

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



# Michigan Medicaid Fraud Control Unit: 2021 Review

**Suzanne Murrin**  
Deputy Inspector General  
for Evaluation and Inspections  
September 2022, OEI-06-21-00270





## Unit Case Outcomes

Federal fiscal years (FYs)  
2018–2020

- 55 indictments
- 53 convictions
- 58 civil settlements and judgments
- \$47.2 million in recoveries

## Unit Snapshot

The Michigan Medicaid Fraud Control Unit (MFCU or Unit) is located within the Michigan Attorney General's Office in East Lansing. At the time of our onsite review in September 2021, the Unit had a total of 31 staff (including 3 staff who worked remotely from Detroit).

## Why OIG Did This Review

The Office of Inspector General (OIG) administers the MFCU grant awards, annually recertifies each Unit, and oversees the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic reviews of Units and issues public reports of its findings.

The primary purpose of this review was to examine three areas of concern that we identified during our ongoing administration and oversight activities of the Michigan MFCU: (1) the number of fraud referrals from the State Medicaid agency, (2) the Unit's fiscal controls, and (3) the Unit's staffing levels. As part of this review, we also examined the Unit's performance and operations.

# Michigan Medicaid Fraud Control Unit: 2021 Review

## What OIG Found

OIG's review of the Michigan MFCU's performance and operations found that the Unit reported strong case outcomes for FYs 2018–2020, with over \$47 million in combined criminal and civil recoveries.

Our review, however, identified several operational challenges that warrant further attention. We made nine findings for which we are making recommendations to improve the Unit's adherence to the MFCU performance standards:

1. The Unit received few fraud referrals from the State Medicaid agency, and despite the Unit taking steps to increase these referrals, they remained low.
2. The Department of Attorney General repeatedly submitted the MFCU's financial reports late, lacked support for some MFCU expenditures, and lacked accounting procedures, raising concerns about the MFCU's fiscal controls.
3. Despite the Unit's request for additional resources to increase its staffing levels, Unit staffing remained constant and did not align with the growing Medicaid expenditures.
4. Although the Unit coordinated with Federal partners, it worked few joint cases with them, missing opportunities for sharing resources and training.
5. The Unit did not always report convictions or adverse actions to Federal partners within the appropriate timeframes.
6. Sixty-two percent of the Unit's case files lacked documentation of periodic supervisory reviews.
7. Although the Unit maintained an annual training plan for its staff, Unit supervisors did not consistently track or verify that staff documented their training.
8. The Unit's case management system made it difficult for Unit staff to retrieve case information and performance data.
9. The Unit's memorandum of understanding (MOU) with the State Medicaid agency did not reflect current practice or law.

# Report in Brief continued

Report No OEI-06-21-00270

## What OIG Recommends

To address the findings and further improve Unit operations, we recommend that the Unit:

1. Build upon its efforts to increase fraud referrals from the State Medicaid agency.
2. Refund the Federal grant for unsupported expenditures and establish processes to ensure Unit involvement and oversight of fiscal controls and reporting.
3. Assess the adequacy of existing staffing levels and, if appropriate, develop a plan to expand the size of the Unit.
4. Seek opportunities, as appropriate, to investigate more joint cases with Federal partners.
5. Develop and implement processes to ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes.
6. Ensure that supervisory reviews of case files are documented in accordance with Unit policy.
7. Ensure that Unit supervisors track and verify that all staff in professional disciplines document their training.
8. Implement a new, comprehensive case management system that allows for efficient access to case documents and information.
9. Revise its MOU with the State Medicaid agency to reflect current practice and law.

The Unit concurred with all nine recommendations.

# TABLE OF CONTENTS

<b>BACKGROUND</b> .....	<b>1</b>
<b>CASE OUTCOMES</b> .....	<b>7</b>
<b>FINDINGS</b> .....	<b>8</b>
The Unit received few fraud referrals from the State Medicaid agency, and despite the Unit taking steps to increase these referrals, they remained low .....	8
The Department of Attorney General repeatedly submitted the MFCU’s financial reports late, lacked support for some MFCU expenditures, and lacked accounting procedures, raising concerns about the MFCU’s fiscal controls .....	10
Despite the Unit’s request for additional resources to increase its staffing levels, Unit staffing remained constant and did not align with the growing Medicaid expenditures .....	12
Although the Unit coordinated with Federal partners, it worked few joint cases with them, missing opportunities for sharing resources and training.....	13
The Unit did not always report convictions or adverse actions to Federal partners within the appropriate timeframes.....	14
Sixty-two percent of the Unit’s case files lacked documentation of periodic supervisory reviews.....	16
Although the Unit maintained an annual training plan for its staff, Unit supervisors did not consistently track or verify that staff documented their training .....	17
The Unit’s case management system made it difficult for Unit staff to retrieve case information and performance data .....	18
The Unit’s MOU with the State Medicaid agency did not reflect current practice or law.....	19
<b>CONCLUSION AND RECOMMENDATIONS</b> .....	<b>20</b>
Build upon its efforts to increase fraud referrals from the State Medicaid agency.....	21
Refund the Federal grant for unsupported expenditures and establish processes to ensure Unit involvement and oversight of its fiscal controls and reporting.....	21
Assess the adequacy of existing staffing levels and, if appropriate, develop a plan to expand the size of the Unit.....	22
Seek opportunities, as appropriate, to investigate more joint cases with Federal partners .....	22
Develop and implement processes to ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes.....	22
Ensure that supervisory reviews of case files are documented in accordance with Unit policy .....	23

Ensure that Unit supervisors track and verify that all staff in professional disciplines document their training.....	23
Implement a new, comprehensive case management system that allows for efficient access to case documents and information .....	23
Revise its MOU with the State Medicaid agency to reflect current practice and law .....	23
<b>UNIT COMMENTS AND OIG RESPONSE.....</b>	<b>24</b>
<b>PERFORMANCE ASSESSMENT .....</b>	<b>26</b>
<b>APPENDICES.....</b>	<b>32</b>
Appendix A: Unit Referrals by Source for Fiscal Years 2018–2020.....	32
Appendix B: Detailed Methodology.....	33
Appendix C: Point Estimates and 95-Percent Confidence Intervals of Case File Reviews .....	36
Appendix D: Unit Comments.....	37
<b>ACKNOWLEDGMENTS AND CONTACT .....</b>	<b>42</b>
Acknowledgments .....	42
Contact.....	42
<b>ABOUT THE OFFICE OF INSPECTOR GENERAL.....</b>	<b>43</b>

# BACKGROUND

---

## OBJECTIVES

1. To examine three previously identified areas of concern related to fraud referrals, fiscal controls, and staffing levels of the Michigan Medicaid Fraud Control Unit (MFCU or Unit).
  2. To examine the Unit's performance and operations.
- 

## Medicaid Fraud Control Units

MFCUs 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>1,2,3</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>4</sup> Each State must operate a MFCU or receive a waiver.<sup>5</sup> Currently, 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate MFCUs.<sup>6</sup>

MFCUs are funded jointly by Federal and State Governments. 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>7</sup> In Federal fiscal year (FY) 2021, combined Federal and State expenditures for the MFCUs totaled approximately \$314 million, of which approximately \$235.5 million represented Federal funds.<sup>8</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> As of December 27, 2020, MFCUs may also receive Federal financial participation to investigate and prosecute abuse or neglect of Medicaid beneficiaries in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, Public Law 116-260, Division CC, Section 207.

<sup>3</sup> References to "State" in this report refer to the States, the District of Columbia, and the U.S. territories.

<sup>4</sup> SSA § 1903(q).

<sup>5</sup> SSA § 1902(a)(61).

<sup>6</sup> The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

<sup>7</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>8</sup> OIG analysis of MFCUs' reporting of expenditures for FY 2021. Unless stated otherwise, all FYs are October 1 through September 30.

## OIG Grant Administration and Oversight of MFCUs

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.<sup>9, 10</sup> As part of its oversight, OIG conducts a desk review of each Unit during the annual recertification process. OIG also conducts periodic inspections and reviews. Finally, OIG provides ongoing training and technical support to the Units.

In its annual recertification review, OIG examines the Unit's reapplication materials, 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>11</sup> the Unit's compliance with applicable laws, regulations, and OIG policy transmittals;<sup>12</sup> and the Unit's case outcomes.

OIG further assesses Unit performance by conducting inspections and reviews of selected Units. These inspections and reviews result in public reports of findings and recommendations for improvement. In these reports, OIG may also provide observations regarding Unit operations and practices, including beneficial practices that may be useful to share with other Units. OIG also provides training and technical assistance to Units, as appropriate, during inspections and reviews.

## Michigan MFCU

The Michigan MFCU, also known as the Healthcare Fraud Division, is located within the Michigan Department of Attorney General in East Lansing. The Office of Fiscal Management within the Department of Attorney General administers the MFCU's accounting and other fiscal functions. At the time of our onsite review in September 2021, the Unit had 31 employees—14 investigators (including 3 supervisory investigators and 1 chief investigator), 8 attorneys (including the MFCU director and deputy director), 1 analyst, 1 auditor, and 7 support staff.<sup>13</sup> During our review period of FYs 2018–2020, the Unit spent approximately \$16.2 million in Federal and State funds. To fulfill the State's obligation to provide a 25-percent share of the MFCU grant funding (amounting to approximately \$4 million), the Unit used proceeds from MFCU cases that were allocated to a designated fund for this purpose.

---

<sup>9</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>10</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>11</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 (September 26, 1994).

<sup>12</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>13</sup> Three Unit attorneys reported to the office in East Lansing and worked remotely from Detroit.

## Referrals

During FYs 2018–2020, the Unit reported receiving fraud and patient abuse or neglect referrals from several sources, including private citizens and the Michigan Department of Licensing and Regulatory Affairs (the State Survey and Certification agency), among other sources.<sup>14, 15</sup> See Appendix A for a list of Unit referrals by source for FYs 2018–2020.

When the Unit receives a referral of fraud or patient abuse or neglect, an assigned investigator determines whether the referral has merit and falls within the Unit's jurisdiction to open it as an investigation. If the investigator determines that the referral has merit and is within the Unit's jurisdiction, the investigator presents the referral to the Unit's intake committee for approval.<sup>16</sup> If the investigator determines that the referral does not have merit and/or is outside of the Unit's jurisdiction, the investigator presents it to the chief investigator to decline. When a referral is declined, the Unit closes the referral and either refers it to another agency or sends it back to the referring agency.

