



**U.S. Department of Health and Human Services  
Office of Inspector General**

# **Montana Medicaid Fraud Control Unit: 2019 Onsite Inspection**

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





## Montana Medicaid Fraud Control Unit: 2019 Onsite Inspection

### What OIG Found

The Montana Medicaid Fraud Control Unit (MFCU or Unit) reported 13 indictments; 19 convictions; 33 civil settlements and judgments; and \$3.4 million in recoveries for fiscal years (FYs) 2016–18. Based on the information we reviewed, we found that the Unit operated in accordance with applicable laws, regulations, and policy transmittals. However, we made two findings involving the Unit’s adherence to Performance Standard 7.

1. The Unit lacked a central repository for case information, making access to case data and pertinent case documents inefficient.
2. The Unit’s practices for conducting periodic supervisory review were not fully reflected in its policies and procedures manual.

In addition to the findings, we made observations regarding Unit operations and practices, the most significant of which was as follows:

- While the Unit received an adequate number of fraud referrals, few fraud referrals came from the Medicaid agency’s program integrity unit, Surveillance and Utilization Review (SURS).

We also identified the following beneficial practice that may be useful as a model to other Units:

- To encourage referrals, the Unit regularly trained cadets at the Montana Law Enforcement Academy and trained other law enforcement personnel through its participation in the Montana Elder Abuse Task Force.

### What OIG Recommends and How the Unit Responded

We recommend that, to address the two findings, the Montana Unit: (1) implement a comprehensive case management system that allows for efficient access to case documents and information; and (2) revise its policies and procedures manual to address the frequency of its periodic supervisory reviews. The Unit concurred with both recommendations.

Full report can be found at [oig.hhs.gov/oei/reports/oei-12-19-00170.asp](https://oig.hhs.gov/oei/reports/oei-12-19-00170.asp)

### Unit Case Outcomes

FYs 2016–18

- 13 indictments
- 19 convictions
- 33 civil settlements and judgments
- \$3.4 million in recoveries

### Unit Snapshot

The Unit is part of the Montana Department of Justice, Division of Criminal Investigation (DCI)

9 MFCU staff— 4 investigators, 1 attorney, 2 auditors, and 2 support staff—located in Helena

Unit was established in 1995

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# TABLE OF CONTENTS

BACKGROUND	1
PERFORMANCE ASSESSMENT	5
Case Outcomes	5
The Unit reported 13 indictments; 19 convictions; and 33 civil settlements and judgments for FYs 2016 through 2018	
The Unit reported total recoveries of \$3.4 million for FYs 2016 through 2018	
Performance Standard 1: Compliance with requirements	6
Based on the information we reviewed, the Montana Unit complied with applicable laws, regulations, and policy transmittals	
Performance Standard 2: Staffing	6
The Unit was fully staffed at the time of our review, but had vacancies during the review period	
Performance Standard 3: Policies and procedures	6
The Unit maintained policies and procedures	
Performance Standard 4: Maintaining adequate referrals	6
The Unit took steps to maintain an adequate volume and quality of referrals involving fraud and patient abuse and neglect	
To encourage referrals, the Unit regularly trained cadets at the Montana Law Enforcement Academy and trained other law enforcement personnel through its participation in the Montana Elder Abuse Task Force	
Although the Unit received an adequate number of fraud referrals, few fraud referrals came from Surveillance and Utilization Review (SURS)	
Performance Standard 5: Maintaining a continuous case flow	9
Nearly all case files contained documentation of supervisory approval to open, and, as appropriate, all contained supervisory approval to close	
Performance Standard 6: Case mix	9
The Unit's case mix included both cases of fraud and cases of patient abuse or neglect, covering a number of provider types; the Unit focused its resources on criminal rather than civil cases	
Performance Standard 7: Maintaining case information	10
The Unit lacked a central repository for case information, making access to case data and pertinent case documents inefficient	

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The Unit's practices for conducting periodic supervisory review were not fully reflected in its policies and procedures manual	
<b>Performance Standard 8: Cooperation with Federal authorities on fraud cases</b>	12
The Unit investigated cases jointly with OIG	
The Unit reported all convictions and adverse actions during the review period to Federal partners within appropriate timeframes	
<b>Performance Standard 9: Program recommendations</b>	13
The Unit made recommendations to the Medicaid agency	
<b>Performance Standard 10: Agreement with Medicaid agency</b>	13
The Unit's memorandum of understanding (MOU) with the Medicaid agency reflected current practice, policy, and legal requirements	
<b>Performance Standard 11: Fiscal control</b>	14
Based on our limited review, we identified no deficiencies in the Unit's fiscal control of its resources	
<b>Performance Standard 12: Training</b>	14
The Unit maintained a training plan and offered staff in-service briefings on the Unit mission and function	
<b>CONCLUSION AND RECOMMENDATIONS</b>	15
Implement a comprehensive case management system that allows for efficient access to case documents and information	
Revise its policies and procedures manual to address the frequency of its periodic supervisory reviews	
<b>UNIT COMMENTS AND OIG RESPONSE</b>	16
<b>APPENDICES</b>	
A. Medicaid Fraud Control Unit Performance Standards	17
B. Detailed Methodology	22
C. Unit Referrals by Source for Fiscal Years 2016 Through 2018	24
D. Point Estimates and 95-Percent Confidence Intervals of Case File Reviews	25
E. Unit Comments	26
<b>ACKNOWLEDGMENTS</b>	26

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# BACKGROUND

## Objective

To examine the performance and operations of the Montana Medicaid Fraud Control Unit

## Medicaid Fraud Control Units

Medicaid Fraud Control Units (MFCUs or Units) investigate (1) Medicaid provider fraud and (2) patient abuse or neglect in facility settings and prosecute those cases under State law or refer them to other prosecuting offices.<sup>1, 2</sup> Under the Social Security Act (SSA), a MFCU must be a “single, identifiable entity” of State government, “separate and distinct” from the State Medicaid agency, and employ one or more investigators, attorneys, and auditors.<sup>3</sup> Each State must operate a MFCU or receive a waiver.<sup>4</sup>

Currently, 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate MFCUs.<sup>5</sup> Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.<sup>6</sup> In Federal fiscal year (FY) 2018, combined Federal and State expenditures for the Units totaled approximately \$294 million.<sup>7</sup>

<sup>1</sup> SSA § 1903(q)(3). Regulations at 42 CFR § 1007.11(b)(1) clarify that a Unit’s responsibilities include the review of complaints of misappropriation of patients’ private funds in health care facilities.

