

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



# Connecticut Medicaid Fraud Control Unit: 2021 Inspection

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## Unit Case Outcomes

Federal fiscal years (FYs)  
2019–2021

- 30 indictments
- 9 convictions
- 49 civil settlements and judgments
- \$45.8 million in recoveries with \$33.1 million from global\* civil cases, \$9.2 million from nonglobal civil cases, and \$3.5 million from criminal cases

## Unit Snapshot

The Connecticut Medicaid Fraud Control Unit (MFCU or Unit) is located within the Connecticut Office of the Chief State's Attorney (OCSA).

At the time of our onsite inspection in November 2021, the Unit had a total of 13 staff located in Rocky Hill.

\*Global recoveries derive from civil settlements or judgments involving the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

## Connecticut Medicaid Fraud Control Unit: 2021 Inspection

### What OIG Found

From the information we reviewed, we found that the Connecticut MFCU generally operated in accordance with applicable laws, regulations, and policy transmittals. However, we made four findings regarding the Unit's adherence to the MFCU performance standards and compliance with Federal regulations:

1. During our review period, the Unit did not receive referrals of patient abuse or neglect and was unable to take sufficient steps to ensure that it received such referrals.
2. The Unit lacked a central repository for case information, making access to case data and pertinent case documents inefficient.
3. The Unit did not adhere to its policy of documenting supervisory reviews monthly.
4. The Unit did not consistently report convictions or adverse actions to Federal partners within the appropriate timeframes.

In addition to the findings, we made several observations regarding Unit operations and practices.

### What OIG Recommends

To address the findings, we recommend that the Unit (1) develop and implement outreach efforts to ensure that the Unit regularly receives referrals of patient abuse and neglect; (2) seek approval from OCSA to implement a new case management system; (3) conduct and document supervisory reviews of case files in accordance with Unit policy; and (4) ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes. The Unit concurred with all four recommendations.

# TABLE OF CONTENTS

<b>BACKGROUND</b> .....	1
Methodology.....	5
<b>PERFORMANCE ASSESSMENT</b> .....	7
Case Outcomes.....	7
Observation: The Unit reported 30 indictments, 9 convictions, and 49 civil settlements and judgments for FYs 2019–2021.	
Observation: The Unit reported combined civil and criminal recoveries of nearly \$46 million for FYs 2019–2021.	
Performance Standard 1: Compliance with Requirements.....	8
Observation: From the information we reviewed, the Connecticut MFCU generally complied with applicable laws, regulations, and policy transmittals.	
Performance Standard 2: Staffing .....	8
Observation: The Unit’s staff levels were low in relation to State Medicaid expenditures.	
Performance Standard 3: Policies and Procedures .....	9
Observation: The Unit maintained policies and procedures, and staff were familiar with them.	
Performance Standard 4: Maintaining Adequate Referrals.....	9
Finding: During our review period, the Unit did not receive referrals of patient abuse or neglect and was unable to take sufficient steps to ensure that it received such referrals.	
Performance Standard 5: Maintaining Continuous Case Flow.....	11
Observation: The Unit took steps to maintain a continuous case flow and to complete cases within appropriate timeframes.	
Performance Standard 6: Case Mix.....	11
Observation: Despite the lack of patient abuse and neglect cases, the Unit’s mix of cases covered 25 provider types.	
Performance Standard 7: Maintaining Case Information.....	12
Finding: The Unit lacked a central repository for case information, making access to case data and pertinent case documents inefficient.	
Finding: The Unit did not adhere to its policy of documenting supervisory reviews monthly.	

Performance Standard 8: Cooperation with Federal Authorities on Fraud Cases.....	14
Observation: The Unit maintained a good working relationship with Federal agencies, including OI and the U.S. Attorney’s Office.	
Finding: The Unit did not consistently report convictions or adverse actions to Federal partners within the appropriate timeframes.	
Performance Standard 9: Program Recommendations .....	16
Observation: The Unit made programmatic recommendations to the State Medicaid agency during our review period.	
Performance Standard 10: Agreement with Medicaid Agency.....	16
Observation: The Unit had a four-way MOU with the State Medicaid agency, OI, and the State Attorney General’s Office, which created open communication and transparency among the four agencies.	
Performance Standard 11: Fiscal Control .....	17
Observation: From our limited review, we identified no significant deficiencies in the Unit’s fiscal control of its resources.	
Performance Standard 12: Training.....	17
Observation: The Unit maintained a training plan for each professional discipline.	
<b>CONCLUSION AND RECOMMENDATIONS.....</b>	<b>18</b>
Develop and implement outreach efforts to ensure that the Unit regularly receives referrals of patient abuse and neglect.....	18
Seek approval from the Office of the Chief State’s Attorney to implement a new case management system .....	19
Conduct and document supervisory reviews of case files in accordance with Unit policy .....	19
Ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes .....	19
<b>UNIT COMMENTS AND OIG RESPONSE.....</b>	<b>20</b>
<b>DETAILED METHODOLOGY .....</b>	<b>21</b>
<b>APPENDICES.....</b>	<b>24</b>
Appendix A: Unit Referrals by Source for Fiscal Years 2019–2021 .....	24
Appendix B: Point Estimates and 95-Percent Confidence Intervals of Case File Reviews.....	25
Appendix C: Unit Comments.....	26
<b>ACKNOWLEDGMENTS AND CONTACT .....</b>	<b>29</b>
<b>ABOUT THE OFFICE OF INSPECTOR GENERAL.....</b>	<b>30</b>

# BACKGROUND

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## OBJECTIVE

To examine the performance and operations of the Connecticut Medicaid Fraud Control Unit (MFCU or Unit).

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## 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>

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<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 from 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 desk reviews 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 on 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.

## Connecticut MFCU

The Connecticut Unit is located within the Office of the Chief State's Attorney (OCSA) in the Division of Criminal Justice in Rocky Hill, a suburb of Hartford.<sup>13, 14</sup> At the time of our onsite inspection in November 2021, the Unit had 13 staff—7 investigators (including the chief investigator), 3 attorneys (including the director), 2 auditors,

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<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 (Sept. 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> The Unit is one of five State MFCUs that are not part of a State Attorney General's Office. The other four MFCUs that do not reside in an Office of Attorney General are those of the District of Columbia, Illinois, Iowa, and Tennessee.