## Investigations and Prosecutions

Once the Unit accepts a referral, the intake committee, which includes the chief investigator, assigns an investigative team to the case. The investigative team consists of an investigator, at least one attorney, and a supervisory investigator.<sup>17</sup> The investigative team develops and completes an investigative plan, which outlines and assigns key investigative tasks to the team members. The team meets regularly to provide updates and discuss whether any additional steps are needed. The supervisory investigator also reviews each open investigation every 90 days to ensure that cases are progressing. Upon completion of the investigation as outlined in the plan, the Unit attorney assigned to the investigative team determines if there is sufficient evidence to support either civil or criminal prosecution and forwards a recommendation to the Unit director on how to proceed.

---

<sup>14</sup> The State's Survey and Certification agency is responsible for licensing and Federal certification regulatory duties, including accepting and processing complaints for more than 20 provider types in Michigan. Michigan Department of Licensing and Regulatory Affairs, *Agency Contacts – Community and Health Systems*. Accessed at <https://www.michigan.gov/lara/0,4601,7-154-76106-42245--,00.html> on January 24, 2022.

<sup>15</sup> In addition to referrals from external sources, in 2013 OIG approved the Michigan MFCU to engage in data mining, which allows the Unit to self-identify fraud referrals through analysis of Medicaid claims data. Data mining is defined as "the practice of electronically sorting Medicaid or other relevant data, including but not limited to, the use of statistical models and intelligent technologies to uncover patterns and relationships within that data to identify aberrant utilization, billing, or other practices that are potentially fraudulent." 42 CFR § 1007.1.

<sup>16</sup> At the time of our onsite review in September 2021, the Unit's intake committee consisted of the deputy director, the chief investigator, 2 attorneys, 2 supervisory investigators, 1 analyst, and 3 support staff.

<sup>17</sup> The Unit's analyst may also help the investigative team.



## Michigan Medicaid Program

The Michigan Department of Health and Human Services (MDHHS) administers the Michigan Medicaid program, which includes the State's Medicaid fee-for-service and managed care health care delivery systems.<sup>18</sup> In FY 2020, the program served 2.6 million beneficiaries and total program expenditures were \$19.8 billion.<sup>19, 20</sup> During FYs 2018–2020, the State of Michigan had 10 Medicaid managed care organizations (MCOs), which provided health care services to approximately 75 percent of the State's Medicaid beneficiaries.<sup>21, 22</sup>

### Medicaid Program Integrity

MDHHS-Office of Inspector General (MDHHS-OIG)—the State's program integrity unit—and the State's MCOs share primary responsibility for Medicaid program integrity efforts in Michigan.<sup>23, 24</sup> Under the managed care system, MDHHS contracts with the MCOs to process, pay, and monitor claims of providers in the MCOs' networks. Each MCO has a Special Investigative Unit that identifies and investigates potential fraud and abuse in its network and refers suspected allegations of provider fraud or patient abuse or neglect simultaneously to MDHHS-OIG and the MFCU.<sup>25</sup> MDHHS-OIG also conducts its own administrative investigations on referrals received, including those from MCOs, and, after determining that the allegations are credible, refers the suspected fraudulent activity to the MFCU. The MFCU reviews all referrals

---

<sup>18</sup> MDHHS, *Michigan Medicaid Program*. Accessed at <https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome> on April 23, 2022.

<sup>19</sup> The Centers for Medicare & Medicaid Services (CMS), *Medicaid Managed Care Enrollment and Program Characteristics, 2020*, p. 17. Accessed at <https://www.medicare.gov/medicaid/managed-care/downloads/2020-medicare-managed-care-enrollment-report.pdf> on April 23, 2022.

<sup>20</sup> OIG, *MFCU Statistical Data for FY 2020*. Accessed at [https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures\\_statistics/fy2020-statistical-chart.pdf](https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2020-statistical-chart.pdf) on January 24, 2022.

<sup>21</sup> The 10 Medicaid MCOs in Michigan are Aetna Better Health, Blue Cross Complete, HAP Empowered, McLaren, Meridian, Molina Healthcare, Priority Health Choice, Total Health Care, United Healthcare Community Plan, and Upper Peninsula. CMS, op. cit., pp. 74-81.

<sup>22</sup> In July 2020, 1,927,140 Medicaid beneficiaries in Michigan were enrolled in MCOs out of the total of 2,573,851 Medicaid beneficiaries in the State. Ibid.

<sup>23</sup> MDHHS, *The Office of Inspector General – Integrity Division*. Accessed at [https://www.michigan.gov/mdhhs/0,5885,7-339-73970\\_93787\\_94352\\_94355\\_94416\\_94427---,00.html](https://www.michigan.gov/mdhhs/0,5885,7-339-73970_93787_94352_94355_94416_94427---,00.html) on January 24, 2022.

<sup>24</sup> MDHHS-OIG has three divisions that are responsible for (1) investigating Medicaid fraud; (2) investigating welfare fraud (e.g., fraud related to food assistance programs); and (3) providing investigative and administrative support to the agency. MDHHS, *The Office of Inspector General – About Us*. Accessed at [https://www.michigan.gov/mdhhs/0,5885,7-339-73970\\_93787\\_94352---,00.html](https://www.michigan.gov/mdhhs/0,5885,7-339-73970_93787_94352---,00.html) on March 4, 2022.

<sup>25</sup> MCOs began to send referrals simultaneously to MDHHS-OIG and the MFCU after the MFCU requested to be copied on all referrals to MDHHS-OIG in June 2018. Prior to this, MCOs sent referrals to MDHHS-OIG, and MDHHS-OIG then determined which referrals to send to the MFCU.

from MDHHS-OIG and the MCOs to determine whether to open them as investigations and notifies these two agencies in writing of its determination.

## Previous OIG Reports and Oversight

OIG conducted a previous onsite review of the Michigan Unit in 2013.<sup>26</sup> In that review, OIG found that 21 percent of case files lacked documentation of supervisory approval to open cases and 67 percent of cases lacked documentation of periodic supervisory reviews. In addition, the Unit did not refer 69 percent of sentenced individuals to OIG for program exclusion within an appropriate timeframe. OIG also found that the Unit had not updated its policies and procedures manual to reflect current Unit operations, including its memorandum of understanding (MOU) with the State Medicaid agency.

On the basis of these findings, OIG recommended that the Unit (1) ensure that supervisory approval to open cases and periodic supervisory reviews are documented in Unit case files; (2) ensure that it refers individuals for exclusion to OIG within an appropriate timeframe; (3) revise its policies and procedures manual to reflect current Unit operations; and (4) revise its MOU with the State Medicaid agency to reflect current law and practice. The Unit concurred with the four recommendations and, based on the information received from the Unit, OIG considered the recommendations implemented as of November 2015.

## Methodology

We conducted an onsite review of the Michigan Unit in September 2021. The review team consisted of OIG evaluators, OIG agents, OIG auditors, and a chief investigator from another State MFCU. Our review covered the 3-year period of FYs 2018–2020. The primary purpose of this review was to examine three previously identified areas of concern related to fraud referrals, fiscal controls, and staffing levels. We identified these areas of concern through our ongoing oversight of the Unit during the review period. As part of this onsite review, we also examined the Unit's operations and adherence to the 12 MFCU performance standards and applicable Federal laws, regulations, and policy transmittals. In examining the Unit's operations and performance, we applied the published MFCU performance standards listed in the Performance Assessment on page 26. We did not assess adherence to every performance indicator for every standard.

We based our review on an analysis of data from seven sources: (1) Unit documentation, such as policies and procedures; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit's managers and selected staff; (5) review of a random sample of case files that were open at any point during the review period; (6) review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the

<sup>26</sup> OIG, Michigan State Medicaid Fraud Control Unit: 2013 Onsite Review, OEI-09-13-00070, January 2014.

National Practitioner Data Bank (NPDB) during the review period; and (7) onsite review of Unit operations. See Appendix B for a detailed methodology.

## Standards

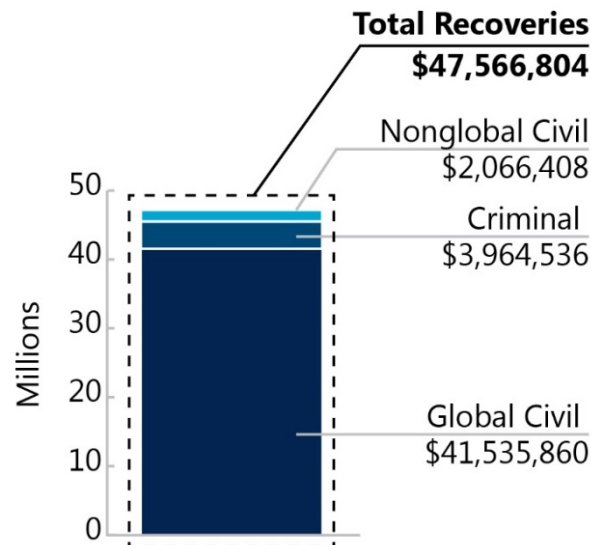
We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program,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

# CASE OUTCOMES

**The Michigan Unit reported 55 indictments, 53 convictions, and 59 civil settlements and judgments for FYs 2018–2020.**<sup>27</sup> The Unit reported strong case outcomes that involved a broad number of provider types. The Unit’s caseload also included a good balance of criminal and civil cases as well as fraud and patient abuse or neglect cases. Of the Unit’s 53 convictions, 30 involved provider fraud and 23 involved patient abuse or neglect. For more information, see Performance Standard 6 on page 28 in the Performance Assessment.



**The Unit reported \$47.6 million in total recoveries for FYs 2018–2020.** Of the Unit’s total recoveries, global civil recoveries represented approximately \$41.5 million.<sup>28</sup>



Source: OIG analysis of Unit statistical data, FYs 2018–2020.

<sup>27</sup> OIG provides information on MFCU operations and outcomes, but does not direct or encourage MFCUs to investigate or prosecute a specific number of cases. MFCU investigators and prosecutors should apply professional judgement and discretion in determining what cases to pursue.

<sup>28</sup> “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.