<sup>2</sup> References to “State” in this report refer to the States, the District of Columbia, and the U.S. territories.

<sup>3</sup> SSA § 1903(q).

<sup>4</sup> SSA § 1902(a)(61).

<sup>5</sup> The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

<sup>6</sup> SSA § 1903(a)(6). For a Unit’s first 3 years of operation, the Federal Government contributes 90 percent of funding, and the State contributes 10 percent. Thereafter, the Federal Government contributes 75 percent, and the State contributes 25 percent.

<sup>7</sup> OIG analysis of MFCU annual statistical reporting data for FY 2018. The Federal FY 2018 was from October 1, 2017, through September 30, 2018.

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## OIG Grant Administration and Oversight of Medicaid Fraud Control Units

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.<sup>8,9</sup> As part of its oversight, OIG reviews and recertifies each Unit annually and conducts periodic onsite reviews.

In its annual recertification review, OIG examines the Unit's reapplication, case statistics, and questionnaire responses from Unit stakeholders. Through the recertification review, OIG assesses a Unit's performance, as measured by the Unit's adherence to published performance standards;<sup>10</sup> the Unit's compliance with applicable laws, regulations, and OIG policy transmittals;<sup>11</sup> and the Unit's case outcomes. (See Appendix A for MFCU performance standards, including performance indicators for each standard.)

OIG further assesses Unit performance by conducting onsite Unit reviews that may identify findings and make recommendations for improvement. During an onsite review, OIG also makes observations regarding Unit operations and practices, and may identify beneficial practices that may be useful to share with other Units. Finally, OIG provides training and technical assistance to Units while onsite, as appropriate, and on an ongoing basis.

The Montana MFCU is in Helena and is part of the Montana Department of Justice's Division of Criminal Investigation (DCI). At the time of our April 2019 inspection, the Unit employed four investigators (one of whom is the director and supervising agent), two auditors, an attorney, and two support staff.<sup>12</sup> The director supervises all staff. During our review period of FYs 2016–18, the Unit spent \$2,328,676, with a State share of \$582,169.

**Referrals.** The Unit receives referrals from several sources, including private citizens, law enforcement, health care providers, and the State Medicaid agency's program integrity unit. When the Unit receives a referral, a Unit staff person completes a referral form and forwards it to the director. The director determines whether the referral is within the MFCU's jurisdiction. If the referral does not fall within the Unit's purview, the director refers it to

<sup>8</sup> As part of grant administration, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal Financial Reports that detail MFCU income and expenditures.

<sup>9</sup> The SSA authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979.

<sup>10</sup> MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012). The performance standards were developed by OIG in conjunction with the MFCUs and were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

<sup>11</sup> OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals are located at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>.

<sup>12</sup> The Unit director mentioned throughout the report refers to the director at the time of the onsite inspection.

## Montana Medicaid Program

## Prior OIG Report

the appropriate agency or organization. If the referral is within the Unit's purview, the director assigns an auditor to gather relevant preliminary information, such as Medicaid eligibility and Medicaid billing exposure. The director reviews the preliminary data and determines whether to open a case. If the director decides to open a case, the director forwards the referral form to the DCI's Bureau Chief for a case number.

**Investigations and Prosecutions.** When the Unit opens a case, the director assigns an agent to work with the previously assigned auditor. The Unit attorney informally monitors the investigative progress of cases and meets frequently with the investigative team. Following the investigative phase of the case, the agent and/or auditor "prepare the case file for presentation to the Unit prosecutor." The attorney prosecutes the cases.

**Montana Department of Public Health and Human Services.** The Montana Department of Public Health and Human Services (DPHHS) administers Montana's Medicaid program and reimburses private and public providers for a range of preventative, primary, and acute care services. Services must be medically necessary, provided by a provider enrolled in Montana Medicaid, and covered by Medicaid. In June 2019, 242,044 beneficiaries were enrolled in Medicaid.<sup>13</sup> In FY 2018, total Medicaid expenditures were \$1.9 billion.<sup>14</sup>

DPHHS is also responsible for Medicaid program integrity efforts, including identifying aberrant billing practices, sanctioning those who have abused the Medicaid program, recovering overpayments, and making provider fraud referrals to the MFCU for investigation. The program integrity unit in DPHHS is known as Surveillance and Utilization Review (SURS). SURS employed eight staff during State FY 2018–19.<sup>15</sup>

OIG conducted a previous onsite review of the Montana Unit in 2012.<sup>16</sup> In that review, OIG found 95 percent of Unit case files contained documentation of supervisory approval to open cases; however, 40 percent of closed case files lacked documentation of supervisory approval to close cases. In addition, OIG found that 65 percent of Unit case files lacked documentation of periodic supervisory reviews. OIG found that the Unit

<sup>13</sup> Medicaid.gov, "June Medicaid and CHIP Enrollment Data Highlights, Montana," <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>. Accessed on September 12, 2019.

<sup>14</sup> OIG, *MFCU Statistical Data for FY 2018*, [https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures\\_statistics/fy2018-statistical-chart.pdf](https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2018-statistical-chart.pdf). Accessed on September 30, 2019.

<sup>15</sup> The State FY is July 1 to June 30.

<sup>16</sup> OIG, *Montana State Medicaid Fraud Control Unit: 2012 Onsite Review*, <https://oig.hhs.gov/oei/reports/oei-09-12-00700.asp>. Accessed on September 30, 2019.

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also did not refer sentenced providers to OIG for program exclusion within the appropriate timeframe. The Unit's memorandum of understanding (MOU) with DPHHS did not reflect current law and practice as required, and the Unit did not always adhere to the MOU stipulations. OIG also observed that the Unit received a limited number of fraud referrals from DPHHS. OIG recommended that the Montana Unit: (1) ensure that supervisory approval to close cases and periodic supervisory reviews are documented in Unit case files; (2) ensure that it refers providers for exclusion to OIG within the appropriate timeframe; (3) revise its MOU with DPHHS; and (4) adhere to the MOU provisions. In response, the Unit developed a case review form and amended its policies and procedures for case review and for the opening and closing of cases. In addition, the Unit amended its policies and procedures for the reporting of convictions to OIG for program exclusion. Furthermore, the Unit revised its MOU with DPHHS and established a quarterly cross-training program, as stipulated in the MOU. Based on information received from the Unit, OIG considered the recommendations implemented.

