report's recommendations, concurred in part with four recommendations, and did not indicate whether it concurred with the other recommendation. The Unit's comments included a plan to address all six OIG recommendations.

The Unit concurred in part with the recommendation to develop and implement effective hiring and training practices that conform to current laws, regulations, and performance standards. The Unit stated that it is exploring immediate and long-term solutions to correct its hiring issues. The Unit reported that it will work with OIG to reimburse any costs associated with hiring investigators for 89-day appointments. The Unit also reported plans to hire an auditor by September 2015, and reported that it has adopted and implemented Unit-specific policies and procedures for its operations and that these policies and procedures include a training plan for all professional staff. The Unit stated that it continually renewed 89-day short-term appointment contracts to fill investigator positions, and therefore consistently employed investigators for more than a year. However, the State of Hawaii Human Resources Manual states that 89-day non-civil service appointments should be used to fulfill relatively short-term needs not exceeding 89 calendar days. OIG reiterates that applicable Federal regulations define a Unit employee as someone who is hired for long-term duty intended to last for at least a year, and that *OIG State Fraud Transmittal 89-1* states that hiring temporary staff does not meet the Congressional intent of developing a MFCU team with specialized expertise.

The Unit concurred with the recommendation to revise its MOU with the Medicaid agency to reflect current law and practice and indicated that a revised MOU was signed and implemented in July 2015.

Although the Unit did not indicate whether it concurred with the recommendation to develop and implement policies and procedures that conform to current laws, regulations, and performance standards, the Unit concurred with the related finding and indicated its plans to address this recommendation. The Unit reported that it has officially adopted and implemented Unit-specific policies and procedures, that it will memorialize all periodic supervisory reviews in its electronic case tracking system, and that it will use the electronic case tracking system to monitor case progress and document explanations for investigation and/or prosecution delays. Additionally, the Unit stated its belief that OIG did not give due attention to the Unit's electronic case tracking system in

conducting our review. OIG disagrees, because we included all relevant information from the Unit's case tracking system in our review and analysis of Unit cases. However, because the Unit's utilization of its case tracking system started near the end of the review period, information from the system had only limited impact on the finding overall.

The Unit concurred in part with the recommendation to establish regular communications with Federal agencies. The Unit stated that it had regular communications with Federal agencies, but acknowledged that these communications weren't documented. The Unit indicated that it will document all communications with Federal partners going forward and will host quarterly meetings with Federal partners to discuss fraud trends and specific fraud cases.

The Unit concurred in part with the recommendation to develop and implement procedures to ensure Unit staff investigate cases within the Unit's grant authority. The Unit reported that it has included in its new written policies and procedures a checklist to guide Unit staff on determining whether a potential case is within the Unit's grant authority. The Unit also indicated that it will work with OIG to determine the amount the Unit will reimburse OIG for work performed on cases outside of the Unit's grant authority. Finally, the Unit indicated that it has created a form that will certify that Unit staff work solely on Unit-related matters. In its comments, the Unit also stated its beliefs that it had sufficient policies and procedures in place to determine if cases were within the Unit's grant authority and that it had the authority to act on the three cases in question. However, as described in the report, the Unit did not have such authority because none of the three patient abuse and neglect allegations occurred in Medicaid-funded or board-and-care facilities.

The Unit concurred in part with the recommendation to establish fiscal controls. The Unit indicated that it will work with OIG to determine the amount the Unit should reimburse OIG for missing equipment and for incorrectly reported program income and indirect costs. The Unit reported that two items missing during the onsite review have been located, and that Unit equipment is no longer used by non-Unit staff. Although the Unit stated its intent to continue classifying copying costs as reimbursement, it stated that it will include these costs as program income in its reports to OIG. OIG reiterates that these costs are defined as program income, pursuant to Federal regulations, and should be recorded as such in Unit financial records.