# FINDINGS

Our review examined three previously identified areas of concern related to the Michigan MFCU's fraud referrals, fiscal controls, and staffing levels; and assessed the Unit's adherence to the MFCU performance standards. We made nine findings regarding the Unit's adherence to the standards—including three findings that were also identified in OIG's 2013 onsite review—and for which we are issuing recommendations. Despite identifying several operational challenges that warrant further attention, we found that the Unit had strong case outcomes for FYs 2018–2020. See the Performance Assessment on page 26 for our full assessment of the Unit's adherence to all 12 MFCU performance standards, including other observations of Unit operations and practices.

## The Unit received few fraud referrals from the State Medicaid agency, and despite the Unit taking steps to increase these referrals, they remained low

During FYs 2018–2020, the Michigan MFCU received a total of 2,148 fraud referrals, but only 4 originated from MDHHS-OIG. OIG found the number of referrals that the Unit received from MDHHS-OIG to be very low compared to the number of referrals that similarly sized MFCUs received from State Medicaid program integrity units. For the similarly sized MFCUs, these referrals ranged from 28 to 236 during the same 3-year period.<sup>29</sup> Appendix A identifies the Michigan MFCU's referrals, by source, during FYs 2018–2020.

The Michigan MFCU's low number of fraud referrals is concerning because MFCUs investigate and prosecute fraud largely on the basis of actionable referrals from the State Medicaid program integrity units.<sup>30</sup> MDHHS-OIG should be a consistent fraud referral source for the MFCU, given that it has access to Medicaid claims data and has the responsibility to identify and refer potential fraud cases to the MFCU.

---

<sup>29</sup> We compared the Michigan MFCU, which had 31 staff in FY 2020, to similarly sized MFCUs, such as those with staff sizes that ranged from 21 to 39 employees. Although comparison across similarly sized MFCUs provides context for the case outcomes of a particular MFCU, many factors other than the size of a MFCU's staff can affect case outcomes.

<sup>30</sup> In accordance with 42 CFR § 455.23, State Medicaid agencies must refer all credible allegations of fraud to the respective MFCUs. CMS 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 but not limited to the following: (1) Fraud hotline tips verified by further evidence. (2) Claims data mining. (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be 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."

A total of four fraud referrals from MDHHS-OIG during our 3-year review period likely underrepresents potential Medicaid provider fraud in the State of Michigan. Michigan’s Medicaid program is 1 of the 10 largest Medicaid programs in the United States, and the U.S. Department of Justice established Detroit as a Health Care Fraud Strike Force city in 2010 because advanced data analysis identified the city as a “hot spot” with “high levels of billing fraud.”<sup>31</sup>

## The Unit took several steps to help increase the number of fraud referrals from MDHHS-OIG

Over the course of our review period, the Unit established bimonthly meetings with MDHHS-OIG, provided and attended trainings between the two agencies, and improved the timeliness of its investigations in an effort to increase the number of fraud referrals from MDHHS-OIG. These steps hold promise to increase the number of fraud referrals from MDHHS-OIG.

**Established Bimonthly Meetings.** In FY 2020, the Unit established a schedule of bimonthly meetings with MDHHS-OIG to communicate the status of MDHHS-OIG’s referrals that were accepted for investigation and to discuss potential future referrals. These meetings were initiated in response to a previous concern raised by MDHHS-OIG’s investigative staff that the Unit did not regularly provide them status updates on accepted referrals. MDHHS-OIG reported an improvement in proactive updates as a result of these meetings.

**Performance Standard 4:**  
The Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

**Provided and Attended Trainings.** The Unit provided MDHHS-OIG one training every year during our review period. Examples of training included a presentation on the False Claims Act and a litigation simulation, which MDHHS-OIG officials reported was well-received. Additionally, MFCU staff attended two MDHHS-OIG trainings during our review period. Both agencies reported that they plan to organize future trainings and opportunities to share knowledge and operational insights about each other’s agencies.

**Improved Timeliness of Its Investigations.** The Unit improved the timeliness of its investigations, making a focused effort to resolve or close aging cases. We found that the number of cases open longer than 3 years decreased by 37 percent during FYs 2018–2020. This improvement addressed a previous concern raised by MDHHS-OIG that the pace of MFCU investigations was “slow” and affected MDHHS-OIG’s ability to take administrative action (e.g., collect overpayments) when the MFCU

<sup>31</sup> The Health Care Fraud Strike Force consists of an interagency team of Federal, State, and local law enforcement agencies that investigate and prosecute fraud in areas with concentrated fraudulent activity. As of June 2022, there are 16 Health Care Fraud Prevention and Enforcement Action Team (HEAT) Strike Force cities and regions across the United States. Department of Justice, *Strike Force Operations*. Accessed at <https://www.justice.gov/criminal-fraud/strike-force-operations> on April 13, 2022.

ultimately decided to decline prosecution of the referral.<sup>32</sup> Before the recent improvement in the pace of MFCU investigations, MDHHS-OIG staff reported that they had been “more conservative” in the number of referrals they sent to the MFCU.

## **The Department of Attorney General repeatedly submitted the MFCU’s financial reports late, lacked support for some MFCU expenditures, and lacked accounting procedures, raising concerns about the MFCU’s fiscal controls**

According to Performance Standard 11, the MFCU should promptly submit to OIG its financial documentation (i.e., budgets and Federal Financial Reports) and apply accepted accounting principles in its control of Unit funding. Similar to what is done in other States, the MFCU’s fiscal controls were administered by an office within the Michigan Department of Attorney General, the Office of Fiscal Management. However, we found that its fiscal controls were noncompliant with Federal regulations in three areas.<sup>33</sup> Specifically, we found that the Office of Fiscal Management, on behalf of the Michigan MFCU, (1) submitted most of the MFCU’s Federal Financial Reports late; (2) lacked support for some MFCU expenditures; and (3) had not updated its policies and lacked detailed procedures for its new accounting system. At the time of our review, the Unit director acknowledged that he had limited involvement with the Office of Fiscal Management, and therefore, he was not aware of the extent of the fiscal control issues identified in this report. Both the Unit director and Office of Fiscal Management staff expressed that greater MFCU involvement in fiscal oversight would be beneficial.

### **The Department of Attorney General submitted 13 of 15 Federal Financial Reports for the MFCU late**

We found that the Office of Fiscal Management submitted 13 of 15 required Federal Financial Reports late during our review period.<sup>34</sup> The MFCU must submit its quarterly financial reports to OIG within 1 month after the close of each quarter and must submit its final financial report to OIG within 3 months after the close of the fiscal year.<sup>35</sup> Of these late financial reports, one was more than 6 months late, three were more than 3 months late, and five were more than 1 month late. The other four were submitted within a few days to a few weeks late. These financial reports are important for ensuring that the Unit’s expenditures meet grant requirements and assisting with fiscal monitoring of the Unit’s funds spent. Moreover, the Unit may

---

<sup>32</sup> During OIG’s review, we did not examine or verify MDHHS-OIG’s concern that MFCU investigations were unreasonably slow.

<sup>33</sup> 45 CFR §§ 75.341, 75.381(a), and 75.403(g).

<sup>34</sup> 45 CFR § 75.341. The MFCU Award Terms and Conditions require quarterly financial reporting.

<sup>35</sup> 45 CFR §§ 75.341 and 75.381(a); MFCU Award Terms and Conditions.

experience significant delays in Federal reimbursement if these financial reports are not submitted timely.

Staff from the Office of Fiscal Management reported that they experienced significant staff turnover during our review period, which contributed to the late submissions of Federal Financial Reports. Although OIG provided technical assistance and training on completing and submitting financial reports to newly hired staff in the Office of Fiscal Management, these staff were not employed long enough to learn the MFCU grant requirements. The Unit director reported that he did not review or approve any financial reports during our review period and that he was unaware that he could request to review and approve these reports.

### **The Department of Attorney General did not maintain documentation for 8 of the 120 sampled MFCU expenditures**

The MFCU must adequately document expenditures for the expenditures to be allowable under Federal awards.<sup>36</sup> However, we found that the Office of Fiscal Management did not maintain documentation for 8 of the 120 sampled MFCU expenditures, totaling \$42,798 (\$32,098 Federal share). These expenditures were related to items such as employee travel and services. Prior to FY 2020, expenditure documentation was not required to be stored electronically within the Office of Fiscal Management's accounting system. During this time, it was the MFCU's responsibility to provide the Office of Fiscal Management any documentation stored outside of the accounting system (i.e., paper files). Documents not included within the OFM accounting system were considered missing or misfiled. Starting in FY 2020, the Office of Fiscal management reported that all of the MFCU's expenditure documentation is required to be stored electronically. Despite this change, we found missing documentation during all 3 years of our review period. The Unit director reported that he was unaware that documentation for some MFCU expenditures was missing.

### **The Department of Attorney General lacked policies and procedures for its new accounting system**

The State must account for its MFCU grant funds in accordance with State laws and procedures for expending and accounting for its own funds.<sup>37</sup> The State of Michigan implemented a new accounting system in FY 2018; however, as of April 2022, the Office of Fiscal Management had not updated its policies and procedures to provide guidance for the new system. According to staff in the Office of Fiscal Management, the lack of detailed procedures and staff's unfamiliarity with the new accounting system contributed to delays and uncertainties with the Unit's fiscal reporting.

---

<sup>36</sup> 45 CFR § 75.403(g).

<sup>37</sup> 45 CFR §§ 75.302(a) and 75.400.



## Despite the Unit’s request for additional resources to increase its staffing levels, Unit staffing remained constant and did not align with the growing Medicaid expenditures

According to Performance Standard 2(b), the Unit should employ a number of staff that is commensurate with the State’s Medicaid expenditures and enables Units to effectively investigate and prosecute an appropriate volume of case referrals and workload for Medicaid fraud and patient abuse or neglect. We found that, despite a significant increase in the State Medicaid expenditures in the last 10 years, the Unit’s number of employees remained constant. State Medicaid expenditures increased from \$12.6 billion in FY 2011 to \$21.3 billion in FY 2021, representing a 70 percent increase, while the Unit’s number of staff increased only by 3 employees—from 28 to 31 employees (see Exhibit 1).

**Exhibit 1: The Unit’s number of staff remained constant while the State Medicaid expenditures increased significantly during FYs 2011–2021.**



Source: OIG analysis of Unit-provided documentation, FYs 2011–2021. State Medicaid expenditures are reported in the billions of dollars.