## Methodology

OIG conducted the onsite inspection of the Montana MFCU in April 2019. Our review covered the 3-year period of FYs 2016 through 2018. We based our inspection on an analysis of data and information from 7 sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's managers and selected staff; (5) a review of a random sample of 56 case files from the 96 nonglobal case files that were open at some point during the review period; (6) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (7) observation of Unit operations. (See Appendix B for a detailed methodology.) In examining the Unit's operations and performance, we applied the published performance standards in Appendix A, but we did not assess adherence to every performance indicator for every standard.

## Standards

We conducted this inspection in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program, but they are subject to the same internal quality controls as other OIG evaluations, including internal and external peer review.

# PERFORMANCE ASSESSMENT

Below are the results of OIG’s assessment of the performance and operations of the Montana Unit. OIG identified the Unit’s case outcomes; found that the Unit complied with legal and policy requirements; and, for each of the performance standards, made a finding or observation(s), including highlighting a beneficial practice.

## CASE OUTCOMES

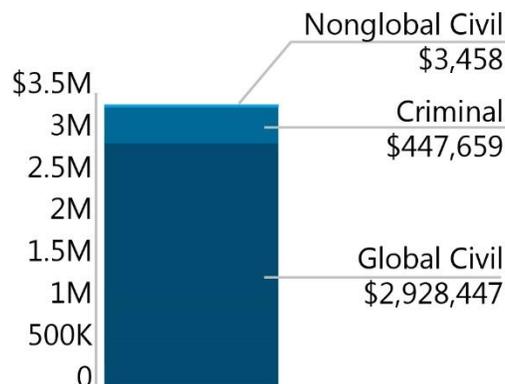
### Observations

The Unit reported 13 indictments; 19 convictions; and 33 civil settlements and judgments for FYs 2016 through 2018. From the 19 convictions, 14 convictions involved provider fraud and 5 involved patient abuse or neglect.



The Unit reported total recoveries of \$3.4 million for FYs 2016 through 2018. (See Exhibit 1 for the sources of those recoveries.)

### Exhibit 1: The Unit reported combined civil and criminal recoveries of \$3.4 million (FYs 2016–18).



Source: OIG analysis of Unit statistical data, FYs 2016–18.

Note: “Global” civil recoveries derive from civil settlements or judgments in global cases, which are cases that involve the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

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**STANDARD 1**

A Unit conforms with all applicable statutes, regulations, and policy directives.

**Observation**

**Based on the information we reviewed, the Montana Unit complied with applicable laws, regulations, and policy transmittals.** We did not identify any legal or compliance concerns related to Unit operations.

**STANDARD 2**

A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.

**Observation**

**The Unit was fully staffed at the time of our review, but had vacancies during the review period.** During the review period, the Unit was approved by OIG for eight staff in FY 2016 and nine staff in FYs 2017–18. At the time of our review, the Unit was staffed in accordance with the staffing allocations approved by OIG. However, the Unit experienced vacant positions during FY 2016 (two investigators), FY 2017 (one investigator), and FY 2018 (one support staff).

**STANDARD 3**

A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.

**Observation**

**The Unit maintained policies and procedures.** The Unit maintained a policies and procedures manual specific to the MFCU's functions and jurisdiction. The Unit updated the manual as needed and maintained a record of these updates. This Unit manual was separate from the DCI manual that details protocols related to the division as a whole.

**STANDARD 4**

A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

**Observation**

**The Unit took steps to maintain an adequate volume and quality of referrals involving fraud and patient abuse and neglect.** The Unit director met with key stakeholders regularly. The Unit director met monthly with the SURS supervisor to discuss fraud referrals and case updates, as well as to coordinate work. The Unit director also met monthly with stakeholders who were sources of patient abuse and neglect referrals—supervisors from Adult Protective Services, Licensure (surveyors of assisted living facilities), Certification (surveyors of skilled nursing facilities), and the

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State Ombudsman. The Unit director also reported the encouragement of referrals by making personal contacts with home care agencies and other care providers. Finally, the Unit reported that investigators conducted outreach to local law enforcement by making personal contact with local police departments when working cases in a local area.

## Observation

### *Beneficial Practice*

**To encourage referrals, the Unit regularly trained cadets at the Montana Law Enforcement Academy and trained other law enforcement personnel through its participation in the Montana Elder Abuse Task Force.** The Unit attorney and an investigator provided training to cadets at the Montana Law Enforcement Academy twice per year, one purpose of which was to encourage referrals to the Unit. Specifically, the training focused on the MFCU's mission; elder abuse, including financial abuse; and drug diversion, with an emphasis on how the MFCU can assist with crimes that the cadets might encounter against vulnerable and elderly persons.

As an additional method of encouraging referrals from local law enforcement, the Unit participated as a member of the Montana Elder Abuse Task Force,<sup>17</sup> which provided training as part of a 3-year grant from the National Clearinghouse on Abuse in Later Life.<sup>18</sup> The purpose of the training was to provide first responders, county attorneys, court officials, and law enforcement officers with information about elder abuse, including investigative strategies; possible criminal charges; and local resources or services available to assist officers and victims of abuse. Since 2017, the Montana Elder Abuse Task Force has provided training to over 60 law enforcement personnel through 3 8-hour training sessions provided in locations across the State.

## Observation

**Although the Unit received an adequate number of fraud referrals, few fraud referrals came from SURS.** The Unit received 232 fraud referrals during the review period, most commonly from private citizens, providers, and law enforcement. Only eight of these fraud referrals were received from SURS, the Medicaid agency's program integrity unit. OIG's 2012 onsite review of the Unit also observed that the Unit received a limited number of

<sup>17</sup> The MFCU, the Attorney General's Office, Adult Protective Services, Big Sky Senior Services, and The Friendship Center comprised the Elder Abuse Task Force.

<sup>18</sup> Administered by a grant from the U.S. Department of Justice's Office on Violence Against Women, the National Clearinghouse on Abuse in Later Life provides grants to enhance training and services to address elder abuse, neglect, and exploitation. Grant funds may be used to develop services for older victims; create or enhance coordinated community response; organize training and cross-training for professionals; and conduct outreach activities and public awareness.