<sup>14</sup> Connecticut State Division of Criminal Justice, *Office of the Chief State's Attorney*. Accessed at <https://portal.ct.gov/DCJ/About-Us/About-Us/Office-of-the-Chief-States-Attorney> on March 1, 2022.

and 1 support staff.<sup>15</sup> During our review period of FYs 2019–2021, the Unit spent approximately \$7.5 million (with a State share of approximately \$1.9 million).

## Referrals

During FYs 2019–2021, the Unit reported receiving referrals of Medicaid provider fraud primarily from the State Medicaid agency, known as the Department of Social Services (DSS). The referral process and other aspects of the working relationship are memorialized in a memorandum of understanding (MOU) between the MFCU, DSS, the State Attorney General’s Office, and OIG’s Office of Investigations (OI). The Connecticut Unit is the only MFCU that includes OI as a signatory in an MOU with State partners. This MOU instructs DSS to refer allegations of fraud to the MFCU, the State Attorney General’s Office, and OI simultaneously. The Unit also has an MOU with the State Department of Public Health (DPH) that directs DPH to share referrals of potential fraud and patient abuse or neglect with the Unit.<sup>16, 17</sup> See Appendix A for a list of Unit referrals by source for FYs 2019–2021.

When the Unit receives a referral, the chief investigator performs an initial review, and then assigns it to an auditor and/or investigator for preliminary review of the facts alleged in the referral to determine whether the Unit has authority and jurisdiction to open a case. At the end of the review, the chief investigator submits a report with a recommendation to the director, who ultimately decides whether the Unit should accept or decline the referral. If the director declines to open a referral for investigation, the director or chief investigator evaluates the referral for possible administrative action by DSS or another agency.

## Investigations and Prosecutions

The Connecticut Unit has Statewide jurisdiction to investigate and prosecute all criminal Medicaid provider fraud and patient abuse and neglect cases.<sup>18, 19</sup> The Unit

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<sup>15</sup> The Unit had two directors during our review period. The previous, longstanding director passed away in February 2021, and the current director accepted the position in March 2021.

<sup>16</sup> During our review period, the Unit did not report receiving any referrals of patient abuse or neglect. For more information about the Unit’s lack of patient abuse and neglect referrals and cases, see Performance Standard 4 on page 9.

<sup>17</sup> DPH serves as Connecticut’s State agency for protecting the public health and providing health information, policy, and advocacy. DPH houses the Facility Licensing and Investigations Section, which is charged with licensing and regulating the State’s health care institutions. Connecticut State DPH, *Welcome to the Facility Licensing and Investigations Section Webpage*. Accessed at <https://portal.ct.gov/DPH/Facility-Licensing--Investigations/FLIS> on March 30, 2022.

<sup>18</sup> Connecticut State Division of Criminal Justice, *Medicaid Fraud Control Unit*. Accessed at <https://portal.ct.gov/DCJ/Programs/Programs/Medicaid-Fraud-Control-Unit> on March 1, 2022.

<sup>19</sup> Connecticut General Statutes § 51-281.

refers all civil matters to the Connecticut Attorney General's Office, which has Statewide authority to investigate and prosecute civil cases.<sup>20</sup>

Once the Unit opens a case, it assigns the matter to a team consisting of a Unit attorney, an investigator, and an auditor. The chief investigator meets monthly with investigators and auditors assigned to each case to review their investigative files and ensure that cases are progressing. When available, the assigned attorney also attends the case reviews. The Unit also meets monthly with all staff to discuss the investigations to ensure that they move forward. According to its four-way MOU, if the Unit determines that a case does not have substantial potential for criminal prosecution, the Unit refers the matter to DSS and the State Attorney General's Office for potential administrative and/or civil action.

## Connecticut Medicaid Program

DSS administers the State Medicaid program and provides care for the approximately 960,000 beneficiaries enrolled in the program.<sup>21</sup> Connecticut operates its Medicaid program entirely on a fee-for-service basis.<sup>22</sup> DSS houses the State Medicaid program integrity unit, which investigates allegations of fraud in the Connecticut Medicaid program and, when appropriate, refers credible allegations of fraud to the MFCU, the State Attorney General's Office, and OI.<sup>23</sup>

## Prior OIG Report

OIG conducted a previous onsite review of the Connecticut Unit in 2013.<sup>24</sup> In that review, OIG found that the Unit (1) did not always maintain case files effectively; (2) did not follow policies and procedures for case management; (3) did not provide OIG with adequate information to initiate exclusion of convicted individuals; (4) did not work exclusively on Unit-related matters; (5) did not properly allocate its vehicle

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<sup>20</sup> The Office of Attorney General William Tong, *About the Attorney General's Office*. Accessed at <https://portal.ct.gov/AG/About-Us> on March 1, 2022.

<sup>21</sup> CMS, *State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data*, January 2022. Accessed at [https://data.medicare.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360/data?conditions\[0\]\[property\]=report\\_date&conditions\[0\]\[value\]=2021-07-01&conditions\[0\]\[operator\]=%3D&conditions\[1\]\[property\]=preliminary\\_updated&conditions\[1\]\[value\]=P&conditions\[1\]\[operator\]=%3D](https://data.medicare.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360/data?conditions[0][property]=report_date&conditions[0][value]=2021-07-01&conditions[0][operator]=%3D&conditions[1][property]=preliminary_updated&conditions[1][value]=P&conditions[1][operator]=%3D) on February 15, 2022.

<sup>22</sup> Kaiser Family Foundation, *Share of Medicaid Population Covered under Different Delivery Systems*, July 2021. Accessed at <https://www.kff.org/medicaid/state-indicator/share-of-medicare-population-covered-under-different-delivery-systems/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> on March 14, 2022.

<sup>23</sup> The Provider Investigations Unit, located within DSS's Office of Quality Assurance, serves as the program integrity unit. DSS, *The Office of Quality Assurance*. Accessed at <https://portal.ct.gov/DSS/Quality-Assurance/The-Office-of-Quality-Assurance> on February 28, 2022.

<sup>24</sup> OIG, *Connecticut Medicaid Fraud Control Unit: 2013 Onsite Review*, OEI-07-13-00540, September 2014.



costs; and (6) did not regularly communicate and coordinate with OIG to investigate and prosecute health care fraud.