While OIG does not prescribe MFCU staffing levels, OIG observed that the Michigan MFCU was significantly smaller than the MFCUs in States with similarly sized Medicaid programs. Applying a statistical regression model to all 53 States with MFCUs (including the District of Columbia and two U.S. territories) for FY 2021, OIG estimated a staff size of 50 for the Michigan MFCU.<sup>38</sup>

The Unit director expressed to OIG the need for additional staff across all disciplines. However, he explained that low staffing levels are common across State offices in Michigan, including the MFCU, and that the State legislature has been hesitant to increase the size of State government for many years. Between FYs 2001 and 2021,

<sup>38</sup> OIG’s FY 2021 statistical regression model used States’ Medicaid expenditures and MFCU’s staff size in its analysis. Applying a 90-percent confidence interval, the Michigan MFCU had a lower bound of 22 staff and an upper bound of 116 staff.

the number of State employees in Michigan decreased by 39 percent.<sup>39</sup> In February 2021, the Unit director submitted a request to the Department of Attorney General to add four more staff to the Unit, but according to the director, the Department of Attorney General never advanced this request to the State legislature.

The Unit director believed that the Unit's stagnant staffing levels had limited the Unit's ability to conduct data mining, which could generate additional fraud referrals. Although the Unit identified some cases through data mining, the Unit director explained that effective data mining efforts require considerable resources and ongoing support, including training staff. The Unit currently employs one data analyst who is trained in data mining but also has additional analytical responsibilities. Unit management reported that in addition to the need for another data analyst, the Unit will need more investigative staff to work cases generated from increasing data mining efforts and fraud referrals from MDHHS-OIG.

The MFCU's staffing limitations also affected its participation in other fraud and patient abuse or neglect initiatives, such as the Health Care Fraud Strike Force.<sup>40</sup> The director explained that these law enforcement initiatives are very "staff-intensive," which would present a workload issue for the existing MFCU staff.

## Although the Unit coordinated with Federal partners, it worked few joint cases with them, missing opportunities for sharing resources and training

Performance Standard 8(b) states that the Unit should cooperate and, as appropriate, coordinate with OIG and other Federal agencies on cases being pursued jointly; cases involving the same suspects or allegations; and cases that are referred to the Unit by OIG or another Federal agency. We found that the Unit coordinated with Federal partners—OIG and the U.S. Attorney's Offices—during our review period

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

<sup>39</sup> House Fiscal Agency, "Budget Briefing: State Budget Overview," *The Michigan House of Representatives*, January 2021, p. 23. Accessed at [https://www.house.mi.gov/hfa/PDF/Briefings/state\\_budget\\_overview\\_briefing\\_fy20-21.pdf](https://www.house.mi.gov/hfa/PDF/Briefings/state_budget_overview_briefing_fy20-21.pdf) on June 6, 2022.

<sup>40</sup> The director reported that the Unit routinely participated in special initiatives prior to 2011, including "Project \$CAMS," a Statewide law enforcement initiative to protect nursing home residents from financial exploitation. The initiative was sponsored by the Michigan Department of Attorney General and the Office of Inspector General for the Social Security Administration, and included other partners, such as the U.S. Department of Treasury and the Health Care Association of Michigan.

through its “deconfliction” of cases with Federal partners.<sup>41</sup>

We found that aside from participating in deconfliction, the Unit worked few joint cases with Federal partners. During our 3-year review period, the Unit investigated 13 cases jointly with OIG, which represented only 1 percent of the Unit’s total cases. Additionally, we found that the Unit did not participate in the Health Care Fraud Strike Force operations, which OIG co-leads with the U.S. Department of Justice. According to OIG staff, one reason for the low number of joint cases was that the Unit did not have an office in Detroit (although three MFCU attorneys worked there remotely), where many OIG cases are investigated. We found that despite working few cases with OIG, the Unit maintained a positive working relationship with OIG, including regularly communicating about cases, requesting assistance from OIG’s computer forensic team, and responding quickly to OIG’s data requests.

Similarly, we found that the Unit maintained a positive working relationship with the two U.S. Attorney’s Offices (in the Eastern and Western Districts) but had few cases prosecuted by either Office. Despite the low number of joint cases, officials in those districts described the Unit as a valuable resource and reported positive interactions with Unit staff. For example, the Western District reported consulting with the Unit on cases.

One potential advantage of joint State-Federal cases is the opportunity to access and share expertise and resources (e.g., equipment and personnel) more effectively with other law enforcement agencies. We found that the Unit missed such opportunities by working few joint cases with Federal partners. The Unit also missed valuable opportunities for “on-the-job” training through joint casework with OIG and other Federal partners, which can be especially valuable for complex Medicaid fraud cases. During our onsite review, Unit management and staff expressed interest in working more joint cases with Federal partners.

## The Unit did not always report convictions or adverse actions to Federal partners within the appropriate timeframes

Performance Standard 8(f) states that the Unit should transmit to OIG all pertinent 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 courts.<sup>42</sup> Pertinent information includes charging documents, plea agreements, and sentencing orders, so that convicted individuals can be excluded from Federal health care programs. The Unit must also report any adverse actions against health care

---

<sup>41</sup> In law enforcement, deconfliction is the process of identifying and discussing cases that involve the same suspects and allegations to avoid duplicative and overlapping actions. Even though the Unit coordinated its cases with Federal partners, case coordination was not consistently documented in the Unit’s case management system. For more information about the deficiencies of the Unit’s case management system, see Finding on page 18.

<sup>42</sup> 42 CFR § 1007.11(g). Convictions include those obtained by either Unit prosecutors or non-Unit prosecutors in any case investigated by the Unit.

practitioners, providers, or suppliers to the NPDB within 30 calendar days of the date of the adverse action.<sup>43, 44</sup> Consistent with findings from our 2013 onsite review, we found that the Unit did not always report convictions to OIG or adverse actions to the NPDB within the appropriate timeframes during FYs 2018–2020 (see Exhibit 2).<sup>45</sup>

**Exhibit 2: The MFCU reported 48 percent of its convictions and 83 percent of its adverse actions late to Federal partners.**



Source: OIG analysis of Unit-provided documentation, FYs 2018–2020.

**The Unit reported 48 percent of its convictions to OIG more than 30 days after sentencing**

The Unit reported 25 of its 52 convictions (48 percent) to OIG more than 30 days after sentencing.<sup>46</sup> Specifically, the Unit reported 7 convictions between 31 to 60 days after sentencing, 1 conviction between 60 to 90 days after sentencing, and 17 convictions more than 90 days after sentencing. Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in improper payments to providers by the Medicaid program or other Federal health care programs as well as possible harm to beneficiaries.

Unit management explained that one of the Unit’s staff members, who had been assigned to submit convictions to OIG, failed to submit them on time. The Unit reported these convictions to OIG as soon as it realized that the convictions had not been reported.

<sup>43</sup> 45 CFR § 60.5. Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(g)(1).

<sup>44</sup> Performance Standard 8(g) states that the Unit should report “qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases.” The HIPDB and the NPDB merged in 2013; therefore, we reviewed the reporting of adverse actions under NPDB requirements. See 78 Fed. Reg. 20473 (April 5, 2013).

<sup>45</sup> The 2013 OIG onsite review found that the Unit failed to report 44 of 64 convictions (69 percent) to OIG for program exclusion. Of these convictions, the Unit did not report 19 of them until 2 years after sentencing and 6 of them until 3 years after sentencing. Unit management reported that they were unaware of the Federal requirement that Units must report to OIG individuals who were sentenced for financial exploitation of residential health care facility patients. The Unit reported these individuals to OIG at the time of the onsite review after it learned about the requirement.

<sup>46</sup> OIG did not include late reporting of convictions where the MFCU encountered significant delays in receiving necessary sentencing information from the court.

## The Unit reported 83 percent of its adverse actions to the NPDB more than 30 days after the adverse action

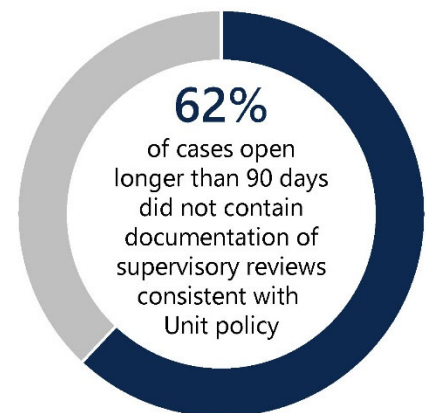
The Unit reported 30 of its 36 adverse actions (83 percent) to the NPDB more than 30 days after the adverse action. Of the 30 adverse actions submitted late, the Unit reported 9 adverse actions between 31 to 60 days after the action and 21 adverse actions more than 90 days after the action. The NPDB is intended to restrict the ability of health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions. If a Unit fails to report adverse actions to the NPDB, individuals may be able to find new health care employment with an organization that is not aware of the adverse action against them.

Unit management explained that several factors impacted the Unit's timeliness in reporting to the NPDB. For example, the Unit staff member who was designated to report convictions to OIG was also responsible for reporting adverse actions to the NPDB, and failed to submit either. The Unit reported these adverse actions to the NPDB as soon as it realized that the actions were not reported. Unit management also said that it was unaware that the Unit was required to report individuals sentenced for financial exploitation of residential health care facility patients to the NPDB, in addition to OIG. After OIG provided technical assistance to the Unit related to this requirement, the Unit reported the adverse actions to the NPDB.

## Sixty-two percent of the Unit's case files lacked documentation of periodic supervisory reviews

Performance Standard 7(a) states that supervisory reviews should be conducted periodically, consistent with Unit policies and procedures, and noted in the case file. During our review period, the Unit policy required a supervisory review of case files every 90 days. Periodic supervisory review of cases during the investigation and prosecution phases can help ensure timely completion of cases and constitute "on-the-job" training and development opportunities for new investigators, and documenting those reviews in the case files can help ensure that cases are properly managed.