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fraud referrals from SURS.<sup>19</sup> Given that the SURS program has responsibility for identifying aberrant billing practices of Medicaid providers in Montana, SURS should be a significant source of quality referrals for the Unit. See Appendix C for all sources of referrals involving fraud and patient abuse or neglect during FYs 2016–18.

Two factors may have limited the number of referrals SURS sent to the MFCU. First, SURS did not refer all potential fraud to the Unit. A 2017 Montana State legislative audit found that SURS, contrary to Federal regulation and its agreement with the MFCU, was not referring to the MFCU all cases of “suspected fraud” it identified.<sup>20</sup> Instead, the audit report found that SURS referred to the MFCU only “credible allegations of fraud” that were identified “based on further investigation by the department” and that would require SURS to consider imposition of a payment suspension.<sup>21, 22</sup> Specifically, the legislative auditor found that seven cases of “suspected fraud” were not referred to the MFCU. As result of the legislative auditor’s recommendation to refer all suspected fraud to the MFCU, SURS began to refer cases of suspected provider fraud. This led to the increase in referrals to the MFCU in FY 2018 (from two in FY 2017 to five in FY 2018).

As a second reason for the low number of referrals from SURS, both Unit and SURS management reported that a 2017 Montana law limited fraud referrals by restricting SURS to a 6-month “look back” period when conducting an initial Medicaid overpayment audit. Specifically, they stated that SURS can only request up to 6 months of records from a provider for

<sup>19</sup> From FYs 2010 through 2012, the Unit received only seven fraud referrals from SURS, including only one referral in FY 2012.

<sup>20</sup> Under the terms of the MOU between the Montana Department of Justice and DPHHS, DPHHS will, at the earliest practical opportunity in its preliminary investigation, advise the MFCU of any suspected fraud, as provided in 42 CFR 455.21(a)(1).

<sup>21</sup> Montana Legislative Audit Division, *Report 17-14: Montana Financial-Compliance Audit: Department of Public Health and Human Services for the Two Fiscal Years Ended June 30, 2017*, <https://leg.mt.gov/content/Publications/Audit/Report/17-14.pdf>. Accessed on September 20, 2019.

<sup>22</sup> Regulations enforced by Centers for Medicare & Medicaid Services require State Medicaid agencies to refer both “suspected provider fraud” and “credible allegations of fraud” to MFCUs. 42 CFR 455.21(a)(1) and 455.23(d). The regulations do not define “suspected provider fraud.” The regulations define “credible allegation of fraud” at 42 CFR 455.2 as an allegation that has been verified by the State from any source, including fraud hotline complaints; claims data mining; and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered “credible” when they have indicia of reliability and the Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

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claims paid by Medicaid up to 3 years before the request was made.<sup>23, 24</sup> SURS management reported that being able to review just 6 months of records made it challenging to identify trends in the data and possible fraudulent activity, thus limiting the number of referrals made to the Unit.

## STANDARD 5

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

### Observation

**Nearly all case files contained documentation of supervisory approval to open, and, as appropriate, all contained supervisory approval to close.** Ninety-eight percent of case files contained documentation of supervisory approval to open them. All cases that were closed at the time of our review (66 percent) contained documentation of supervisory approval to close them. This observation reflects significant improvement from the 2012 onsite review, which found that 40 percent of closed case files lacked documentation of approval to close them.

## STANDARD 6

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

### Observation

**The Unit's case mix included both cases of fraud and cases of patient abuse or neglect, covering a number of provider types; the Unit focused its resources on criminal rather than civil cases.** Of the 143 cases that were open from FY 2016 to FY 2018, 81 percent (116 cases) involved provider fraud and 19 percent (27 cases) involved patient abuse or neglect. At the end of FY 2018, the Unit's open cases covered 20 different provider types. The most common provider types were pharmaceutical manufacturers, personal care services attendants, and psychologists, representing 48 of the Unit's 81 open cases.

The Unit focused its resources on criminal cases rather than civil cases. From FY 2016 to FY 2018, the Unit opened just two civil cases that were not

<sup>23</sup> Montana Code Annotated 53-6-1402(3)(a).

<sup>24</sup> Montana Code Annotated 53-6-1402(3)(b). If the audit demonstrates a significant error rate from the initial overpayment audit, the department (DPHHS SURS) or the auditor with the department's approval may request additional records related to the issue under review for purposes of a followup audit.

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global cases.<sup>25</sup> Performance Standard 6(e) states that as part of its case mix, a Unit seek to maintain, consistent with legal authorities, a balance of criminal and civil fraud cases. Unit management and staff reported that the Unit did not have the resources or expertise to litigate provider fraud civilly within the Unit. However, the director stated that the Unit would refer a civil case to the U.S. Attorney's Office (USAO) if the restitution amount met the USAO's threshold for prosecution. The Unit worked the two nonglobal civil cases opened during the review period jointly with OIG and USAO.

## STANDARD 7

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

### Finding

**The Unit lacked a central repository for case information, making access to case data and pertinent case documents inefficient.** Performance Standard 7 states that a Unit should maintain case files in an effective manner; develop a case management system that allows efficient access to case information and other performance data; and maintain case files in an effective manner. The Unit's approaches to maintaining basic case information and to maintaining electronic case files differed from each other; we discuss each of them below.

The Unit used several repositories for tracking case information and other performance data, rather than a consolidated information management system. Performance Standards 7(e) and 7(f) state that a Unit have an information management system that manages and tracks case information from initiation to resolution, and that this system allow for the monitoring and reporting of case information. The Unit director maintained a Microsoft Access database to track basic information about cases—the case number; the referral source and date; the case status (open/closed); the case type and provider type; and the date that the case opened and closed. The outcomes of cases were not included in this database. Rather, the Unit director reported using multiple spreadsheets designed to track the outcomes of cases, such as convictions, indictments, and monetary recoveries.<sup>26</sup> For example, one such spreadsheet, which tracked court-ordered restitution requirements and defendant payments, was maintained by the Unit's auditor.

<sup>25</sup> Global cases are civil false claims actions that involve the U.S. Department of Justice and a group of State MFCUs. The Montana MFCU participated in 47 global cases during the review period.