OIG recommended that the Unit (1) ensure that case files are maintained in an effective manner; (2) adhere to Unit policies and procedures for case management; (3) refer individuals for exclusion to OIG with the appropriate information for exclusion; (4) ensure that Unit professional staff perform only Unit-related duties in accordance with performance standards and Federal regulations; (5) properly allocate vehicle costs; and (6) regularly communicate and coordinate with OI to investigate and prosecute Medicaid provider fraud.

To address these recommendations, the Unit (1) implemented a new policy to standardize its case files; (2) hired additional staff in order to assign cases more timely, and revised its policies and procedures for supervisory reviews of case files; (3) revised its policy for reporting convictions to OIG; (4) instructed its OCSA financial officer to credit the value of non-MFCU time back to the grant; (5) implemented a vehicle cost allocation; and (6) began meeting and communicating regularly with OI.<sup>25</sup> On the basis of information received from the Unit, OIG considered the recommendations implemented as of August 2015. As we discuss further below, several issues from the prior OIG report continued in this inspection.

## Methodology

We conducted an onsite inspection of the Connecticut MFCU in November 2021. Our inspection covered the 3-year period of FYs 2019–2021. We based the inspection on an analysis of data and information from 7 sources as follows: (1) a review of Unit documentation; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with Unit management and selected staff; (5) a review of a random sample of 62 case files from the Unit’s 121 nonglobal case files that were open at any point during the review period; (6) a review of convictions submitted to OIG for program exclusion and adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (7) an onsite review of Unit operations. See the Detailed Methodology on page 21.

In examining the Unit’s operations and performance, we applied the published MFCU performance standards, but we did not assess adherence to every performance indicator for every standard.

## 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

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<sup>25</sup> The policies and procedures the Unit developed from its implementation of OIG’s recommendations were still in place during FYs 2019–2021.

quality controls as are other OIG evaluations, including internal and external peer review.

# PERFORMANCE ASSESSMENT

In assessing the performance and operations of the Connecticut MFCU, we identified the Unit's case outcomes and assessed whether the Unit complied with legal requirements and adhered to the 12 MFCU performance standards. We made four findings regarding the Unit's adherence to the performance standards and compliance with Federal regulations. We also made several observations regarding Unit operations and practices.

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## Case Outcomes

**Observation: The Unit reported 30 indictments, 9 convictions, and 49 civil settlements and judgments for FYs 2019–2021.<sup>26</sup>**

All nine convictions involved Medicaid provider fraud.<sup>27</sup>

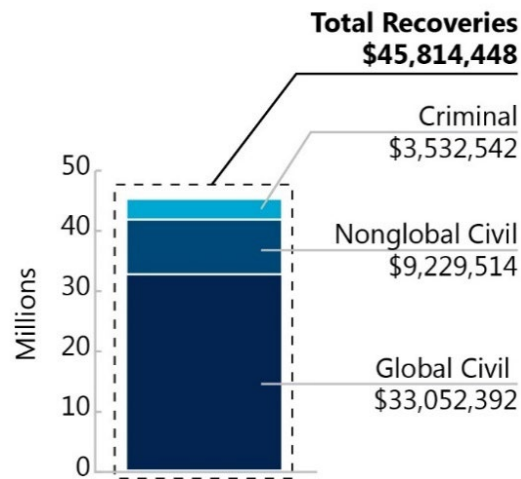


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<sup>26</sup> The State of Connecticut does not obtain indictment by grand jury proceedings. Typically, the Connecticut MFCU obtains an arrest warrant to initiate the legal proceeding. Upon the submission of an application for an arrest warrant by a prosecuting authority, a judicial authority may issue a warrant for the arrest of an accused person if the judicial authority determines that the affidavit shows that there is probable cause to believe that an offense has been committed and that the accused committed it. State of Connecticut, *Connecticut Practice Book, Section 36-1*, 2022. Accessed at <https://jud.ct.gov/Publications/PracticeBook/PB.pdf> on July 8, 2022.

<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 attorneys should apply professional judgment and discretion in determining what criminal and civil cases to pursue.

**Observation: The Unit reported combined civil and criminal recoveries of nearly \$46 million for FYs 2019–2021.**



Source: OIG analysis of Unit statistical data, FYs 2019–2021.

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

## Performance Standard 1: Compliance with Requirements

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

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

From the information reviewed, we found that the Unit was generally in compliance with applicable requirements. However, we identified one area of concern related to the Unit’s reporting of convictions and adverse actions to Federal partners, as described under Performance Standard 8 below (see page 14).

## 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.

**Observation: The Unit’s staff levels were low in relation to State Medicaid expenditures.**

The Unit’s staff levels were low in relation to the State Medicaid expenditures during our review period. According to Performance Standard 2(b), the Unit should employ a total number of professional staff that is commensurate with the State’s total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse or neglect. In FY 2021, Connecticut’s Medicaid expenditures were over \$7.3 billion, and at the end of that

year, the Unit employed 13 staff. We observed that the Unit's staff size was low compared to that of other Units; our analysis shows that a Unit with a similar level of Medicaid expenditures would, on average, employ 21 staff.<sup>28</sup> We also observed that, in FY 2021, the Unit had approximately \$562.4 million in Medicaid expenditures per Unit employee, compared to the national average of \$361.5 million in Medicaid expenditures per Unit employee across all Units. Despite the low number of staff, Unit management did not express concern about negative impacts on the Unit's ability to investigate or prosecute cases in a timely manner.

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### 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 policies and procedures, and staff were familiar with them.**

The Unit maintained a policies and procedures manual, which was last updated in November 2018. Unit staff reported that they were familiar with Unit policies and procedures and could access the manual electronically on the Unit's shared drive.

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### 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: During our review period, the Unit did not receive referrals of patient abuse or neglect and was unable to take sufficient steps to ensure that it received such referrals.**

According to Performance Standard 4(d), for States in which Units have original jurisdiction to investigate or prosecute patient abuse and neglect cases, the Unit should take steps to ensure that pertinent agencies refer such cases to the Unit. Despite having independent, or original, jurisdiction to investigate and prosecute cases of patient abuse and neglect, the Unit did not receive any such referrals from its referral sources during FYs 2019–2021.<sup>29</sup> Consequently, the Unit did not obtain any patient abuse or neglect indictments or convictions during our review period.