Consistent with findings from our 2013 onsite review, we found that for cases that were open longer than 90 days, 62 percent did not contain documentation of quarterly supervisory reviews



consistent with Unit policy.<sup>47</sup> Of these case files, 37 percent did not contain documentation of supervisory reviews every 90 days (i.e., the supervisory reviews were conducted less frequently) and 25 percent did not contain documentation of any supervisory review during our 3-year review period. Unit management and staff explained that investigative teams generally discussed their cases with supervisors during team meetings and other informal conversations. The Unit's collaborative approach of involving investigators, the data analyst, and attorneys in team meetings helped ensure that cases were properly managed and progressed as planned. However, the investigative teams did not consistently document supervisory reviews or team meetings in the case files. We found that the Unit inconsistently documented its supervisory reviews because of the deficiencies of its case management system (see Finding on page 18). See Appendix C for an expanded list of case file review point estimates and confidence intervals.

## Although the Unit maintained an annual training plan for its staff, Unit supervisors did not consistently track or verify that staff documented their training

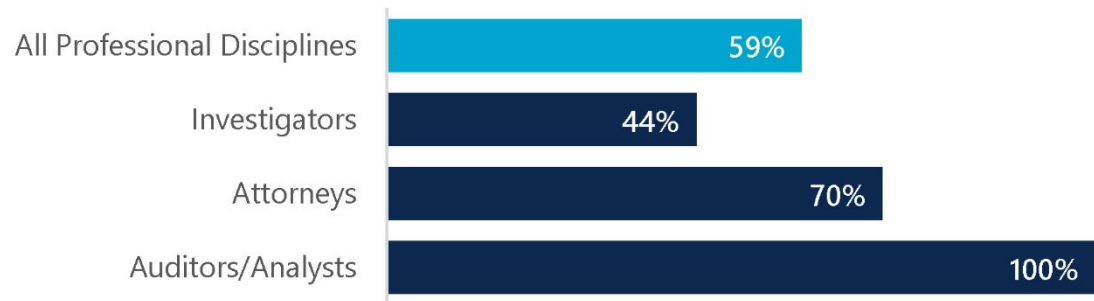
Performance Standard 12(a) states that the Unit should maintain a training plan for all professional disciplines (i.e., investigators, attorneys, and auditors/analysts) that includes an annual minimum number of training hours. In reviewing the Unit's training records, we found that the Unit maintained training plans for all professional disciplines and required that these staff complete a minimum number of training hours annually. However, we found that staff did not consistently enter their completed training in the Unit's training system, and Unit supervisors did not track or verify that staff recorded their training hours (see Exhibit 3 on the next page). Specifically, we found that 44 percent of investigators, 70 percent of attorneys, and 100 percent of auditors/analysts did not document their completed training in the Unit's training system during our review period.

**Performance Standard 12(b):**  
The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.

---

<sup>47</sup> The 2013 OIG onsite review found that the Unit's case files lacked periodic supervisory reviews and recommended that the Unit ensure that periodic supervisory reviews were documented. In response, the Unit developed a case status form to ensure that periodic supervisory reviews were documented in the case files. The Unit also revised its policies and procedures manual to reflect its required practice of conducting quarterly supervisory reviews.

**Exhibit 3: More than half of all Michigan MFCU staff in professional disciplines did not document training hours according to Unit policy.**



Source: OIG analysis of Unit-provided documentation, calendar years 2018–2020.

In interviews, Unit staff reported that they did not always document trainings, particularly if they were conducted outside of the Department of Attorney General because those trainings had to be entered manually in the Unit’s training system. Staff explained that either documenting trainings manually in the system was too time-consuming or the staff simply forgot to record the hours. Unit supervisors reported sending officewide reminders to staff about entering training hours in the system but acknowledged that they did not consistently follow up to ensure that all staff entered those hours into the system. As a result, Unit supervisors could not identify which staff needed reminders to complete or document trainings in order to meet minimum training hours.

## The Unit’s case management system made it difficult for Unit staff to retrieve case information and performance data

At the time of our review, the Unit used the Department of Attorney General’s officewide case management system to maintain and retrieve case file information. Although the system stored different types of files electronically, we found that its features limited the Unit’s ability to efficiently organize and retrieve pertinent case information. For example, the case management system limited the size of files that could be uploaded and how documents were organized, and we found it difficult to locate specific documents within the system. Unit staff further reported that they found it difficult to label files in a descriptive manner using the system’s pre-set classifications and default naming settings. Finally, Unit management reported that the case management system lacked the ability to efficiently generate the performance data reports required by OIG and that the Unit had to use manual workarounds within the system to track case outcomes, such as monetary recoveries, and other performance data.

**Performance Standard 7(f):**  
The Unit should have a system that allows for the monitoring and reporting of case information.

We found that to mitigate these shortcomings, Unit staff used the system on an inconsistent basis and sometimes relied on files saved on their computers or in paper form to document case information and progression. Although Unit investigators were expected to upload all necessary documents immediately, some investigators did not upload documents until the end of their investigations. Uploading these documents in a timely manner would benefit both Unit supervisors and newly assigned staff by enabling them to review case information and progression efficiently. After the onsite review, OIG provided the Unit with technical assistance on how to better document and organize case information using its current system. For a long-term solution, Unit management reported that it is exploring different case management systems that would allow for more efficient access and retrieval of case information.

## The Unit's MOU with the State Medicaid agency did not reflect current practice or law

According to OIG regulation, the State Medicaid agency and the Unit should establish procedures by which the Unit will receive referrals of potential fraud from MCOs.<sup>48</sup> At the time of our onsite review in September 2021, the Unit's MOU with MDHHS-OIG lacked procedures for receiving potential fraud referrals from MCOs.<sup>49</sup> Although not included in the MOU, Unit staff reported that they had established informal procedures for how to receive MCO referrals. Starting in FY 2018, the Unit requested that all MCOs send referrals simultaneously to the Unit and MDHHS-OIG.

Further, we found that the MOU did not include a provision requiring the Unit to review its MOU with MDHHS-OIG at least every 5 years to ensure that it reflects current practice and law, as required by OIG regulation and Performance Standard 10(a).<sup>50</sup> The Unit director acknowledged that the MOU needed to be updated and stated that the Unit had already started negotiations with MDHHS-OIG staff. The Unit director explained that in addition to including these two provisions, the revised MOU would include any other relevant information from the 2021 OIG onsite review.

---

<sup>48</sup> 42 CFR § 1007.9(d)(3)(iv).

<sup>49</sup> This is different from the issue found in OIG's 2013 onsite review, which found that the Unit's MOU with MDHHS-OIG did not include the referral process for providers who were subject to a payment suspension based on a credible allegation of fraud. 42 CFR § 1007.9(d).

<sup>50</sup> 77 Fed. Reg. 32648 (June 1, 2012); 42 CFR § 1007.9(d)(3)(v).



# CONCLUSION AND RECOMMENDATIONS

We made nine findings based on our review of three previously identified areas of concern (fraud referrals, fiscal controls, and staffing levels) and the Unit's adherence to the MFCU performance standards, which warrant further attention. The Unit director acknowledged the operational challenges that we identified and was taking steps to address them at the time of our review. Despite the many challenges, we found that the Michigan MFCU had strong case outcomes for FYs 2018–2020.

Through our review, we found that the Unit received few fraud referrals from the State Medicaid agency, and despite the Unit taking steps that hold promise to increase these referrals, they remained low. We also found that the Department of Attorney General repeatedly submitted the MFCU's financial reports late, lacked support for some expenditures, and lacked accounting procedures, raising concerns about the MFCU's fiscal controls. We found that despite the Unit's request for additional resources to increase its staffing levels, Unit staffing remained constant and did not align with the growing Medicaid expenditures.

Although the Unit coordinated and had positive relationships with Federal partners, we found that the Unit worked few joint cases with them, missing opportunities for sharing resources and training. We also found that, although the Unit maintained an annual training plan for its staff, Unit supervisors did not consistently track or verify that staff documented their training. Further, we found that the Unit's case management system made it difficult for Unit staff to retrieve case information and performance data.

Additionally, we found that some operational issues have persisted since OIG's onsite review in 2013. We found that the Unit did not always report convictions and adverse actions to Federal partners within the appropriate timeframes. We also found that although Unit supervisors reported conducting periodic supervisory reviews of all case files, 62 percent of the Unit's case files lacked documentation of periodic supervisory reviews. Lastly, we found that the Unit's MOU with the State Medicaid agency did not reflect current practice or law. To address the findings in this report and further improve Unit operations, we make nine recommendations to the Michigan MFCU.

## **We recommend that the Michigan MFCU:**

### **Build upon its efforts to increase fraud referrals from the State Medicaid agency**

To ensure that the Unit receives an adequate number of fraud referrals, the Unit should continue to build upon its efforts to address MDHHS-OIG's concerns, such as providing regular updates and feedback on active and potential referrals, as well as seeking more opportunities to participate in training. The Unit should also continually assess whether its efforts are helping increase referrals of potential fraud and if there are other ways to improve its relationship with MDHHS-OIG.

### **Refund the Federal grant for unsupported expenditures and establish processes to ensure Unit involvement and oversight of its fiscal controls and reporting**

On the basis of OIG's finding, the Unit and the Office of Fiscal Management should (1) refund the Federal grant of \$32,098 for unsupported expenditures and (2) establish internal controls to prevent unsupported expenditures in the future and ensure compliance with Federal regulations. Specific to establishing internal controls, the Unit and the Office of Fiscal Management should take the following actions to address the fiscal issues identified in this report:

- a) create internal controls to ensure that the Unit submits all required Federal Financial Reports timely;
- b) maintain supporting documentation for future expenditures on the Federal grant; and
- c) make clear in the Unit's policies and procedures manual the Unit's fiscal responsibilities in supporting allowable costs and submitting timely and accurate financial reports.

As an example of an internal control, the Unit and the Office of Fiscal Management could establish processes in which the Unit director reviews and approves all financial submissions prepared by the Office of Fiscal Management to ensure that financial reports submitted to OIG are accurate. As a further aid to ensure timely submissions to OIG, the Unit and the Office of Fiscal Management could create internal deadlines to prepare and review the financial documents ahead of grant deadlines.

## **Assess the adequacy of existing staffing levels and, if appropriate, develop a plan to expand the size of the Unit**

The Unit should perform an assessment of its staffing needs and the potential benefits of additional staff resources for Unit operations. In developing this assessment, the Unit should consider including its current needs to further develop its data mining capabilities and participate in Federal law enforcement initiatives. The Unit should also consider providing specific information on the return on investment of current resources and how additional resources could augment the Unit's outcomes. On the basis of the results of its assessment, the Unit should, if appropriate, develop an expansion plan to increase its staffing levels to meet the needs of the Medicaid program. OIG would be available to review the expansion plan and offer any technical assistance for its implementation.