<sup>26</sup> The Unit used the Microsoft Access database and the spreadsheets to report summary case information to OIG, pursuant to 42 CFR 1007.17(a)(2) and Performance Standard 7(f).

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The Unit's electronic case files, maintained in a folder system on a shared drive, did not permit efficient access to important case documents. According to the Unit's policies and procedures manual, the Unit's electronic case files consisted of groups of folders on the shared drive filed under Unit employees' names. When OIG conducted its review of the Unit's case files, reviewers located some case documents in folders under investigators' names, per the policies and procedures manual. However, OIG reviewers also found that, depending on the age of the investigation and case type, some portions of case files were stored in other folders (of which there were several different types). OIG reviewers had trouble locating case documents, such as subpoenas, court documents, and investigative reports, because no single folder existed for each case. Because of the lack of a single folder for each case as well as the lack of a case index or log, reviewers had difficulty determining the status of the case and understanding the case in its entirety. OIG reviewers also observed that this folder system would make it difficult to determine whether the Unit had received a prior complaint about a new suspect.

At the time of our inspection, the Unit's parent division, DCI, was planning to implement a centralized case management system across the division at some point in 2019. After our inspection, the director reported the Unit was evaluating what case information could be entered into the new system and what information would need to be tracked separately for reporting requirements. The director also reported that the Unit would enter all investigative and audit work for open cases into the new system.

## Finding

**The Unit's practices for conducting periodic supervisory review were not fully reflected in its policies and procedures manual.** Performance Standard 7(a) states that supervisory reviews should be conducted periodically, consistent with MFCU policies and procedures, and noted in the case file. The Unit's policies and procedures manual, in describing the process for reviewing case files, stated that the Unit director electronically maintained a "case progress review form" that included the date of the case progress review meetings and tracked investigative and audit activity for each open case. The manual further stated that when the director closed a case, she signed the form and placed it in the original paper case file.

The policies and procedures manual did not describe the frequency of the meetings or identify the meeting participants. The Unit director reported that the case review occurred as part of staff meetings held on a monthly to bimonthly basis. Because the Unit's policy and procedures manual did not include a specific frequency for periodic supervisory case reviews, in our review of case files, we considered whether the Unit conducted and documented case reviews on a bimonthly basis, consistent with the Unit's usual practices in reviewing case files. We found that 98 percent of case files contained documentation of at least one supervisory review. However, 52 percent of these lacked regular, bimonthly documentation of reviews. Of

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the case files in our sample that lacked documentation of regular, bimonthly review, most gaps between reviews ranged from 3 to 5 months. OIG's 2012 onsite review of the Unit also found that case files lacked documentation of supervisory reviews and recommended that the Unit ensure that periodic supervisory reviews be documented.<sup>27</sup> In response, the Unit adopted the "case review progress form" and clarified in its policies and procedures that the director was responsible for documenting the reviews.

Periodic supervisory review of cases can help ensure the timely completion of cases, and documenting those reviews in the case files can help ensure that cases are properly managed. However, in OIG's experience, conducting and documenting official case file reviews as frequently as monthly or bimonthly may present an unwarranted burden on the investigators, as well as the director, who has the responsibility of documenting the reviews. A schedule with less frequent case file reviews would not preclude the Unit from continuing to meet monthly or bimonthly to discuss cases.

## STANDARD 8

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

### Observations

**The Unit investigated cases jointly with OIG.** During the review period, the Unit reported working six joint cases with OIG. Although OIG did not have a special agent based in Montana during the review period, the Unit worked joint cases with a special agent from another State. In late September 2018, an OIG agent was stationed in Helena. At the time of our inspection in April 2019, Unit management and staff reported that having a local OIG agent was a positive development which had led to increased communication and interaction.

**The Unit reported all convictions and adverse actions during the review period to Federal partners within appropriate timeframes.** Performance Standard 8(f) states that the Unit should transmit information on convictions to OIG within 30 days of sentencing so that convicted individuals can be excluded from Federal health care programs.<sup>28</sup> The Unit reported all 17 convictions during the review period within 30 days. This observation reflects significant improvement from the 2012 onsite review, which found that the Unit did not report any of its six sentenced providers to OIG within

<sup>27</sup> The 2012 onsite review found that 65 percent of case files lacked documentation of periodic supervisory reviews.

<sup>28</sup> Effective May 21, 2019, 42 CFR 1007.11(g) requires the Unit to transmit information on convictions within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court.

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the appropriate timeframe. Additionally, Federal regulations require that Units report any adverse actions resulting from investigations or prosecution of healthcare providers to the NPDB within 30 calendar days of the date of the final adverse action.<sup>29</sup> Performance Standard 8(g) states that the Unit should report qualifying cases to the NPDB.<sup>30</sup> During the review period, the Unit reported 17 adverse actions; all were reported within 30 days of the qualifying action.

## STANDARD 9

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

### Observation

**The Unit made recommendations to the Medicaid agency.** Performance Standard 9(b) states that the Unit, when warranted and appropriate, make recommendations regarding program integrity issues to the Medicaid agency. During the review period, the Unit recommended to DPHHS that fraud prevention be included as part of training being developed for home care agencies to provide to caregivers and home care consumers. DPHHS adopted the MFCU's recommendation, and now includes fraud prevention as part of home health training. The Unit also recommended, as a result of a Unit case, that DPHHS require home care agencies to more frequently observe the care provided by home care workers than the current requirement of every 180 days. The Unit reported that it had not received a response from DPHHS to that recommendation.

## STANDARD 10

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

### Observation

**The Unit's MOU with the Medicaid agency reflected current practice, policy, and legal requirements.** The Montana Department of Justice and DPHHS had a current MOU, amended on May 1, 2018. The MOU reflected all policy and legal requirements as well as the current practices between the parties, including addressing referrals of both suspected fraud and credible allegations of fraud to the MFCU.

<sup>29</sup> 45 CFR 60.5. Examples of adverse actions include but are not limited to convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(a) and (g)(1).

<sup>30</sup> 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.

## STANDARD 11

A Unit exercises proper fiscal control over its resources.

### Observation

**Based on our limited review, we identified no deficiencies in the Unit's fiscal control of its resources.** From the responses to a detailed questionnaire about fiscal controls and interviews with fiscal staff, we identified no issues related to the Unit's budget process, accounting system, cash management, procurement, electronic data security, property, or personnel. In our inventory review, we located 30 of the 30 sampled inventory items.