Unit management reported that State regulatory agencies, such as DPH, typically received patient abuse or neglect complaints. Despite a longstanding MOU that required DPH to refer to the Unit allegations of Medicaid patient abuse or neglect, DPH referred no such complaints during our review period. In interviews with DPH officials, they explained that DPH investigated patient abuse or neglect complaints for

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<sup>28</sup> OIG does not prescribe MFCUs' staffing levels. We assessed the Unit's staffing levels using a linear regression model to compare Medicaid expenditures to actual staff.

<sup>29</sup> Prior to FY 2019, the Unit reported receiving referrals of patient abuse and neglect and opening investigations from those referrals. One of those investigations, which the Unit opened in FY 2018, was still open during our review period.

administrative action and typically referred criminal allegations to local police departments. As a result, DPH and local police departments, rather than the MFCU, conducted most investigations of alleged patient abuse or neglect.

In addition to preventing the MFCU from identifying appropriate patient abuse and neglect referrals for investigation, this existing arrangement may also have an impact on the Unit's ability to submit convicted providers to OIG for exclusion from Federal health care programs. If local law enforcement agencies have convicted providers of patient abuse or neglect crimes in connection with a health care item or service, they may not know to inform OIG to exclude these providers from Federal health care programs.<sup>30</sup>

We found that the Unit conducted limited outreach to potential referral sources, including DPH, to encourage referrals of patient abuse or neglect during our review period. The Unit's outreach largely consisted of the following efforts: (1) the Unit maintained a website outlining the Unit's authority to investigate and prosecute fraud and patient abuse or neglect; and (2) the Unit included its contact information in press releases, requesting the public to report any suspected Medicaid provider fraud and patient abuse or neglect to the Unit. We found that the passing of the former Unit director further limited the Unit's outreach regarding referrals of patient abuse and neglect. Unit management reported that the former Unit director was responsible for conducting outreach efforts and facilitating the Unit's relationships with referral agencies, but when he became ill during our review period, it hampered the Unit's outreach.<sup>31</sup>

In interviews, both DPH and Unit management recognized that their working relationship was limited. DPH officials reported that they had little contact with the Unit during our review period. The officials expressed interest in receiving training on the types of referrals the Unit would like to receive from DPH and the information the Unit would need for those referrals. During our onsite visit, Unit management acknowledged that the Unit should be conducting more outreach to encourage referrals. The new Unit director explained that the lack of patient abuse or neglect referrals was a concern that she planned to address soon.

Following our onsite visit in November 2021, the Unit director reported to us that the Unit initiated steps to address the absence of patient abuse or neglect referrals. The director reported that to encourage such referrals, Unit managers met with DPH officials to discuss the Unit's responsibility for investigating and prosecuting cases of patient abuse and neglect. The director stated that the two agencies plan to discuss the types of patient abuse or neglect referrals that the Unit would like to receive as well as procedures for future communication. The director also stated that DPH will conduct training for the Unit investigators about reviewing medical charts for patient abuse and neglect referrals. Additionally, the director informed us that the Unit's

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<sup>30</sup> 42 USC § 1320a-7(a)(2).

<sup>31</sup> The current director assumed the outreach duties after becoming the Unit director in March 2021.

outreach has begun to generate patient abuse and neglect referrals as well as additional fraud referrals.

Further, the Unit director expressed interest in hiring additional staff, including a nurse investigator, if the Unit is successful in increasing its patient abuse and neglect caseload. A nurse investigator may be helpful in conducting the Unit's future outreach efforts, reviewing patient abuse or neglect referrals, and investigating those cases. As we observe under Performance Standard 2, the Unit's staff levels were low in relation to the State Medicaid expenditures (see page 8), and an increased caseload may suggest the need for additional staff.

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## 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: The Unit took steps to maintain a continuous case flow and to complete cases within appropriate timeframes.**

Our review of the Unit's case files found that most investigations and subsequent prosecutions or settlements were completed in a timely manner. Further, most case files contained appropriate documentation of supervisory approval for case openings and case closings. Specifically, we observed that 97 percent of case files contained documentation of supervisory approval to open a case, and 85 percent of the Unit's closed cases contained supervisory approval to close a case. See Appendix B for the point estimates and confidence intervals for our case file review.

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## 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: Despite the lack of patient abuse and neglect cases, the Unit's mix of cases covered 25 provider types.**

Of the 121 nonglobal cases that were open during our review period, 99 percent (120 cases) involved provider fraud and 1 percent (1 case) involved patient abuse and neglect.<sup>32</sup> The Unit opened its one case of patient abuse and neglect in FY 2018, and the case was still open during our review period.<sup>33, 34</sup> During FYs 2019–2021, the

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<sup>32</sup> We excluded all global cases from our review of the Unit's case files because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs.

<sup>33</sup> The case of patient abuse and neglect was closed at the time of our inspection.

<sup>34</sup> For more information about the Unit's lack of patient abuse and neglect referrals and cases, see Performance Standard 4 on page 9.

Unit's cases covered 25 different provider types, including dentists, personal care services attendants, clinical social workers, and pharmaceutical manufacturers.

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## 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: The Unit lacked a central repository for case information, making access to case data and pertinent case documents inefficient.**

Performance Standards 7(e) and 7(f) state that the Unit should have a case management system that manages and tracks case information from initiation to resolution. This system should also allow for the monitoring and reporting of case information.<sup>35</sup> Rather than using one consolidated case management system, the Unit used several repositories to track case information and other performance data.

At the time of our onsite inspection, the Unit stored case information in different locations, including a legacy case management system, an internal electronic file structure, and various spreadsheets. The Unit used the legacy case management system during most of our review period, but because the system was antiquated, the chief investigator created an electronic file structure on the Unit's shared drive where investigators stored their case documents. The chief investigator also kept a separate master case list spreadsheet to track case progression and another spreadsheet to track monthly supervisory reviews.

We found that using several repositories to track case information presented challenges when attempting to locate documents and track case statuses during our case file review. For example, we found that the legacy system limited the amount of information an investigator could add to the case files. Specifically, the system allowed investigators to enter notes about cases but did not allow them to upload case documents. Further, the Unit's files within the electronic case file structure did not maintain consistent naming conventions, track case progression, or identify joint cases with partner agencies. During our onsite visit, OIG provided the Unit with technical assistance regarding methods to mitigate the inefficiencies of its self-created electronic case file structure.