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 Hawaii 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	1,630	1,450	1,653	4,733	1,578
Provider Fraud	33	37	39	109	36
Total	1,663	1,487	1,692	4,842	1,614

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		
Adult Protective Services	0	1,601	0	1,418	0	1,637	4,656	96.2%
State Medicaid Agency	25	1	30	2	33	6	97	2.0%
State Certification and Licensing Agency	0	26	0	25	1	9	61	1.3%
Private Citizens	1	1	3	3	3	0	11	0.2%
Other	5	0	2	0	1	0	8	0.2%
MFCU Hotline	1	1	1	0	1	0	4	0.1%
Other State Agencies	1	0	0	1	0	0	2	<0.1%
Law Enforcement	0	0	0	0	0	1	1	<0.1%
Licensing Board	0	0	1	0	0	0	1	<0.1%
Provider Associations	0	0	0	1	0	0	1	<0.1%
Total	33	1,630	37	1,450	39	1,653	4,842	100%
Annual Total	1,663		1,487		1,692			
Annual Average*							1,614	

Source: MFCU response to OIG data request.

*These figures are rounded.

APPENDIX B

Investigations Opened and Closed by the Hawaii 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	88	46	86	220	73
Patient Abuse and Neglect	65	37	73	175	58
Provider Fraud	23	9	13	45	15
Closed	86	149	84	319	106
Patient Abuse and Neglect	55	106	66	227	76
Provider Fraud	31	43	18	92	31

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	10	4	2	10	11	6
Non-Direct Care	0	2	0	0	0	0
Nursing Facilities	4	3	5	10	5	4
Other Long-Term Care Facilities	28	24	22	44	42	46
Physician's Assistants/Nurses/Nurse Practitioner/Certified Nurse Aides	9	5	0	23	5	4
Other	14	17	8	19	10	6
Total	65	55	37	106	73	66

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	0	1	0	2	0	0
Other Facilities	1	0	2	2	0	1
Subtotal	1	1	2	4	0	1
Practitioners						
Counselors/ Psychologists	1	2	2	1	0	1
Dentists	2	2	0	2	0	0
Doctors of Medicine or Osteopathy	10	10	1	16	2	4
Other Practitioners	2	3	0	2	1	1
Subtotal	15	17	3	21	3	6
Medical Support						
Durable Medical Equipment Suppliers	0	0	0	1	0	1
Home Health Care Agencies	0	0	0	1	0	0
Laboratories	0	1	1	0	0	0
Pharmacies	1	3	0	1	2	1
Transportation Services	0	0	0	6	0	0
Other Medical Support	6	9	3	9	8	9
Subtotal	7	13	4	18	10	11
Total	23	31	9	43	13	18

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.⁶⁴ In addition, we looked for any practices that appeared to benefit the MFCU.

Data Collection and Analysis

Review of MFCU Documentation. We collected and reviewed (1) MFCU documentation 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. We also checked documentation to ensure that the MFCU referred sentenced individuals to OIG for program exclusion and that the MFCU reported adverse actions to the NPDB. Additionally, we confirmed with the MFCU director that the documentation we had was current at the time of our review, and we requested any additional data or clarification, as needed. The data we collected from the MFCU were current as of April 20, 2015. 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 staffing. We obtained the MFCU's claimed grant expenditures for FYs 2011 through 2013 to (1) review final Federal Status Reports⁶⁵ 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

⁶⁴ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>.

⁶⁵ The MFCU transmits Federal Status Reports to OIG's Office of Management and Policy on a quarterly and annual basis. These financial reports detail MFCU income and expenditures.

Management System (PMS)⁶⁶ and revenue accounts to identify any unreported program income.⁶⁷

Structured Interviews With Key Stakeholders. We conducted structured interviews with 10 individual stakeholders among 6 agencies who were familiar with MFCU operations. Specifically, we interviewed two staff from the Medicaid agency's Financial Integrity Division; two Assistant U.S. Attorneys; an investigator for the U.S. Attorney's Office; the Criminal Justice Division supervisor for the Hawaii Attorney General's Office;⁶⁸ the OIG Assistant Special Agent in Charge for the State of Hawaii; a Hawaii Adult Protective Services supervisor; and two managers from the Recovery Audit Contractor. 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 could be useful to other MFCUs in their operations.

Survey of MFCU Staff. We conducted an online survey of MFCU staff.⁶⁹ We requested and received responses from 11 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 data specialist. We asked them to provide us with additional information so that we could 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.

Onsite Review of Case Files. We selected a simple random sample of 100 case files from the 431 cases that were open at any point from

⁶⁶ 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.

⁶⁷ 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).