## STANDARD 12

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

### Observation

**The Unit maintained a training plan and offered staff in-service briefings on the Unit mission and function.** The Unit had a training plan for its investigators, attorney, and auditors pursuant to Performance Standard 12(a), which states that the Unit maintain a training plan that includes an annual minimum number of training hours and is at least as stringent as required for professional certification. During State FYs 2016 to 2018, Unit staff in the professional disciplines generally met or exceeded the minimum number of training hours required by the Unit training plan. (The Unit's annual training plan requires 20 hours every 2 years for investigators and 15 hours every year for attorneys and auditors.)

The Unit offered staff in-service briefings on topics related to the mission and function of the Unit, including evidence handling; Miranda warnings; search and seizure (including investigative subpoenas); relevant legal authority, as contained in the Montana Code Annotated and the Administrative Rules of Montana; and investigations of cases of home health care fraud, elder abuse, and financial exploitation.

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# CONCLUSION AND RECOMMENDATIONS

Based on the information we reviewed, we found that the Montana Unit complied with applicable legal requirements and generally adhered to performance standards, but we identified two areas in which the Unit should improve its adherence to Performance Standard 7, related to case information. We found that the Unit lacked a central repository for case information, making access to case data and pertinent case documents inefficient. We also found that the Unit's practices for conducting periodic supervisory review were not fully reflected in its policies and procedures manual.

We also observed that the Unit received few fraud referrals from SURS. We encourage the Unit to continue to take steps to encourage an adequate volume and quality of referrals from SURS.

To address the two findings, we recommend that the Montana Unit:

**Implement a comprehensive case management system that allows for efficient access to case documents and information.**

The Unit reported that it will be adopting a new division-wide case management system in 2019. We recommend that the Unit, in adopting the system or another alternative, ensure that the system store both case documents and case information. The Unit should also develop procedures regarding roles and responsibilities for maintaining case information and case documents in the new system. We believe that such a system would improve the Unit's ability to consistently maintain and retrieve case documents; more efficiently report on the status and outcomes of cases; and search for prior complaints on new suspects.

**Revise its policies and procedures manual to address the frequency of its periodic supervisory reviews.**

The Unit should revise its written policies and procedures for conducting and documenting periodic supervisory reviews of case files. The revisions should include a specific frequency for conducting such reviews. As part of such revisions, the Unit may wish to consider whether to modify its schedule for reviewing case files to make the reviews less frequent, such as quarterly. Additionally, the revisions should include any changes to the process of documenting supervisory reviews that resulted from implementation of the comprehensive case management system. Finally, the Unit should implement processes to ensure that periodic supervisory reviews are consistently documented.

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# UNIT COMMENTS AND OIG RESPONSE

The Montana Unit concurred with both of our recommendations.

The Unit concurred with our first recommendation to implement a comprehensive case management system that allows for efficient access to case documents and information. The Unit stated that the division-wide case management system is now online and being integrated into the Unit's practices. Specifically, the Unit stated that the new system will allow case information and documents to be accessible from one access point and will allow the Unit to monitor the status of cases from the receipt of the complaint to the final disposition. The Unit also stated that it planned to customize the system to generate reports tailored to the reporting requirements of OIG, with efforts being made to reduce the need for separate spreadsheets to track data. Finally, the Unit stated that it is creating policy and procedures for the roles and responsibilities for maintaining case information and case documents within the new system.

The Unit also concurred with our second recommendation to revise its policies and procedures manual to address the frequency of its periodic supervisory reviews. The Unit stated that it is in the process of revising its policy regarding supervisory case file reviews, including altering the frequency of the reviews to quarterly.

For the full text of the Unit's comments, see Appendix E.

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# APPENDIX A: Medicaid Fraud Control Unit Performance Standards<sup>31</sup>

**1) A Unit conforms with all applicable statutes, regulations, and policy directives, including:**

- A) Section 1903(q) of the Social Security Act, containing the basic requirements for operation of a MFCU;
- B) Regulations for operation of a MFCU contained in 42 CFR part 1007;
- C) Grant administration requirements at 45 CFR part 92 and Federal cost principles at 2 CFR part 225;<sup>32</sup>
- D) OIG policy transmittals as maintained on the OIG website; and
- E) Terms and conditions of the notice of the grant award.

**2) A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.**

- A) The Unit employs the number of staff that is included in the Unit's budget estimate as approved by OIG.
- B) The Unit employs a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
- C) The Unit employs an appropriate mix and number of attorneys, auditors, investigators, and other professional staff that is both commensurate with the State's total Medicaid program expenditures and that allows the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.
- D) The Unit employs a number of support staff in relation to its overall size that allows the Unit to operate effectively.
- E) To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for each location.

**3) A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.**

- A) The Unit has written guidelines or manuals that contain current policies and procedures, consistent with these performance standards, for the investigation and (for those Units with prosecutorial authority) prosecution of Medicaid fraud and patient abuse and neglect.

<sup>31</sup> 77 Fed. Reg. 32645 (June 1, 2012).

<sup>32</sup> For FYs 2016 and later, grant administration requirements are found at 45 CFR part 75.

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- B) The Unit adheres to current policies and procedures in its operations.
  - C) Procedures include a process for referring cases, when appropriate, to Federal and State agencies. Referrals to State agencies, including the State Medicaid agency, should identify whether further investigation or other administrative action is warranted, such as the collection of overpayments or suspension of payments.
  - D) Written guidelines and manuals are readily available to all Unit staff, either online or in hard copy.
  - E) Policies and procedures address training standards for Unit employees.
- 4) A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.**
- A) The Unit takes steps, such as the development of operational protocols, to ensure that the State Medicaid agency, managed care organizations, and other agencies refer to the Unit all suspected provider fraud cases. Consistent with 42 CFR 1007.9(g), the Unit provides timely written notice to the State Medicaid agency when referred cases are accepted or declined for investigation.
  - B) The Unit provides periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.
  - C) The Unit provides timely information to the State Medicaid or other agency when the Medicaid or other agency requests information on the status of MFCU investigations, including when the Medicaid agency requests quarterly certification pursuant to 42 CFR 455.23(d)(3)(ii).
  - D) For those States in which the Unit has original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit takes steps, such as the development of operational protocols, to ensure that pertinent agencies refer such cases to the Unit, consistent with patient confidentiality and consent. Pertinent agencies vary by State but may include licensing and certification agencies, the State Long Term Care Ombudsman, and adult protective services offices.
  - E) The Unit provides timely information, when requested, to those agencies identified in (D) above regarding the status of referrals.
  - F) The Unit takes steps, through public outreach or other means, to encourage the public to refer cases to the Unit.
- 5) A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.**
- A) Each stage of an investigation and prosecution is completed in an appropriate timeframe.
  - B) Supervisors approve the opening and closing of all investigations and review the progress of cases and take action as necessary to ensure that each stage of an investigation and prosecution is completed in an appropriate timeframe.
  - C) Delays to investigations and prosecutions are limited to situations imposed by resource constraints or other exigencies.
- 6) A Unit's case mix, as practicable, covers all significant providers types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.**