After our onsite visit, Unit management reported that OCSA officials had adopted a new Statewide case management system; however, Unit management assessed the new system and reported that it would not meet the Unit's needs. Specifically, the Unit reported that data within the Statewide case management system would be shared among all users in the State and that the system lacked the functionality that the Unit needed for investigations. The Unit director has communicated these

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<sup>35</sup> The 2014 OIG report found that the Unit did not always maintain case files in an effective manner. Specifically, OIG found that some of the Unit's case files lacked basic organizational structure and documentation of case progression. In response to OIG's recommendation, the Unit implemented a policy to standardize its case files.



concerns to OCSA officials and reported that she is considering other case management systems.

**Finding: The Unit did not adhere to its policy of documenting supervisory reviews monthly.**

According to Performance Standard 7(a), reviews by supervisors should be conducted periodically, consistent with the Unit's policies and procedures, and should be noted in the case file. The previous OIG report found that 82 percent of the Unit's applicable cases lacked documentation of quarterly supervisory reviews consistent with Unit policy during FYs 2010–2012. In response to OIG's recommendation, the Unit required the supervisor to submit the supervisory reviews to the director. In July 2013, the Unit changed its frequency of supervisory reviews from quarterly to monthly.

We reviewed sampled case files to determine whether they contained documentation of monthly supervisory reviews, consistent with the Unit's policy. We found that 88 percent of applicable case files lacked documentation of one or more monthly supervisory reviews. Further, 7 percent of the Unit's applicable case files did not contain documentation of any supervisory reviews at all. (See Appendix B for the point estimates and confidence intervals for the case file reviews.)

Unit management explained that investigative teams generally discussed their cases with the chief investigator during their scheduled team meetings and other informal conversations, often more frequently than monthly. However, the investigative teams did not consistently document these conversations in the case files. We found that the Unit inconsistently documented its supervisory reviews because of its technical difficulties with remote work due to the COVID-19 pandemic and the inefficiencies of its case management system, among other reasons.<sup>36</sup>

In OIG's experience, conducting and documenting official case file reviews as frequently as monthly may present an unwarranted burden on investigators as well as supervisors. We found that the monthly supervisory reviews required by the Unit's policy may have been more frequent than necessary, which may have contributed to the Unit's difficulty meeting its policy.

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<sup>36</sup> After the onsite visit, the Unit director reported to us that the Unit's technical difficulties surrounding remote work were resolved.

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## 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.

**Observation: The Unit maintained a good working relationship with Federal agencies, including OI and the U.S. Attorney’s Office.**

In its 2014 report, OIG found that the Unit did not regularly communicate and coordinate with OI investigators to investigate and prosecute health care fraud. OIG recommended that the Unit improve cooperation with the OI investigators. Following that onsite review, the Unit reported that its relationship with OI improved and that the two agencies began to meet regularly.

We found that during our review period of FYs 2019–2021, the Unit and OI maintained a good working relationship and jointly investigated a total of 21 cases. An OI investigative supervisor reported that the Unit and OI have continued to work well together and have fostered that relationship over the years. OI management also attributed the good working relationship to OI’s four-way MOU with the MFCU, DSS, and the State Attorney General’s Office, citing that the arrangement worked as a “force multiplier” and enhanced trust between the agencies.<sup>37</sup> Additionally, OI management and the Unit chief investigator reported communicating openly and regularly with each other.

Further, we observed a strong working relationship between the MFCU and the U.S. Attorney’s Office in Connecticut. We interviewed the Assistant U.S. Attorney who serves as the criminal health care fraud coordinator and regularly works joint cases with the MFCU. The Assistant U.S. Attorney attributed the strong working relationship to the longstanding work history and open communication between the two agencies and stated that the Unit “works together seamlessly with the other Federal investigative agencies” in Connecticut.

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

According to Federal requirements and Performance Standard 8(f), the Unit should generally transmit 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—reports of all MFCU convictions for the purpose of permitting OIG to exclude those convicted parties from Federal health care programs.<sup>38</sup> We found that the Unit either reported late or did not report seven of its nine convictions to OIG for exclusion, and

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<sup>37</sup> For additional information about the benefits of the MOU, see the observation in Performance Standard 10 on page 16.

<sup>38</sup> 42 CFR § 1007.11(g).

the Unit did not report court delays to explain the late reporting.<sup>39</sup> Of the nine convictions, the Unit submitted four convictions late: one was submitted within 31 to 60 days after sentencing, two were submitted within 61-90 days after sentencing, and one was submitted 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.

Further, the Unit did not submit three of its nine convictions to OIG during our review period.<sup>40</sup> The Unit explained that these three convictions were joint Federal cases, and Unit officials were unaware of the requirement to submit these convictions for OIG exclusion. Although this may appear to be an understandable error, Federal requirements make no exception for joint cases. OIG has also provided guidance that Units should report all convictions for OIG exclusion.<sup>41</sup> Reporting convictions in joint cases reduces the risk of system error and ensures that OIG has a complete and accurate record of all convicted parties, including full names and current addresses.

Federal regulations, consistent with Performance Standard 8(g), also require that the Unit report any adverse actions of health care providers to the NPDB within 30 calendar days of the final adverse action date.<sup>42</sup> The Unit did not report 4 of its 11 adverse actions to the NPDB within the appropriate timeframe. Of the four adverse actions submitted late, two were submitted within 31 to 60 days after the action and two were submitted more than 90 days after the action. The NPDB is intended to restrict physicians, dentists, and other health care practitioners from moving from State to State without disclosure or discovery of previous medical malpractice and adverse actions.<sup>43</sup> If a Unit fails to report adverse actions to the NPDB, other health care organizations may unknowingly hire individuals who have adverse actions made against them.

Unit management attributed the delayed submissions to OIG and the NPDB to staff being out of the office due to long-term illness and working remotely during the COVID-19 pandemic.

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<sup>39</sup> In its 2014 report, OIG found that the MFCU did not provide OIG with adequate information to initiate exclusion of convicted individuals. OIG recommended that the Unit submit appropriate information for individuals' exclusions to OIG. Although we did not find this same issue during our 2021 inspection, we found that the Unit did not submit all of its convictions to OIG timely.