## **Seek opportunities, as appropriate, to investigate more joint cases with Federal partners**

The Unit should seek more opportunities, as appropriate, to investigate joint cases with Federal partners and should consider seeking to join the Health Care Fraud Strike Force initiative. Participating in the Strike Force and other Federal cases would provide the Unit with opportunities for sharing resources with Federal partners and receiving additional training on complex fraud cases. The Unit should also assess its office location and consider whether opening additional office locations in other parts of the State, such as the Detroit area, is warranted by the volume of case referrals and potential workload; this may facilitate increased collaboration with OIG and other Federal partners stationed there.

## **Develop and implement processes to ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes**

The Unit should develop and implement processes to ensure that it reports all convictions to OIG within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court. The Unit should also develop and implement processes to ensure that it reports all adverse actions to the NPDB within 30 days of the action. The Unit's processes for reporting convictions and adverse actions to Federal partners should be included in its policies and procedures manual. The Unit should also inform staff that all convictions and adverse actions must be reported to Federal partners and emphasize the importance of timely reporting. The Unit could provide training to staff on reporting convictions and adverse actions to Federal partners to ensure that such reporting will occur in the event that staff members assigned to submit such reports are unavailable. The Unit

could also implement automated reminders that alert staff of this time-sensitive responsibility.

## **Ensure that supervisory reviews of case files are documented in accordance with Unit policy**

The Unit should ensure that supervisors document reviews of case files consistent with Unit policy. The Unit could develop a system—electronic or otherwise—that reminds supervisors to both conduct and document the periodic reviews.

## **Ensure that Unit supervisors track and verify that all staff in professional disciplines document their training**

Unit supervisors should track and verify whether professional staff document training in the Unit’s training system to ensure that they complete the minimum number of annual training hours. To ensure that all professional staff document their training, the Unit could remind staff about the importance of reporting their training hours and set up automatic reminders for staff who are noncompliant in documenting training.

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

The Unit should seek approval from the Department of Attorney General to acquire a new case management system that allows for efficient access to case information and performance data. The Unit should ensure that the new case management system enables the Unit to efficiently meet its needs, including the ability to store case documents and information and produce performance data.

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

The Unit should revise its MOU with MDHHS-OIG to establish procedures by which the Unit will receive referrals of potential fraud from MCOs. The Unit should also revise its MOU to include the requirement that the Unit and MDHHS-OIG agree to review, and if necessary, update the MOU no less frequently than every 5 years to ensure that the agreement reflects current law and practice.

# UNIT COMMENTS AND OIG RESPONSE

The Michigan MFCU concurred with all nine of our recommendations.

First, the Unit concurred with our recommendation to build upon its efforts to increase fraud referrals from the State Medicaid agency. The Unit reported that it will continue to demonstrate to MDHHS-OIG the value of increased program surveillance and referrals to the MFCU. The Unit reported that it will continue to hold formal meetings with MDHHS-OIG, as directed by its memorandum of understanding, and will promote joint training with MDHHS-OIG.

Second, the Unit concurred with our recommendation to refund the Federal grant for unsupported expenditures and establish processes to ensure Unit involvement and oversight of fiscal controls and reporting. The Unit stated that the Department of Attorney General will refund the Federal grant \$32,098 within 60 days of receiving repayment instructions. The Unit also reported that the Office of Fiscal Management within the Department of Attorney General plans to update and/or establish policies and procedures to ensure that all expenditures are supported and all Federal Financial Reports are filed timely. The Unit also noted that updates to accounting policies and procedures are underway to reflect the current accounting system, which the Unit expects to be completed in FY 2023. Additionally, the Unit reported that it plans to update the Unit operations manual to include a new section on grant management and fiscal duties. Under the new section, the Unit director will have joint responsibility with the Office of Fiscal Management for filing the Federal Financial Reports on time.

Third, the Unit concurred with our recommendation to assess the adequacy of existing staffing levels and, if appropriate, develop a plan to expand the size of the Unit. The Unit reported that it plans to draft an expansion plan, which it expects to complete by November 30, 2022. However, the Unit noted that regardless of available funding, the Department of Attorney General is bound by a legislatively imposed staffing cap and cannot hire more employees than allowed by the cap. In the event of an increase in the staffing cap, the Unit reported that it will have an expansion plan in place for potential implementation, subject to the approval of the Department of Attorney General.

While OIG appreciates that the Unit is developing an expansion plan, we continue to recommend that the Unit perform an assessment of its particular needs as a basis for developing the plan. OIG is available to provide technical assistance in formulating the plan and urges the Unit to continue communicating to the Department of Attorney General the level of staffing that is necessary to fulfill the Unit's mission.

Fourth, the Unit concurred with our recommendation to seek opportunities, as appropriate, to investigate more joint cases with Federal partners. The Unit reported that the director met with the new leader for the Detroit Health Care Fraud Strike Force and has additional meetings planned to discuss a role for the MFCU on the Strike Force.

Fifth, the Unit concurred with our recommendation to develop and implement processes to ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes. The Unit reported that it faced challenges during the review period to complete this task within the timeframes. The Unit is adding a section to its operations manual to ensure compliance with reporting requirements.

Sixth, the Unit concurred with our recommendation to ensure that supervisory reviews of case files are documented in accordance with Unit policy. The Unit reported that it will make changes to its case management system and operations manual and will provide training to managerial staff.

Seventh, the Unit concurred with our recommendation to ensure that Unit supervisors track and verify that all staff in professional disciplines document their training. The Unit reported that it will improve its process to document and track training and will update the operations manual to reflect this change.

Eighth, the Unit concurred with our recommendation to implement a new, comprehensive case management system that allows for efficient access to case documents and information. The Unit recognized that a case management system tailored to the MFCU would enhance Unit operations, but stated that the Department of Attorney General has adhered to a philosophy of maintaining an enterprise-wide system for all the Divisions in the Department to avoid a patchwork of systems with challenges in support, cost, and interoperability.

The Unit stated that it will continue to promote advancements in case management, either with a new system tailored to the Unit or with improvements to the current system, but understands that the Department of Attorney General is responsible for serving many Divisions and interests with fixed resources. OIG appreciates that the Department of Attorney General wants to avoid an inefficient patchwork of multiple case management systems, but continues to recommend that the Unit implement a system that will adequately serve its needs. OIG has identified the Unit's existing system as a significant barrier to improving the Unit's operations. If the Unit is unable to adequately adapt or modify the current enterprise-wide system, OIG continues to recommend that the Unit seek the necessary permission from the Department of Attorney General to acquire a new, comprehensive system to serve the Unit's needs.

Ninth, the Unit concurred with our recommendation to revise its MOU with MDHHS-OIG to reflect current practice and law. The Unit reported that it has formed a working group with MDHHS-OIG that will revise the MOU.

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

# PERFORMANCE ASSESSMENT

We assessed the Michigan MFCU's adherence to the 12 MFCU performance standards, including its compliance with applicable laws, regulations, and policy transmittals. From this review, we found that the Unit generally operated in accordance with applicable laws, regulations, and policy transmittals and reported strong case outcomes for FYs 2018–2020. We made nine findings that warrant further attention, which are presented here and in the body of the report. We also made observations about Unit operations and practices. The complete MFCU performance standards, including performance indicators, were published at 77 Fed. Reg. 32645 (June 1, 2012), and appear on OIG's website at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/>.

---

## Performance Standard 1: Compliance with Requirements

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

**Observation: From the information we reviewed, the Michigan MFCU generally complied with most applicable laws, regulations, and policy transmittals.**

However, we identified four compliance concerns. Two compliance concerns related to the Unit's coordination with Federal partners and its reporting of convictions and adverse actions to Federal partners, as reported under Performance Standard 8. The third compliance concern related to the Unit's MOU with the State Medicaid agency, as reported under Performance Standard 10. The fourth compliance concern related to the Unit's fiscal controls, as reported under Performance Standard 11.

---

## Performance Standard 2: Staffing

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.

**Finding: Despite the Unit's request for additional resources to increase its staffing levels, Unit staffing remained constant and did not align with the growing Medicaid expenditures.**

See page 12.

---

### Performance Standard 3: Policies and Procedures

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 written policies and procedures.**

The Unit maintained a policies and procedures manual, referred to as the operations manual, specific to the MFCU's functions and jurisdiction and separate from the Department of Attorney General's policies and procedures manual. The Unit's operations manual is available to Unit staff on a shared drive and was updated three times during our review period, most recently in September 2020.

The Unit's current operations manual is an improvement from the one reviewed during OIG's 2013 onsite review when we found that the Unit lacked certain policies for periodic supervisory reviews. During our 2021 onsite review, we observed that the current manual included procedures for the supervisory reviews, among other features. However, we found that the Unit staff did not always follow these procedures in practice. See page 16.

---

### Performance Standard 4: Maintaining Adequate Referrals

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

**Finding: The Unit received few fraud referrals from the State Medicaid agency, and despite the Unit taking steps to increase these referrals, they remained low.**

See page 8.

**Observation: The Unit conducted outreach to increase its visibility and generate more fraud and patient abuse or neglect referrals.**

The Unit reported several outreach efforts that improved the number and quality of both fraud and patient abuse or neglect referrals during our review period. Starting in FY 2018, the Unit requested that the State's 10 MCOs send referrals simultaneously to the Unit and MDHHS-OIG. We observed that the MCO referrals increased from 1 in FY 2018 to 57 in FY 2020. In FY 2020, the Unit and MDHHS-OIG established a pilot program wherein they would meet monthly with two MCOs to provide feedback on their referrals in real time. All four agencies reported improved communication and a better understanding on what constitutes a quality fraud referral. The Unit and MDHHS-OIG also reported plans to expand the program to other MCOs in the State.

Additionally, during our review period, both fraud and patient abuse or neglect referrals increased from the public, which was the Unit's largest source of referrals. To generate more referrals from the public, the Unit offered resources and assistance to local police departments, resulting in stronger relationships with local law enforcement officers who handle complaints from the public. During the review



period, the Unit received a total of 2,699 referrals, of which 86 percent (2,325) were from the public. See Appendix A for all sources of fraud and patient abuse or neglect referrals during FYs 2018–2020.