⁶⁸ The Criminal Justice Division supervisor supervises the MFCU director.

⁶⁹ We did not survey the MFCU director or chief investigator.

FY 2011 through FY 2013.⁷⁰ The design of this sample allowed us to estimate the percentage of all 431 cases with various characteristics at the 95-percent confidence level. We reviewed 91 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 (such as investigation delays) from a qualitative perspective.⁷¹ 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; the security of data and case files; and the general functioning of the MFCU.

⁷⁰ This figure includes cases opened before FY 2011 that remained open at some point during FYs 2011–2013. This figure does not include multi-State (“global”) civil False Claims Act cases, which consist of cases worked by staff from the Federal Government or other MFCUs. The MFCU identified 24 global cases on the list of case files submitted to OIG. For the purposes of our review of case files, these 24 global cases were not included as part of the MFCU's population of case files. In addition, four cases in our simple random sample were global cases that were mistakenly identified by the MFCU as nonglobal cases. In addition, the Unit could not locate five case files on our sample list. We did not review these case files; therefore, although we selected 100 case files for our initial random sample, the total number of case files we actually reviewed was 91. Including the 28 global cases, the total number of MFCU cases open during the review period was 459.

⁷¹ Although we selected 50 case files for a more comprehensive review, 1 of these case files was for a global case that was mistakenly identified as a nonglobal case. In addition, the Unit could not locate three of the case files that we selected for a more comprehensive review. Therefore, the total number of case files receiving a more comprehensive review was 46.

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 of the Unit's case files, 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 3 population values for all 431 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 six estimates.

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

Case Type	Population Count and (%) n=431	Sample Count* and (%) n=91	Sample Count* and (%) n=46
Closed	404 (94%)	86 (94%)	42 (91%)
Open	27 (6%)	5 (6%)	4 (9%)
Civil (Nonglobal)	21 (5%)	2 (2%)	1 (2%)
Criminal	410 (95%)	89 (98%)	45 (98%)
Patient Abuse/Neglect	282 (65%)	58 (64%)	28 (61%)
Provider Fraud (Nonglobal)	149 (35%)	33 (36%)	18 (39%)

Source: The Hawaii 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
Cases Files With No Documentation of Periodic Supervisory Reviews	44	70.5%	55.7–82.7%*
Case Files With No Documentation Explaining Investigation Delays	91	22.0%	14.6–30.9%
Cases Closed Because the Statute of Limitations Had Expired	91	4.4%	1.4–10.2%

*Because only 44 case files met the criteria for our review of periodic supervisory reviews, our 95-percent confidence interval is relatively wide for this estimate.

APPENDIX E
Unit Comments

DAVID Y. IGE
GOVERNOR



DOUGLAS S. CHIN
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FIRST DEPUTY ATTORNEY GENERAL

August 26, 2015

Ms. Suzanne Murrin
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Department of Health & Human Services
Cohen Building, Room 5660
Office of Inspector General
Washington, DC 20201

Dear Ms. Murrin:

Thank you for your Onsite Review (OEI-09-14-00540). The Hawai'i Department of the Attorney General acknowledges and appreciates your oversight role.

We have included in this packet the summary recommendation from the Onsite Review team and our plan to implement your recommendations. We believe that, once fully implemented, our actions will satisfy your objectives. Please do not hesitate to contact me if you have any questions or need additional information.

Very truly yours,


for Douglas S. Chin
Attorney General

DAVID Y. IGE
GOVERNOR



DOUGLAS S. CHIN
ATTORNEY GENERAL

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RE: Hawaii State Medicaid Fraud Control Unit: 2014 Onsite Review,
OEI-09-14-00540

Dear Ms. Murrin:

Thank you for your above referenced report. What follows are Hawaii Medicaid Fraud Control Unit's (hereinafter "HMFCU") comments as requested.

Recommendation 1: Develop and implement effective hiring and training practices that conform to current laws, regulations, and performance standards.

Recommendation: Hire all investigators on a long-term basis.

HMFCU concurs in part with HHS-OIG's (hereinafter "HHS-OIG") recommendation. HMFCU respectfully requests that HHS-OIG reconsider its finding and, in any event, permit HMFCU to continue to employ its emergency hire Special Agents until such time as any deficiency can be addressed and overcome.