<sup>40</sup> We observed that OIG has excluded these three convicted providers.

<sup>41</sup> OIG, *State Fraud Policy Transmittal No. 2020-1: Plea Negotiations and Reporting Convictions to the Office of Inspector General*, April 2020.

<sup>42</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 (SSA § 1128E(g)(1)).

<sup>43</sup> NPDB, *About Us*. Accessed at <https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp> on June 30, 2022.

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## Performance Standard 9: Program Recommendations

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

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

The Unit, in collaboration with OI and the State Attorney General's Office, made recommendations to DSS regarding potential program deficiencies identified by the agencies during their investigations and prosecutions. For example, the agencies identified programmatic vulnerabilities and made recommendations related to behavioral health providers. Specifically, the Unit recommended that DSS clarify billing rules regarding licensed and unlicensed behavioral health providers, in both clinical and nonclinical settings, to ensure that DSS appropriately pays for services rendered. The Unit also recommended that DSS establish edits to the State's claims payment system to limit the number of hours that a behavioral health provider may bill in 1 day. DSS implemented the Unit's recommendations and made programmatic changes as suggested.

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## 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.

**Observation: The Unit had a four-way MOU with the State Medicaid agency, OI, and the State Attorney General's Office, which created open communication and transparency among the four agencies.**

During our review period, the MFCU had an MOU with DSS, OI, and the State Attorney General's Office. This MOU is unique in that the Connecticut Unit is the only MFCU that has an MOU with OI. The four-way MOU reflected current practice, policy, and legal requirements and was last updated in January 2019. The MOU described each agency's role in the fraud referral process and provided guidelines for their collaboration.

We found that the unique four-way working relationship had benefits for each agency, as it appeared to enhance communication and collaboration among the four agencies. An official in the State Attorney General's Office stated that the MOU created "a framework" for the agencies' strong working relationship. Unit management also observed, as benefits of the MOU, open communication, information sharing, and clearly defined investigative roles. An OI manager expressed that the MOU's system of simultaneous referrals to the MFCU, the Attorney General, and OI created "automatic investigative partners" among the three agencies. The DSS program integrity director reported that the MOU arrangement worked well and resulted in successful collaboration on fraud referrals among the four agencies. OIG

found that the MOU created multiple benefits for the fraud referral process among the four agencies, including the ability to discuss the specifics of each referral efficiently and to determine which agency should investigate and prosecute the referral.

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## Performance Standard 11: Fiscal Control

A Unit exercises proper fiscal control over its resources.

**Observation: From our limited review, we identified no significant deficiencies in the Unit's fiscal control of its resources.**

From the Unit's responses to a detailed fiscal controls questionnaire and from follow-up with fiscal staff and Unit officials, we identified no significant issues related to the Unit's budget process, accounting system, cash management, procurement, electronic data security, property, or personnel. In our inventory review, we located 30 of the 30 sampled inventory items.

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## Performance Standard 12: Training

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

**Observation: The Unit maintained a training plan for each professional discipline.**

The Unit had an annual training plan that required Unit attorneys, investigators, and auditors to complete an annual minimum number of training hours. The plan required Unit employees to complete an in-house basic training program, as well as Medicaid fraud and discipline-specific training.

# CONCLUSION AND RECOMMENDATIONS

From the information we reviewed, we found that the Connecticut Unit generally complied with applicable legal requirements and adhered to performance standards. However, we identified four areas in which the Unit should improve its adherence to the performance standards and/or program requirements. We found that the Unit did not receive any patient abuse or neglect referrals during FYs 2019–2021. As a result, the Unit did not have any patient abuse or neglect indictments or convictions during our review period.

In addition, we found that the Unit lacked a central repository for case information, which made accessing case data and pertinent documents inefficient. Further, we found that the Unit documented periodic supervisory reviews in most of its case files but did not adhere to its policy of documenting these reviews monthly. Finally, we found that the Unit did not report all of its convictions and adverse actions to Federal partners within the appropriate timeframes.

To address the findings in this report, we make four recommendations to the Connecticut MFCU.

## **We recommend that the Connecticut Unit:**

### **Develop and implement outreach efforts to ensure that the Unit regularly receives referrals of patient abuse and neglect**

The Unit should develop and implement a written plan to ensure that pertinent agencies refer suspected abuse and neglect cases to the Unit. The plan should include steps for conducting outreach efforts and educating referral sources, such as State regulatory agencies and local law enforcement agencies. If hired, the nurse investigator could contribute to this outreach. In developing the plan, the Unit could consider educating referral sources regarding the expanded MFCU authority to investigate and prosecute abuse or neglect of Medicaid beneficiaries in noninstitutional or other settings. Once the plan is established, the Unit should continue outreach with these referral sources to ensure that any referrals the Unit receives are of good quality and within the Unit's jurisdiction. If the Unit is successful in generating more cases from referrals of patient abuse or neglect, it would likely result in an increased workload for Unit staff, and the Unit could consider hiring additional staff to better handle the increased number of cases.

## **Seek approval from the Office of the Chief State's Attorney to implement a new case management system**

The Unit should seek approval from OCSA officials to implement a new, comprehensive system that meets the functional needs for Unit investigations. The Unit should also ensure that the new case management system has sufficient capacity to contain case documents, case information, and performance data. For example, the system should have the ability to (1) house all documents for each case; (2) upload documents and information even when investigators are in the field; (3) track case progression; (4) show joint cases with partner agencies and link those joint cases; and (5) include the cases' supervisory reviews.

## **Conduct and document supervisory reviews of case files in accordance with Unit policy**

The Unit should conduct and document reviews of case files consistent with Unit policy. The Unit should assess whether its current policy of monthly reviews should be revised to a quarterly or other less frequent schedule.

## **Ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes**

The Unit should ensure that it consistently reports all convictions, including those worked jointly with Federal partners, 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 ensure that it reports all adverse actions to the NPDB within 30 days of the action. The Unit could provide training to staff on reporting convictions and adverse actions to Federal partners and could implement automated reminders to alert staff about when to report the convictions and adverse actions.

# UNIT COMMENTS AND OIG RESPONSE

The Connecticut MFCU concurred with all four of our recommendations.