---

## Performance Standard 5: Maintaining Continuous Case Flow

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 for case openings and closings.**

According to Performance Standard 5(b), supervisors should approve the opening and closing of all investigations. Our review found that nearly all the case files contained documentation of supervisory approval of case openings and closings. An estimated 91 percent of case files had supervisory approval to open the case for investigation, and an estimated 98 percent of the Unit’s closed cases contained supervisory approval to close the case. See Appendix C for point estimates and confidence intervals for our case file review.

---

## Performance Standard 6: Case Mix

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 caseload included both fraud and patient abuse or neglect cases and covered a broad mix of provider types.**

Of the 923 cases that were opened during FYs 2018–2020, 83 percent (762) involved fraud, and 17 percent (161) involved patient abuse or neglect. During this period, the Unit’s cases covered 38 different provider types, including pharmaceutical manufacturers, medical device manufacturers, and pharmacies.

---

## Performance Standard 7: Maintaining Case Information

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: Sixty-two percent of the Unit’s case files lacked documentation of periodic supervisory reviews.**

See page 16.

**Finding: The Unit’s case management system made it difficult for Unit staff to retrieve case information and performance data.**

See page 18.

---

## Performance Standard 8: Cooperation with Federal Authorities on Fraud Cases

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

**Finding: Although the Unit coordinated with Federal partners, it worked few joint cases with them, missing opportunities for sharing resources and training.**

See page 13.

**Finding: The Unit did not always report convictions or adverse actions to Federal partners within the appropriate timeframes.**

See page 14.

---

## Performance Standard 9: Program Recommendations

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

**Observation: The Unit made two programmatic recommendations to the State Medicaid agency during our review period.**

First, the Unit recommended that MDHHS amend the State Medicaid Provider Manual to prevent behavioral health providers with a criminal history from providing therapy services to children with Autism Spectrum Disorders, consistent with the State's Public Health Code. Second, to reduce fraud in the State's home health program, the Unit recommended that MDHHS identify and recover overpayments from providers who did not provide services to beneficiaries or provided services in violation of the State's Medicaid policy. As part of this recommendation, the Unit requested that any of the beneficiary's family members be ineligible to receive Medicaid payment for providing any home health services to the beneficiary. At the time of our review, these two recommendations had not yet been implemented by MDHHS.

---

## Performance Standard 10: Agreement with Medicaid Agency

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.

**Finding: The Unit's MOU with the State Medicaid agency did not reflect current practice or law.**

See page 19.

---

## Performance Standard 11: Fiscal Control

A Unit exercises proper fiscal control over its resources.

**Finding: The Department of Attorney General repeatedly submitted the MFCU's financial reports late, lacked support for some MFCU expenditures, and lacked accounting procedures, raising concerns about the MFCU's fiscal controls.**

See page 10.

**Observation: The Department of Attorney General submitted three of its indirect cost rate proposals late to the approving agency.**

A State government with Federal grants must develop (and, when required, submit) indirect cost rate proposals to the relevant Federal agency within 6 months after the close of the fiscal year to receive reimbursement for indirect costs.<sup>51, 52, 53</sup> During our review period, we found that the Department of Attorney General submitted its FY 2018 indirect cost rate proposal 4 months late, its FY 2019 indirect cost rate proposal 2.5 months late, and its FY2020 indirect cost rate proposal 1.5 months late. All three rate proposals received a filing extension to June 30 of the applicable submission year. The Office of Fiscal Management reported that the indirect cost proposals were late because an external vendor, who was responsible for creating these proposals, had not completed them on time.

---

## Performance Standard 12: Training

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

**Finding: Although the Unit maintained an annual training plan for its staff, Unit supervisors did not consistently track or verify that staff documented their training.**

See page 17.

**Observation: The Unit improved its onboarding training for investigators after our review period.**

In September 2020, the Unit implemented a new training program, called The Field Training Program, after receiving feedback from its investigators. We found this new training program more thorough for new investigators compared to the one

---

<sup>51</sup> 45 CFR Part 75, Appendix VII(A). Indirect costs are costs that incur for common or joint purposes. Indirect costs help with more than one cost category type (e.g., salaries, equipment, supplies) and cannot be readily identified with a particular cost category. Because of diverse accounting practices of governmental units, entities calculate indirect costs rates using various cost categories.

<sup>52</sup> 45 CFR Part 75, Appendix VII(B)(7), defines an indirect cost rate as "a device for determining in a reasonable manner the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of the indirect costs to a direct cost base."

<sup>53</sup> 45 CFR Part 75, Appendix VII(D)(1)(d). HHS' Program Support Center approved the MFCU's indirect cost rate proposals during our review period.

previously in place. For example, the new training program includes Medicaid-specific content areas and requires that new investigators shadow a senior investigator for at least the first 6 months. At the time of our onsite review, Unit management reported that they were still formalizing the training program.

# APPENDICES

## Appendix A: Unit Referrals by Source for Fiscal Years 2018–2020

Referral Source	FY 2018		FY 2019		FY 2020		3-Year Total		
	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Fraud	Abuse or Neglect	Total
Anonymous	97	0	117	15	96	32	310	47	357
Licensing board	1	1	6	2	1	1	8	4	12
Long-Term Care Ombudsman	0	1	0	2	0	2	0	5	5
Medicaid agency - Program Integrity Unit (DHHS-OIG)	2	0	1	0	1	0	4	0	4
Other law enforcement	4	1	3	1	1	1	8	3	11
Private health insurer	13	0	4	0	0	0	17	0	17
State survey and certification agency	13	36	0	54	1	4	14	94	108
<b>Sub-Total</b>	<b>594</b>	<b>120</b>	<b>747</b>	<b>233</b>	<b>807</b>	<b>198</b>	<b>2,148</b>	<b>551</b>	<b>2,699</b>
<b>Total</b>	<b>714</b>		<b>980</b>		<b>1,005</b>		<b>2,699</b>		

Source: OIG analysis of Unit Annual Statistical Reports, FYs 2018–2020.

## Appendix B: Detailed Methodology

We collected and analyzed data from the seven sources described below to examine three identified areas of concern related to the Michigan MFCU's fraud referrals, fiscal controls, and staffing levels, and to assess the Unit's performance. We used the data sources to make findings and recommendations, as well as observations about the Unit's case outcomes and operations and practices concerning the performance standards.

### Data Collection and Analysis

#### Review of Unit Documentation

Prior to the onsite visit, we reviewed recertification information for FYs 2018–2020, including (1) the Unit's annual reports, (2) the Unit director's recertification questionnaires, (3) the Unit's MOU with the State Medicaid agency's program integrity unit (MDHHS–OIG), (4) the OIG Special Agent in Charge questionnaires, and (5) data mining logs. We also reviewed the Unit's annual statistical reports, which allowed us to determine the total number of the referrals that the Unit received from a variety of sources. This also allowed us to determine the Unit's case outcomes—indictments, investigations, criminal convictions, civil settlements and judgments, and monetary recoveries (criminal, global civil, and nonglobal civil)—for FYs 2018–2020. Additionally, we examined prior OIG findings and recommendations and reviewed the Unit's implementation of those recommendations.

As part of our review of Unit staff levels, we assessed them using a simple linear regression model to compare Medicaid expenditures to actual staff. We also examined other Unit documentation to determine the length of each staff member's employment with the Unit during our review period. Additionally, we reviewed the Unit's annual training to assess staff's adherence to the training plans and determine whether staff received adequate training.

We also reviewed Unit policies and procedures and held discussions with Unit management during the onsite review to gain a better understanding of those documents. We confirmed with the Unit director that the information we had was current, and we requested any additional data and clarification as needed.

#### Review of Unit Financial Documentation

OIG auditors reviewed the Unit's internal fiscal controls related to late submissions of Federal Financial Reports to OIG and the Unit's use of fiscal resources to identify issues with its internal controls. Prior to the onsite review, we administered an internal controls questionnaire to Unit staff and fiscal staff from the Department of Attorney General. The questionnaire covered topics such as accounting, budgeting, personnel, procurement, property, equipment, and the Unit's financial policies and procedures. During the onsite review, we followed up with the respondents to clarify any issues identified in the questionnaire.

We also examined the Unit's claimed grant expenditures for FYs 2018–2020. For these expenditures, we (1) reviewed the Unit's payment records to identify unusual patterns of withdrawal amounts; (2) reconciled the Unit's Federal Financial Reports (SF-425 forms) that the Unit submitted to OIG with the Unit's transaction detail report for our review period; (3) compared the Unit's transactions detail reports with its approved budgets; and (4) reviewed the Unit's indirect costs to determine if the costs were adequately allocated to the Unit in accordance with the HHS-approved indirect cost rates.

We selected three purposive samples to assess the Unit's internal controls of fiscal resources:

1. To assess the Unit's expenditures, we selected a sample of 120 transactions totaling \$356,552 and reviewed supporting documentation to determine whether the costs claimed were allowable, allocable, and reasonable, in accordance with Federal regulations.
2. To assess inventory, we selected and verified a sample of 26 fixed assets from a total of 240 items assigned to the Unit.
3. To assess employee time and effort, we also selected and verified a sample of 37 employees' salaries over 3 pay periods from 37 employees who were employed during FYs 2018–2020. Salary documentation consisted of timesheets and payroll adjustments.

### Interviews with Key Stakeholders

During August through October 2021, we interviewed stakeholders from nine entities who were familiar with the MFCU's operations, including officials in MDHHS–OIG, the U.S. Attorney's Office, two MCOs, and the Department of Attorney General's Solicitor General and Fiscal Management staff. We also interviewed Special Agents from OIG's Office of Investigations in the Detroit Field Office. 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 the interviews to develop subsequent interview questions for Unit management and selected staff.

### Onsite Interviews with Unit Management and Selected Staff

With the assistance of OIG Special Agents and the chief investigator from another State MFCU, we conducted structured onsite interviews with the Unit director, chief investigator, and selected staff, including investigators and attorneys. The interviews focused on our three targeted areas (the Unit's fraud referrals, fiscal controls, and staffing levels); Unit operations; and the Unit's training and technical assistance needs. We also followed up on any issues identified from the key stakeholder interviews and our analysis of Unit documentation.