HMFCU understands that HHS-OIG has taken its position despite documentation that HMFCU believes demonstrates that it employed the Special Agents for more than one year. In fact, HMFCU has consistently employed all of its emergency hire Special Agents for more than a year because of a shortage of available candidates that met the requirements to fill the positions. The

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Supervising Special Agent has been employed for more than five (5) years, and the others have been employed more than four (4) years, more than two (2) years, and more than a year and a half. The only Special Agent with less than one year of service started her employment in February 2015 and HMFCU intends to keep her until such time that her position can be filled permanently by a qualified candidate.

Nevertheless, HMFCU will make every effort to assuage HHS-OIG concerns that HMFCU is not in compliance with performance standard 1. It is important to note that HMFCU is not in a position to develop and implement its own hiring practices. HMFCU adheres to the laws, rules, regulations, policies, and procedures promulgated by the State of Hawai'i and executed by the State of Hawai'i Department of Human Resources Development (hereinafter "SOHDHRD"). HMFCU acknowledges that its adherence to SOHDHRD policies occasionally conflicts with HHS-OIG performance standard 1. HMFCU also adheres to restrictions imposed on it by the contract with the Hawai'i Government Employees Association (hereinafter "HGEA"), which also occasionally conflicts with HHS-OIG performance standard 1.

As HHS-OIG was informed, there were no qualified eligible candidates for Special Agents with law enforcement certifications during and through the review period. HMFCU has contacted SHDHRD and asked whether there is presently a list of eligibles. There is none, so SOHDHRD has again opened recruitment for the HMFCU class of Special Agents. HMFCU will update HHS-OIG as the situation develops. Meanwhile, HMFCU plans to make every effort to reconcile its hiring practices with HHS-OIG's recommendations. In deference to HHS-OIG HMFCU has initiated an effort to have the emergency hire Special Agents retained as exempt employees through a grant research program at the University of Hawai'i for a term of employment that exceeds one (1) year, which will put HMFCU in compliance with HHS-OIG performance standard 1. Additionally, HMFCU intends to submit legislation to permanently exempt its Special Agents from civil service which will enable HMFCU to continue to fill its positions with well qualified, competent investigators. In any event, MFCU will not know the outcome of its legislative proposal until the end of the legislative session in June of 2016.

HMFCU does not agree that its ability to effectively investigate and prosecute Medicaid provider fraud is in any way compromised by its current hiring and employment practices. HHS-OIG's Draft Report is devoid of any causal link between this practice and its impact on HMFCU operations. Furthermore, the retention of Special Agents under the present construct enables HFMCU to retain Special Agents who possess remarkable skills and abundant experience. As a group the emergency hire Special Agents have more than 120 years of law enforcement experience. The skills and experience that they bring

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to the unit render them invaluable. In contrast, eligible applicants ordinarily in the pool of eligible candidates have little criminal investigative experience, much less experience with complex fraud cases, and none has had law enforcement experience. As such, terminating skilled and experienced law enforcement agents in favor of unskilled and inexperienced applicants may satisfy HHS-OIG performance standard 1, but would undoubtedly restrict HMFCU's ability to effectively investigate and prosecute cases. If HHS-OIG does not permit HMFCU to operate under its current construct, and instead directs HMFCU to terminate its emergency hire Special Agents, its operations will be immediately and irreparably harmed.

HMFCU did not employ emergency hire Special Agents with intent to exceed its grant authority. This hiring practice was borne of necessity, and was and is intended to ensure that HMFCU can fulfill its mission to investigate and prosecute provider fraud and patient abuse. HMFCU will work with OIG-HHS resolve this issue and, if necessary, to reimburse the federal government for its share of costs.

Recommendation: Hire an auditor or auditors.

HMFCU concurs in part with HHS-OIG's finding. First, during the entire review period (2011-2013) HMFCU employed an auditor, so it was in compliance with 42 CFR §1007.13(a)(2). This individual retired 12/31/13, and as such HHS-OIG treated the vacant auditor position as a condition noted outside of the review period. As HHS-OIG was and is informed, SOHDRD and the HGEA restrict candidates to those who fit a particular profile. As expressed during the onsite review, the scale of the position does not pay commensurate with the minimum qualifications and duties of the position. Nevertheless, HMFCU secured a recruitment list of eligibles from SOHDRD. There were merely two candidates on the continuous recruitment list for auditors statewide. HMFCU interviewed both and made an offer to one who appears to meet the minimum qualifications. The vacant position should be filled on September 1, 2015.