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

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

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

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- 8) A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.**
- A) The Unit communicates on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.
  - B) The Unit cooperates and, as appropriate, coordinates with OIG's Office of Investigations and other Federal agencies on cases being pursued jointly, case involving the same suspects or allegations, and cases that have been referred to the Unit by OIG or another Federal agency.
  - C) The Unit makes available, to the extent authorized by law and upon request by Federal investigators and prosecutors, all information in its possession concerning provider fraud or fraud in the administration of the Medicaid program.
  - D) For cases that require the granting of "extended jurisdiction" to investigate Medicare or other Federal health care fraud, the Unit seeks permission from OIG or other relevant agencies under procedures as set by those agencies.
  - E) For cases that have civil fraud potential, the Unit investigates and prosecutes such cases under State authority or refers such cases to OIG or the U.S. Department of Justice.
  - F) The Unit transmits to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, all pertinent information on MFCU convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders.
  - G) The Unit reports qualifying cases to the Healthcare Integrity & Protection Databank, the National Practitioner Data Bank, or successor data bases.
- 9) A Unit makes statutory or programmatic recommendations, when warranted, to the State government.**
- A) The Unit, when warranted and appropriate, makes statutory recommendations to the State legislature to improve the operation of the Unit, including amendments to the enforcement provisions of the State code.
  - B) The Unit, when warranted and appropriate, makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency and to other agencies responsible for Medicaid operations or funding. The Unit monitors actions taken by the State legislature and the State Medicaid or other agencies in response to recommendations.
- 10) A Unit periodically reviews its Memorandum of Understanding (MOU) with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.**
- A) The MFCU documents that it has reviewed the MOU at least every 5 years, and has renegotiated the MOU as necessary, to ensure that it reflects current practice, policy, and legal requirements.
  - B) The MOU meets current Federal legal requirements as contained in law or regulation, including 42 CFR 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR 455.23, "Suspension of payments in cases of fraud."

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- C) The MOU is consistent with current Federal and State policy, including any policies issued by OIG or the Centers for Medicare & Medicaid Services (CMS).
  - D) Consistent with Performance Standard 4, the MOU establishes a process to ensure the receipt of an adequate volume and quality of referrals to the Unit from the State Medicaid agency.
  - E) The MOU incorporates by reference the *CMS Performance Standard for Referrals of Suspected Fraud From a State Agency to a Medicaid Fraud Control Unit*.

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

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

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

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

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# APPENDIX B: Detailed Methodology

## Data Collection and Analysis

We collected and analyzed data from the seven sources below to identify any opportunities for improvement and instances in which the Unit did not adhere to the performance standards or was not operating in accordance with laws, regulations, or policy transmittals.<sup>33</sup> We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards.

**Review of Unit Documentation.** Prior to the onsite inspection, we reviewed the recertification analysis for FYs 2016–18, which involved examining the Unit's recertification materials, including (1) the annual reports, (2) the Unit director's recertification questionnaires, (3) the Unit's MOU with the State Medicaid agency (DPHHS), (4) the DPHHS program integrity director's questionnaires, and (5) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for FYs 2016–18. We examined the recommendations from the 2012 OIG onsite review report and the Unit's implementation of those recommendations.

**Review of Unit Financial Documentation.** We conducted a limited review of the Unit's control over its fiscal resources. Prior to the onsite review, we analyzed the Unit's response to a questionnaire about internal controls and conducted a desk review of the Unit's financial status reports. While onsite, we followed up with Montana Department of Justice and Unit officials to clarify issues identified in the questionnaire about internal controls. We also selected a purposive sample of 30 items from the current inventory list of 275 items maintained in the Unit's office and verified those items onsite.

**Interviews With Key Stakeholders.** In February and March 2019, we interviewed key stakeholders, including officials in DPHHS, Adult Protective Services, and USAO. We also interviewed the managers and special agents from OIG's Office of Investigations who work regularly with the Unit. We focused these interviews on the Unit's relationship and interaction with the stakeholders, as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management and staff.

**Onsite Interviews With Unit Management and Selected Staff.** We conducted structured onsite interviews with the Unit's management and select staff in April 2019. We interviewed the Unit director, the attorney, two

<sup>33</sup> All relevant regulations, statutes, and policy transmittals are available online at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>.

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auditors, and three investigators. In addition, we interviewed the supervisor of the Unit—the bureau chief of DCI. We asked these individuals questions related to: (1) Unit operations; (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; (3) opportunities for the Unit to improve its operations and/or performance; (4) clarification regarding information obtained from other data sources; and (5) the Unit’s training and technical assistance needs.

**Onsite Review of Case Files.** To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2016 through 2018 and include the status of the case; whether the case was criminal, civil, or global; and the dates on which the case was opened and closed, if applicable. The total number of cases was 143.

We excluded all global cases from our review of the Unit’s case files because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs. We excluded 47 global cases, leaving 96 case files.

We then selected a simple random sample of 56 cases from the population of 96 cases. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with an absolute precision of +/- 10 percent at the 95-percent confidence level. We reviewed the 56 case files for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals. During the onsite review of the sampled cases, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

**Review of Unit Submissions to the Office of Inspector General and the National Practitioner Data Bank.** We also reviewed all convictions submitted to OIG during the review period so that convicted individuals could be excluded from programs (17) and all adverse actions submitted to the NPDB during the review period (17). We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and all adverse actions to the NPDB for FYs 2016–18. We also assessed the timeliness of the submissions to OIG and the NPDB.