### Onsite Review of Case Files

We asked the Unit to provide us with a list of cases that were open at any point during FYs 2018–2020 and to include the status of each case; whether the case was criminal, nonglobal civil, or global civil; and the dates on which the case was opened and closed, if applicable. The total number of cases that met these parameters was 923. We then excluded a total of 430 cases from our review because they were global civil cases. We excluded all global civil cases because they are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs. From the remaining 493 case files, we selected a simple random sample of 90 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. With the assistance of OIG agents and the chief investigator from another State MFCU, we reviewed the 90 case files for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals. During the review, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

### Review of Unit Submissions to OIG and the NPDB

We also reviewed all convictions submitted to OIG for program exclusion (52) and all adverse actions submitted to the NPDB (36) during FYs 2018–2020 and assessed the timeliness of these submissions.

### Onsite Review of Unit Operations

While onsite, we examined the Unit's workspace and operations of the Unit's office in East Lansing. We looked at the Unit's offices and meeting spaces; security of data and case files; location of select equipment; the functionality of the Unit's electronic case management system; and the general functioning of the Unit.



## Appendix C: Point Estimates and 95-Percent Confidence Intervals of Case File Reviews

**Exhibit C-1: Estimates for All Case File Reviews**

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases That Had Supervisory Approval To Open	90	91.11%	83.77%	95.74%
				85.19%
Percentage of All Closed Cases That Had Supervisory Approval To Close	63	98.41%	91.47%	99.96%

Source: OIG analysis of Michigan Unit case files, FYs 2018–2020.

**Exhibit C-2: Estimates for Case Files Open Longer Than 90 Days**

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases Missing Some or All Supervisory Reviews	84	61.9%	50.66%	72.29%
Percentage of All Cases Missing Some Supervisory Reviews	84	36.9%	26.63%	48.13%
Percentage of All Cases Missing All Supervisory Reviews	84	25%	16.19%	35.64%

Source: OIG analysis of Michigan Unit case files, FYs 2018–2020.

\*The 95-percent confidence intervals for project proportion of supervisory reviews exceed 10-percent absolute precision.



## Appendix D: Unit Comments

P.O. Box 30218  
LANSING, MICHIGAN 48909

DANA NESSEL  
ATTORNEY GENERAL

September 21, 2022

Suzanne Murrin  
Deputy Inspector General for Evaluation and Inspections  
Room 5660  
Cohen Building  
30 Independence Avenue, SW  
Washington, DC 20201

Re: Michigan MFCU 2021 Review, OEI-06-21-00270

Dear Deputy Inspector General Murrin:

Before I provide the formal comments to the draft 2021 Michigan MFCU Review report, I wish to thank the core HHS-OIG team leading the review process. Anthony Soto-McGrath, Keith Peters, and Kristen Calille have been outstanding partners in this process and were professional, responsive, transparent, and helpful.

As you know, HHS-OIG has made nine recommendations to the Michigan MFCU and has asked the MFCU to concur with those recommendations and describe specific actions the MFCU intends to take in response. Each of the recommendations are addressed below.

1. Build upon efforts to increase fraud referrals from the State Medicaid agency.

MFCU Response: The MFCU concurs with this recommendation. Because the MFCU and State Medicaid agency (MDHHS-OIG) are, by design, distinct entities, the MFCU is not able to directly control the number of referrals received from the agency, nor their priorities. However, it is recognized that the MFCU has influence over this process and can and will continue to attempt to demonstrate the value to Medicaid program integrity of increased program surveillance and referrals to the MFCU by MDHHS-OIG.

Specifically, the MFCU will follow a regimen of formal meetings with DHHS-OIG management as guided by the memorandum of understanding between the agencies. The MFCU will use these meetings to both provide and listen to feedback on collaboration with DHHS-OIG. Additionally, the MFCU

will promote the concept of joint training with DHHS-OIG where it has mutual value.

2. Refund the Federal grant for unsupported expenditures and establish processes to ensure Unit involvement and oversight of its fiscal controls and reporting.

MFCU Response: The MFCU concurs with this recommendation. The Michigan Department of Attorney General (DAG) will refund the Federal grant \$32,098 within 60 days of receiving repayment instructions. The DAG Office of Fiscal Management (Fiscal) will update and/or establish if needed, policies and procedures to ensure all expenditures are supported and ensure all Federal Financial Reports (FFR) are filed timely. DAG Fiscal has submitted all FFRs on time beginning with the 12/31/21 report.

Accounting policies and procedures are being updated to reflect the current accounting system (SIGMA). This update will be completed in fiscal year 22-23.

The MFCU will update the Unit Operations Manual to include a new section on grant management and fiscal duties. This section will require the Unit Director to have joint responsibility with DAG Fiscal for filing the FFR on time. This Operations Manual Update will be completed by October 31, 2022. Quarterly recurring meetings for this purpose have already been set going forward.

3. Assess the adequacy of existing staffing levels and, if appropriate, develop a plan to expand the size of the Unit.

MFCU Response: The MFCU concurs with this recommendation. The DAG understands the need for adequate staffing across the broad array of Department responsibilities. As HHS-OIG has learned, each Department in Michigan government is bound by a legislatively imposed staffing cap. Thus, regardless of available funding, the DAG may not hire more full-time employees than allowed by this cap. Until and unless the legislature deems it appropriate to permit the DAG to grow, the DAG must utilize existing employees to satisfy all important and evolving Department priorities.

Nevertheless, the MFCU will produce a draft expansion plan by November 30, 2022. In the event the DAG staffing cap is increased, a thoughtful plan will be in place for potential implementation—subject to the approval of the DAG.

4. Seek opportunities, as appropriate, to investigate more joint cases with Federal partners.

MFCU Response: The MFCU concurs with this recommendation. The MFCU agrees that meaningful engagement with federal partners, particularly the Detroit Strike Force, would be beneficial to the Unit mission. The MFCU Director reached out and met (virtually) the new Strike Force leader and additional meetings to discuss a MFCU role are planned. The MFCU already supports Strike Force cases by providing Medicaid data and expert analysis. The MFCU responded to 65 requests for this type of support from various federal agencies in the last year alone. However, it is understood that a deeper partnership with true joint investigative casework would provide additional mutual benefits.

5. Develop and implement processes to ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes.

MFCU Response: The MFCU concurs with this recommendation. The MFCU does report all convictions to HHS-OIG Exclusions yet has faced challenges in completing that task within the prescribed 30-days. During the review period for this onsite review, a significant number of conviction reports that fell beyond the 30-day threshold were directly due to misconduct by the responsible staff member who resigned during the subsequent disciplinary process.

In order to ensure compliance with reporting requirements, the MFCU will add a section to the Operations Manual codifying applicable standards. This will be completed by October 31, 2022.

6. Ensure that supervisory reviews of case files are documented in accordance with Unit policy.

MFCU Response: The MFCU concurs with this recommendation. The MFCU will take steps to improve compliance with existing requirements governing supervisory case file reviews. Specifically, the Unit will employ new naming conventions to case file notes in the case management system to ensure these reviews are done and documented in a uniform way. This will be memorialized in amendments to the Operations Manual by October 31, 2022, and all managerial staff will be trained on this new information by October 31, 2022.

7. Ensure that Unit supervisors track and verify that all staff in professional disciplines document their training.

MFCU Response: The MFCU concurs with this recommendation. The past method for tracking training history has involved a non-intuitive process within SharePoint that required multiple steps. This contributed to non-compliance in reporting by staff. Effective October 1, 2022, the MFCU will be maintaining a stand-alone spreadsheet to capture and track professional training more accurately. Reporting will be done through the assigned secretary for each professional staff person. This process will be codified in the Operations Manual no later than October 31, 2022.

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

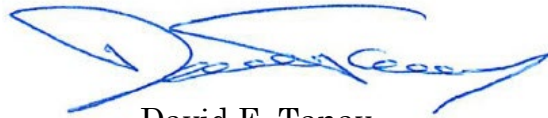
MFCU Response: The MFCU concurs with this recommendation. It is recognized that a purpose-built case management system tailored to the MFCU would enhance Unit operations. However, the DAG has consistently adhered to the philosophy of administering an enterprise-wide case management system—one that serves the needs of all DAG Divisions. There are many arguments in favor of this approach to case management and not allowing individual Divisions to acquire their own custom system—an approach that could create a patchwork of systems with challenges in support, cost, and interoperability.

The MFCU will continue to promote advancements in DAG electronic case management—either with a new system for the Unit or with improvements to the current system—that best serve the Unit while recognizing and respecting the DAG is responsible for serving many Divisions and interests with fixed resources.

9. Revise the MOU with the State Medicaid agency to reflect current practice and law.

MFCU Response: The MFCU concurs with this recommendation. The MFCU agrees that the existing MOU with DHHS-OIG is stale in several respects. A working group of DHHS-OIG staff and MFCU staff has already been formed and has met to work on the necessary revisions to the MOU. The target date for execution of the revised MOU is November 30, 2022.

Sincerely,



David E. Tanay  
Division Chief  
Health Care Fraud Division  
517-241-6500

DET:

cc: Fadwa Hammoud  
Keith Peters

# ACKNOWLEDGMENTS AND CONTACT

## Acknowledgments

Anthony Soto McGrath served as the team leader for this study, and Kristen Calille served as the lead analyst. Medicaid Fraud Policy and Oversight Division staff who participated in the review included Keith Peters. Office of Evaluation and Inspections staff who provided support include Anna Brown, Robert Gibbons, Sarah Smith, Sara Swisher, and Jordan Swoyer.

We would also like to acknowledge the contributions of other Office of Inspector General staff, including two special agents from the Office of Investigations and staff from the Office of Audit Services, including Kathryn Cartwright, Mitchell Collier, and Lisa Capuano. Finally, Lloyd Early of the Ohio MFCU served as a member of the team.

This report was prepared under the direction of Ruth Ann Dorrill, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and Petra Nealy, Deputy Regional Inspector General, as well as in consultation with Richard Stern, Director of the Medicaid Fraud Control Policy and Oversight Division.

## Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at [Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov). OIG reports and other information can be found on the OIG website at [oig.hhs.gov](http://oig.hhs.gov).

Office of Inspector General  
U.S. Department of Health and Human Services  
330 Independence Avenue, SW  
Washington, DC 20201

# ABOUT THE OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

**The Office of Audit Services (OAS)** provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

**The Office of Evaluation and Inspections (OEI)** conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

**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.

**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.