Recommendation: Develop and implement written polices and procedures specific to operations.

HMFCU concurs with HHS-OIG's finding. Although HMFCU did not have written polices specific to the HMFCU, it did follow Departmental and Divisional polices. At the time of the Onsite review, HMFCU had draft polices and procedures. The draft polices and procedures have been officially adopted and implemented. The policies and procedures are specific to HMFCU's operations.

Although HMFCU had, and has, training practices and records of the training that are consistent with HHS-OIG performance standards, HMFCU did

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not have a written training plan. HMFCU has since memorialized the training plan in writing and included it in HMFCU's policies and procedures manual. Lastly, HMFCU provided HHS-OIG with its training records during the review period and after, and notes that HHS-OIG found no deficiencies. HMFCU offered to provide the Policies and Procedures to HHS-OIG with this response, but was informed that the policies and procedures should be presented at a different time.

Recommendation 2: Revise its MOU with the Medicaid agency to reflect current law and practice.

HMFCU concurs with HHS-OIG's recommendation, but concurs only in part with its finding. HMFCU's MOU satisfied performance standard 10 for the substantial majority of the review period. HMFCU had a working draft MOU more than six (6) months prior to the onsite review, which it exchanged with the single state agency. Ultimately, a revised MOU was signed and implemented on July 7, 2015, and it reflects current law and practice. HMFCU offered to provide the MOU to HHS-OIG with this response but was informed that the MOU should be presented at a different time.

Recommendation 3: Develop and implement policies and procedures that conform to current laws, regulations and performance standards.

HMFCU concurs with HHS-OIG's finding that it did not have written policies and procedures specific to HMFCU operations. HMFCU has adopted policies and procedures specific to HMFCU operations. The policies and procedures address the acceptance or declinations of all referrals from the Medicaid agency, safeguarding sensitive information, timely case review and completion of cases, certifications by personnel that they performed HMFCU work only, and timely reporting of adverse actions to the NPDB.

HMFCU concurs in part with HHS-OIG's finding that it failed to document "periodic supervisory reviews". HMFCU did conduct regular supervisory reviews however, the reviews were not specifically referenced in writing as "periodic supervisory reviews". Moving forward all periodic supervisory reviews will be memorialized as "periodic supervisory reviews" pursuant to HMFCU policies and procedures.

HMFCU concurs in part that, during the review period, notes from HMFCU case files did not always reflect action taken which left the review team with the impression that the investigations were not moving forward. During the onsite review HMFCU informed the review team that it had implemented an electronic case tracking system toward the end of the review period which was also in place during the onsite review. The electronic case tracking system was designed to, and did, address this issue. HMFCU believes that, because utilization of the

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case tracking system started near the end of the review period, it was given short shrift in HHS-OIG's draft report. Consequently, HHS-OIG's report is inaccurate because it fails to note that HMFCU had addressed the issue *prior* to the onsite review. Furthermore, HMFCU suffered staffing shortages because of an insufficient pool of qualified Special Agents as noted above. In order to address the resulting backlog, Special Agents were instructed to work on viable cases rather than those which clearly would not result in prosecution. HMFCU believes that this decision impacted the notes in the case files and caused a deficiency in the activity logs which then left HHS-OIG with the impression that the cases were languishing for no reason. Fortunately HMFCU was able to employ emergency hire Special Agents and address the backlog. The backlog has been erased largely because of the retention of emergency hire Special Agents. Without them the non-viable cases would likely linger.

Recommendation 4: Establish regular communication with Federal agencies.

HMFCU concurs in part with the OIG's recommendation. HMFCU believes that it had and continues to have regular contact with Federal agencies. HMFCU did not document those contacts and did not organize regular meetings with Federal agencies. HMFCU personnel have been instructed to document all communications with Federal agencies and stakeholders moving forward. HMFCU will also host quarterly meetings in order to engage federal stakeholders in discussions about fraud trends and cases in order to comply with performance standard 8(a). HMFCU will draft an agenda and will document attendance. The first meeting is scheduled to take place on August 28, 2015.