**Onsite Review of Unit Operations.** During the onsite inspection, we observed the workspace and operations of the Unit’s office in Helena. We observed the Unit’s offices and meeting spaces; security of data and case files; location of select equipment; and general functioning.

# APPENDIX C: Unit Referrals by Source for Fiscal Years 2016 Through 2018

Referral Source	FY 2016		FY 2017		FY 2018		Grand Totals	
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect
Adult Protective Services	2	1	1	1	1	3	4	5
HHS OIG	2	0	5	0	4	1	11	1
Law enforcement—other	5	2	4	2	1	2	10	6
Local prosecutor	1	0	5	1	0	1	6	2
Medicaid agency—PI/SURS <sup>1</sup>	1	0	2	0	5	0	8	0
Medicaid agency—other	4	0	0	1	0	0	4	1
Private citizen	36	5	20	4	25	1	81	10
Private health insurer	1	0	2	0	1	0	4	0
Provider	21	4	9	2	12	2	42	8
State agency—other	1	0	0	1	1	1	2	2
State survey and certification agency	0	0	0	1	0	0	0	1
Other <sup>2</sup>	14	0	29	0	17	0	60	0
<b>Total</b>	<b>88</b>	<b>12</b>	<b>77</b>	<b>13</b>	<b>67</b>	<b>11</b>	<b>232</b>	<b>36</b>
<b>Annual Total</b>	<b>100</b>		<b>90</b>		<b>78</b>		<b>268</b>	

Source: OIG analysis of Unit Annual Statistical Reports, FYs 2016–18.

<sup>1</sup> The abbreviation “PI” stands for program integrity; the abbreviation “SURS” in Montana stands for “Surveillance and Utilization Review.”

<sup>2</sup> All 60 “Other” referrals are global cases from the National Association of Medicaid Fraud Control Units.

# APPENDIX D: Point Estimates and 95-Percent Confidence Intervals of Case File Reviews

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases Closed at the Time of Our Review	56	66.1%	56.3%	75.0%
Percentage of All Cases That Had Supervisory Approval To Open	56	98.2%	92.7%	99.0%
Percentage of All Closed Cases That Had Supervisory Approval To Close	37	100%	92.1%	100%
Percentage of All Cases Open Longer Than 60 Days	56	98.2%	92.7%	99.0%
Percentage of All Case Files Open Longer Than 60 Days and That Contained at Least One Periodic Supervisory Review	55	98.2%	92.6%	98.9%
Percentage of All Case Files Open Longer Than 60 Days and That Contained Some Periodic Supervisory Review, But Not Bimonthly Supervisory Review	54	51.9%	41.9%	61.3%

Source: OIG analysis of Montana MFCU case files, 2019.

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# APPENDIX E: Unit Comments

## DIVISION OF CRIMINAL INVESTIGATION

DEPARTMENT OF JUSTICE  
STATE OF MONTANA

TIM FOX  
Attorney General



Medicaid Fraud Control Unit  
PO Box 201417  
2225 Eleventh Avenue  
Helena, MT 59620-1417

March 10, 2020

Suzanne Murrin  
Deputy Inspector General  
for Evaluation and Inspections  
Office of Inspector General  
Department of Health and Human Services

RE: OEI-12-19-00170

Dear Ms. Murrin,

Thank you for you and your team's efforts in assisting the Montana Medicaid Fraud Control Unit (MFCU) in its pursuit to protect Montana's most vulnerable citizens and ensure the viability of and access to our state's Medicaid program. As a result of the HHS OIG 2019 on site audit, two recommendations were brought to our attention.

The first recommendation was for the MFCU to implement a comprehensive case management system that allows for efficient access to case documents and information. The MFCU concurs with the recommendation and as noted in the Montana Medicaid Fraud Control Unit: 2019 Onsite Inspection report, the Division of Criminal Investigation was in the process of adopting a division-wide case management system. At the time of the composition of this letter, the system has gone online and is being integrated into the MFCUs practices. The process of transitioning from the electronic file and hardcopy folder system to the new records management system is going to take time, but we are confident that HHS OIGs recommendation will be met.

The records management system will allow case information and documents to be accessible from one access point. We will have the ability to monitor the status of case reports from receipt of the complaint to the final disposition. The system also allows for the generation of reports based upon a wide variety of search criteria including but not limited to the case number, case status, case type, date, individual, location, etc. The system allows for a degree of customization. With that in mind, we plan on altering some of the reporting options within the system to allow the unit supervisor to generate reports tailored

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to the reporting requirements of HHS OIG. These changes are currently in progress and will hopefully be completed within the coming months.

Creation of policy and procedures concerning the roles and responsibilities for maintaining case information and case documents within the records management system are also in progress. It is too early to determine with certainty if the system will eliminate the need for all spreadsheets used to track various performance standards and parameters within the MFCU, but efforts to reduce them are being made.

The second recommendation was for the MFCU to revise its policies and procedures manual to address the frequency of its periodic supervisory review of case files. The MFCU concurs with the recommendation and is in the process of not only revising our policy regarding supervisory case file reviews, but multiple additional policies that have been affected by procedural and personnel changes within the unit. As you may have observed during the review of our policies and case files during the onsite audit, a case review document was used when the supervisory reviews took place. We plan to continue with the use of this tool as our means of documentation. Due to the nature and length of time that medical fraud investigations encompass, we feel that monthly supervisory case reviews are cumbersome and unnecessary. Therefore, we plan on altering the frequency of supervisory case reviews to quarterly. We anticipate this process to be completed within the coming months.

I hope that this letter serves as an acceptable response to the recommendations of HHS OIG. If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,



Loren Mardis, Director  
Montana MFCU

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# ACKNOWLEDGMENTS

Susan Burbach of the Medicaid Fraud Policy and Oversight Division served as the team leader for this inspection. Keith Peters of the Medicaid Fraud Policy and Oversight Division also participated in the inspection. Two agents from the Office of Investigations also participated in the inspection. Office of Evaluation and Inspections staff who provided support include Kevin Farber and Frank Rogers.

This report was prepared under the direction of Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at [Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov)

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The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## **Office of Counsel to the Inspector General**

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.