First, the Unit concurred with our recommendation to develop and implement outreach efforts to ensure that the Unit regularly receives referrals of patient abuse and neglect. The Unit reported that since our review, it has established minimum criteria for referrals and protocols to improve the referral process. The Unit also reported strengthening its relationships with stakeholders, such as the Department of Public Health, the Department of Developmental Services, the State Long-Term Care Ombudsman, the State's Agency on Aging, and the State Medicaid Agency. Additionally, the Unit reported that it is working on a request to its management to acquire a new nurse investigator position to assist with Unit investigations and conduct outreach and education regarding patient abuse and neglect.

Second, the Unit concurred with our recommendation to seek approval from the Office of the Chief State's Attorney (OCSA) to implement a new case management system. The Unit reported that it has notified OCSA of the need for a case management system to meet its case tracking needs. A new system would need to include, among other capabilities, the ability to house all documents for each case, upload documents and information while investigators are in the field, and track case progression.

Third, the Unit concurred with our recommendation to conduct and document supervisory reviews of case files in accordance with Unit policy. The Unit reported that technical difficulties during the COVID-19 pandemic inhibited the Unit from recording supervisory reviews in a timely manner but that those issues have been resolved. The Unit also reported that it has revised its policy regarding the frequency of supervisory reviews from a monthly to a quarterly schedule.

Fourth, the Unit concurred with our recommendation to ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes. The Unit stated that it has revised its reporting procedures and explained that the responsibility is now shared among the attorneys and auditors to encourage timely submissions of convictions and adverse actions.

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



# DETAILED METHODOLOGY

## Data Collection and Analysis

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

### Review of Unit Documentation

Prior to the onsite inspection, we reviewed the recertification analysis for FYs 2019–2021, which involved examining the Unit's recertification materials, including (1) the Unit's annual reports; (2) the Unit director's recertification questionnaires; (3) the Unit's MOU with DSS, OI, and the State Attorney General's Office; (4) the DSS program integrity director's questionnaires; and (5) the OI Special Agent in Charge questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for FYs 2019–2021. Additionally, we examined the recommendations from the 2014 OIG onsite review report and the Unit's implementation of the recommendations.

### Review of Unit Financial Documentation

We conducted a limited review of the Unit's control over its fiscal resources. Prior to the onsite inspection, we analyzed the Unit's responses to a questionnaire about internal controls and conducted a review of the Unit's quarterly financial reports. We followed up with OCSA officials and the Unit to clarify any issues identified in the questionnaire about internal controls. We also reviewed the Unit's fixed asset inventory by purposively selecting 30 of the Unit's 75 fixed assets and verifying those items onsite.

### Interviews with Key Stakeholders

In October 2021, we interviewed key stakeholders, including officials in DPH, DSS, OI, the U.S. Attorney's Office, and the Connecticut Attorney General's 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 these interviews to develop subsequent interview questions for Unit management and staff.

## Onsite Interviews with Unit Management and Selected Staff

We conducted structured interviews with the Unit's management and selected staff in November 2021. We interviewed the director, one other attorney, one auditor, and four investigators, including the chief investigator. In addition, we interviewed the supervisor of the Unit—the Deputy Chief State's Attorney. We asked these individuals questions related to (1) Unit operations; (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; (3) opportunities for the Unit to improve its operations and/or performance; (4) clarification regarding information obtained from other data sources; and (5) the Unit's training and technical assistance needs.

## Onsite Review of Case Files

To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2019–2021 and 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 was 219. We excluded all global civil cases from our review of the Unit's case files because global civil cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs. Thus, we excluded 98 global civil cases, leaving 121 case files. We then selected a simple random sample of 62 cases from the population of 121 cases. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with an absolute precision of no more than +/- 10 percent at the 95-percent confidence level. We reviewed the 62 case files for adherence to the relevant performance standards and compliance with statutes, regulations, and policy transmittals. During the onsite review of the sampled case files, 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 9 of the Unit's convictions that should have been submitted to OIG for program exclusion during our review period, and all 11 of the Unit's adverse actions that should have been submitted to the NPDB during our review period. We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and all adverse actions to the NPDB for FYs 2019–2021. We also assessed the timeliness of the submissions to OIG and the NPDB.

## Onsite Review of Unit Operations

During the onsite inspection, we observed the Unit's workspace and operations of the Unit's office in Rocky Hill. We observed the Unit's offices and meeting spaces; security of data and case files; location of select equipment; and the general functioning of the Unit.

# APPENDICES

## Appendix A: Unit Referrals by Source for Fiscal Years 2019–2021

Referral Source	FY 2019		FY 2020		FY 2021		3-Year Total		
	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	Total
Adult Protective Services	0	0	0	0	0	0	0	0	0
Anonymous	0	0	0	0	0	0	0	0	0
HHS-OIG	0	0	0	0	0	0	0	0	0
Law Enforcement (other)	0	0	0	0	0	0	0	0	0
Licensing Board	0	0	1	0	0	0	1	0	1
Local Prosecutor	0	0	0	0	0	0	0	0	0
Long-Term Care Ombudsman	0	0	0	0	0	0	0	0	0
Medicaid Agency (PI/SURS)	25	0	22	0	21	0	68	0	68
Medicaid Agency (other)	18	0	35	0	22	0	75	0	75
Private Citizen	3	0	0	0	1	0	4	0	4
Private Health Insurer	0	0	0	0	0	0	0	0	0
Provider	0	0	0	0	0	0	0	0	0
Provider Association	0	0	0	0	0	0	0	0	0
State Survey and Certification Agency	0	0	0	0	0	0	0	0	0
State Agency (other)	0	0	0	0	0	0	0	0	0
<b>Sub-Total</b>	<b>46</b>	<b>0</b>	<b>58</b>	<b>0</b>	<b>44</b>	<b>0</b>	<b>148</b>	<b>0</b>	<b>148</b>
<b>Total</b>	<b>46</b>		<b>58</b>		<b>44</b>		<b>148</b>		

Source: OIG analysis of Unit Annual Statistical Reports, FYs 2019–2021.