Recommendation 5: Develop and implement procedures to ensure Unit staff investigates cases within the grant authority.

HMFCU concurs in part with HHS-OIG recommendation. HMFCU always had procedures to ensure that HMFCU staff investigates cases solely within the unit's grant authority. Each case is screened by a Deputy Attorney General and the Supervising Special Agent for nexus prior to a case being officially opened for investigation. HMFCU believes that it had authority to act on the three cases referred to in HHS-OIG's Onsite Review. HMFCU has included in its policies and procedures a checklist that is designed to provide guidance with respect to Medicaid nexus.

HMFCU appreciates HHS-OIG's acknowledgement that it would support entirely policy reasons for taking on such cases because there is no agency willing and able to investigate and prosecute them. At the same time HMFCU respects HHS-OIG's finding and will continue to screen all cases referrals to ensure that there is a sufficient nexus between the allegation and Medicaid.

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MFCU will work with OIG-HHS to identify the staff hours and expenditures associated with investigating the three cases, as appropriate, to reimburse the federal government. Additionally, HMFCU will contact HHS-OIG when, in HMFCU's view, there is any doubt about HMFCU's authority to investigate a particular case.

Lastly, HMFCU reached out to NAMFCU for guidance on the subject of annual certifications by its personnel that only MFCU work is performed. NAMFCU is unaware of a specific form or document that serves as an annual certification. HHS-OIG instructed that it has no form or preferred procedure. HMFCU decided that it will have all staff certify monthly, and in writing, that work performed was exclusively within grant authority. HMFCU has crafted a certification form that will be signed by all HMFCU personnel.

Recommendation 6: Establish fiscal controls.

HMFCU concurs in part with OIG-HHS's recommendation. MFCU has well established fiscal controls. HMFCU appreciates the fiscal audit conducted by HHS-OIG because it identified three (3) instances of inadvertent omission of or application of its established fiscal controls. HMFCU has two hundred and eighty-two (282) items on its current inventory. HMFCU concurs that during the audit three (3) pieces of equipment could not be accounted for, however two (2) have since been accounted for. After the Onsite review was completed, HMFCU performed a comprehensive review of all equipment. The inventory spreadsheet was updated to include documentation of the exact physical location for each piece of equipment. The spreadsheet will be updated any time new equipment is purchased, destroyed, changes location. MFCU will work with HHS-OIG to determine any costs that should be reimbursed for the missing CD-rom.

HMFCU has included equipment policies in its overall unit policies and procedures in order to ensure that all HMFCU equipment will be used only by HMFCU staff and only for HMFCU purposes. HMFCU acknowledges HHS-OIG's finding that it was not permissible to share a HMFCU computer with the Criminal Justice Division (CJD) Supervisor. HMFCU believed that it was within its grant authority to provide the CJD supervisor access to a computer because the CJD Supervisor is ultimately responsible for the HMFCU. The computer has been moved back to the HMFCU premises and continues to be used by the former CJD Supervisor who has now assumed the HMFCU Director's position.

HMFCU concurs that indirect costs and program income were reported incorrectly. HMFCU's accountant has been instructed to apply indirect costs retrospectively when there is a cost change during the course of the report period. The oversight was unintended, and HMFCU has calculated the amount it should return to the federal government. The HMFCU continues to characterize

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copying costs for discovery as a reimbursement, not program income. However, HMFCU will now include such costs as program income. HMFCU will work with OIG-HHS to reimburse the Federal government for program income HHS-OIG identified as reimbursable.

HMFCU appreciates HHS-OIG's recommendations and will make every effort to continue fulfilling its mission. HMFCU looks forward to work together with HHS-OIG to address the concerns raised above and ensure that HMFCU maintains compliance with HHS-OIG's performance standards.

Sincerely,



Christopher D.W. Young
Director
Hawai'i Medicaid Fraud Control Unit

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ACKNOWLEDGMENTS

This report was prepared under the direction of Joyce M. Greenleaf, Acting Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, Michael Henry, Deputy Regional Inspector General, and Blaine Collins, Acting Deputy Regional Inspector General.

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