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

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases That Had Supervisory Approval To Open	62	96.77%	90.91%	98.35%
Percentage of All Cases Closed at the Time of Our Review*	62	32.26%	23.97%	42.51%
Percentage of All Closed Cases That Had Supervisory Approval To Close*	20	85.00%	65.31%	93.88%
Percentage of Eligible Cases That Contained Documentation of Supervisory Reviews Consistent with Unit Policy	60	5.00%	1.04%	13.92%
Percentage of Eligible Cases That Contained Documentation of Supervisory Reviews But Not Consistent with Unit Policy*	60	88.33%	77.43%	95.18%
Percentage of Eligible Cases That Contained No Documentation of Supervisory Review	60	6.67%	1.85%	16.20%

Source: OIG analysis of Connecticut MFCU case files, 2021.

\*The 95-percent confidence intervals for these estimates exceed 10-percent absolute precision.

## Appendix C: Unit Comments



PATRICK J. GRIFFIN  
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August 22, 2022

Suzanne Murrin  
Deputy Inspector General for Evaluations and Inspections  
Office of the Inspector General  
Department of Health and Human Services  
330 Independence Avenue, SW  
Room 5660, Cohen Building  
Washington, DC 20201

RE: Connecticut Medicaid Fraud Control Unit  
2021 Inspection for FY 2019-2021 OEI-06-21-00360

Dear Ms. Murrin,

The Connecticut Medicaid Fraud Control Unit is in receipt of your correspondence dated July 26, 2022, enclosing the *Connecticut Medicaid Fraud Control Unit: 2021 Inspection, OEI-06-21-00360*. We thank you and your team for the professionalism and dedication exhibited to improving the Unit. Working with your team has provided valuable insight and findings that will enable our Unit to progress and expand.

We appreciate the opportunity to respond to the findings reached.

**RECOMMENDATION ONE:** Develop and implement outreach efforts to ensure that the Unit regularly receives referrals of patient abuse and neglect.

**RESPONSE:** **The Unit concurs with this recommendation.**

Due to the pandemic and the former Unit Director's long-term illness, outreach efforts were hindered. The Unit had already begun to reinforce our outreach efforts and had received three abuse and/or neglect referrals, which was after OIG's review period but prior to OIG's onsite visit. After OIG's onsite visit, the Unit, through its new Director and Supervisory Inspector, have already had meetings with the Department of Public Health (DPH) on numerous occasions. We have reviewed our Memorandum of Understanding with DPH. We have established minimum criteria and established protocols to improve the referral process. We have continued to meet with DPH to ensure an open line of communication in order to continue to secure appropriate referrals. The Unit has also met with the Department of Developmental Services (DDS) to strengthen a

partnership. We explained our role and expanded jurisdiction. The Unit was provided, and took advantage of, the opportunity to attend DDS' investigator training, which is designed for their new investigators. The training provided our Unit insight and better understanding of DDS' investigative process, allowing us to advance partnership and referral development. The Unit has a scheduled meeting with the Connecticut State Long Term Ombudsman, with a goal towards building an alliance. The Unit has also had conversations with the State's Agency on Aging, introducing ourselves and our mission. We continuously meet and have conversations with the Department of Social Services, the State Medicaid agency, reinforcing our partnership. We are researching and collecting data to present to our management to acquire an additional position within our Unit of a Nurse Investigator. This position will not only enhance our investigations but will provide a community liaison. As noted in the recommendations, the Nurse Investigator will be instrumental with continued outreach and education for our community. With the Unit's successful generation of increased abuse/neglect referrals, we concur with the recommendation that there will be a need for additional staff.

**RECOMMENDATION TWO:** Seek approval from the Office of the Chief State's Attorney to implement a new case management system.

**RESPONSE: The Unit concurs with this recommendation.**

Connecticut Division of Criminal Justice is using a statewide case management system. However, the Unit understands that the functions of the MFCU are distinctive, therefore, we are exploring case management systems, with a focus on a system that excels in investigative functions, which mirror the recommendations of the audit, to include, but not be limited to, the ability to: house all documents for each case, upload documents and information even when in the field, track case progression, show joint cases with our partner agencies and link those cases together, and include the cases' supervisory reviews in the case management system. This case management system would be a supplement to the statewide case management system, thus meeting the comprehensive needs inherent to Medicaid fraud, abuse and/or neglect cases. Along with our IT department, we are meeting with another MFCU to explore their case management system. The Unit has notified management of its case tracking needs and is currently evaluating new case management options.

**RECOMMENDATION THREE:** Conduct and document supervisory reviews of case files in accordance with the Unit policy.

**RESPONSE: The Unit concurs with this recommendation.**

The Unit was performing supervisory reviews every 30 days. When the pandemic forced the closing of all State buildings, we were without computer access, therefore, while the supervisory reviews were being performed, it was impossible to input those reviews into our computerized files in a timely manner. Upon the new Director's appointment, computers with remote access were immediately ordered. All Unit members, except clerical, are now equipped with computers that have remote accessibility. The Unit, as well, has evaluated the policy of monthly reviews and revised that policy to quarterly reviews.

RECOMMENDATION FOUR: Ensure that all convictions and adverse actions are reported to Federal partners with the appropriate timeframes.

**RESPONSE: The Unit concurs with this recommendation.**

The Director has revised the reporting procedures. This responsibility is now divided among the attorneys and the financial fraud examiners (FFE)s, each having a portion of the obligation, to safeguard that the requirements are met in a timely manner. We have also reached out to the State Attorney General's office to request they also report adverse actions to our FFEs so that we may similarly report those actions.

The Connecticut Medicaid Fraud Control Unit embraces the opportunity to improve the Unit's effectiveness and efficiency. The information provided within the report is greatly appreciated. We look forward to our continued partnership.

Sincerely,



Marjorie Lynn Sozanski  
Supervisory Assistant State's Attorney  
Director Connecticut Medicaid Fraud Control Unit



# ACKNOWLEDGMENTS AND CONTACT

## Acknowledgments

Keith Peters of the Medicaid Fraud Policy and Oversight Division served as the team leader for this study, and Anna Brown served as the lead analyst. Others in the Office of Evaluation and Inspections who conducted the study include Jordan Clementi and Kristen Calille. Office of Evaluation and Inspections headquarters staff who provided support include Robert Gibbons and Sarah Swisher.

We would also like to acknowledge contributions of two special agents from the Office of Investigations, and a peer reviewer from another State MFCU.

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 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).

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**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.